MHBP

www.MHBP.com

Customer Service - 800.694.9901

MHBP SM

Brought to you by Aetna

2024

A Fee for Service High Deductible Health Plan (Consumer Option) 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 2024: Page 16
- Summary of Benefits: Page 126

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: $52 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:

481 Consumer Option - Self Only
483 Consumer Option - Self Plus One
482 Consumer Option - 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 71-016

Important Notice from MHBP About

Our Prescription Drug Coverage and Medicare

The US Office of Personnel Management has determined that 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 your FEHB plan 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 monthly Medicare Part D premium will go up at least 1 percent per month for every month that 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 many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may 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.

Potential Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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 800-694-9901 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) under contract (CS1146) between The National Postal Mail Handlers Union, AFL-CIO, a division of LIUNA and 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 800-694-9901 and through our website 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 a 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, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized on page 16. 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 Healthcare Fraud!

Fraud increases the cost of healthcare 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 healthcare provider, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 services 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 800-694-9901 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTHCARE 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 they are 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

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

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 healthcare 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 medication. 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 provider 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 healthcare 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 reaction 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 healthcare 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 healthcare providers and improve the quality of care you receive.
- The National Patient Safety Foundation has information on how to ensure safer healthcare 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 healthcare 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 healthcare 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 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.

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, give you other plans' brochures and 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
- 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, disability leave, pensions, etc., you must also contact your employing or retirement office.

Once enrolled in your FEHB Plan, you should contact your carrier directly for the following address updates and questions about your benefit coverage.

Enrollment types available for you and your family

Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family member. Family members include 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.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before 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 your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: 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 applies 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 for 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 2024 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 2023 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 an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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 additional information about your coverage choices. You can also visit OPM's website, www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you 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). 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, or if you are a covered 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 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 800-694-9901 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 Healthcare, Inc. (AAAHC).
- Administered by Claims Administration Corp., an Aetna company is NCQA accredited 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 Healthcare, 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 healthcare providers.

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 Consumer Option

MHBP Consumer Option is a High Deductible Health Plan (HDHP) and has a higher annual deductible and out-of-pocket maximum limit than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

We have Network providers

Our fee-for-service plan offers services through a network of healthcare providers. If you need assistance with locating a Network provider in your area contact us at 800-694-9901 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 healthcare professional or facility is still a Network provider. If your doctor is not currently participating in the provider network, you can nominate them 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 providers 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 healthcare 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 800-694-9901 for more information about other Non-Network participating providers.

How we pay providers

When you use a Network healthcare 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 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.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a Network provider.

Annual deductible

The annual deductible must be met before Plan benefits are paid for services other than Network Preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, excludes specific injury insurance and accident, disability, dental care, vision care, or long-term care coverage), not enrolled in Medicare, not have received VA (except for veterans with a service-connected disability) or Indian Health Service (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance or any other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA, up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The Internal Revenue Service (IRS) limits annual out-of-pocket expenses for covered services from Network providers, including deductibles, copayments and coinsurance, to no more than $6,750 for a Self Only enrollment, and $13,500 for a Self Plus One or Self and Family enrollment. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your annual out-of-pocket expenses for covered services from MHBP's Network providers, including deductibles, copayments and coinsurance, cannot exceed $6,000 for a Self Only enrollment, or $12,000 for a Self Plus One or Self and Family enrollment. For covered services from Non-Network providers your annual out-of-pocket expenses cannot exceed $7,500 for a Self Only enrollment or $15,000 for a Self Plus One or Self and Family enrollment.

Health Education resources and management tools

Section 5(i) describes the health education resources and account management tools available to help you manage your healthcare and your healthcare dollars.

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 at 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 800-694-9901, or write to: MHBP, PO 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 protected health 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 healthcare services are covered and payable under the health plan and the extent of such coverage and payment. The program assists members in receiving appropriate healthcare and maximizing coverage for those healthcare 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 Care Management Program (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 healthcare providers about cost-effective programs and alternative therapies and treatments.

Certain healthcare 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.

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 healthcare 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 2024

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 this Plan:

- Your share of the premium rate will not change for Consumer Option. *See back cover.*
- We updated our list of services that require prior approval, see Section 3, *How You Get Care.*
- We added coverage for artificial insemination procedures, see Section 5(a), *Infertility services.*
- We modified our gender affirming coverage, see Section 5(b), *Surgical procedures.*
- We added SilverScript Employer Prescription Drug Plan (PDP) under Medicare Part D, see Section 9, *Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP).*
- We modified the Maintenance Choice program, see Section 5(f), *Prescription drug benefits.*
- We removed the Kidney Support Program.
- We removed the ExtraCare® Health Discount Card Program.
- We added Maven's Family building support to our Enhanced Maternity Program, see Section 5(h), *Enhanced Maternity Program.*
- We updated the 2024 IRS HSA limits, see Section 5, *Consumer Option Benefits Overview.*

Clarifications:

- We clarified the conditions covered under our Gene-Based, Cellular and Other Innovative Therapies benefit, see Section 5(a), *Treatment therapies* and Section 5(c), *Outpatient hospital, freestanding ambulatory surgical center or clinic.*
- We clarified the professional services covered under mental health and substance use disorder benefits, see Section 5(e), *Mental Health and Substance Use Disorder Benefit.*

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 800-694-9901 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**

Covered 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 healthcare services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

Benefits are provided under this Plan for the services of covered providers, in accordance with 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.

We list network-contracted covered providers in our network provider directory, which we update periodically, and make available on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at 800-694-9901 for assistance.

- **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 use disorder 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 Healthcare (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 predicted 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 800-694-9901. 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.

Balance Billing Protection

FEHB Carriers must have clauses in their network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the network contracted amount. If a network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

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 determinations 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 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 hospital stay was medically necessary.

- If we determine that the stay was medically necessary, we will pay 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 60% 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 60% 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 60% 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 prior approval 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.

Note: When you have other primary group health insurance coverage and your primary insurance denies coverage, precertification is needed for your hospital admission even though we are secondary.

- 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 precertification is needed for your your hospital admission even though we are secondary.
- Your stay is less than 24 hours.

- Outpatient imaging procedures

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

- CT scan – Computed Tomography
- CTA – Computed Tomography Angiography
- MRI – Magnetic Resonance Imaging
- MRA – Magnetic Resonance Angiography
- 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 precertification 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.

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 preauthorization 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.

Note: When you have other primary group health insurance coverage and your primary insurance denies coverage, precertification is needed for your outpatient procedures even though we are secondary.

- The procedure is performed in an emergency situation.
- You have been admitted to a hospital on an inpatient basis.

- **Organ/tissue transplants**

We require prior approval for all organ/tissue transplant procedures and related services 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 prior approval in this case:
  - Transplant procedures performed outside the United States.

- Other services — Some services require precertification or prior approval 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 800-694-9901 as soon as the need for these services is determined.

  For a current list refer to: 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 affirming surgery
  - Gene therapy, gene editing and gene silencing
  - Hip surgery to repair impingement syndrome
  - Hip and knee arthroplasties
  - Hyperbaric oxygen therapy
  - Infertility services
  - 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)
- 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)
- Rhythm implantable devices
- Shoulder arthroplasty
- Specialty drugs
- Spinal procedures, such as Artificial intervertebral disc surgery, Cervical, lumbar and thoracic laminectomy/laminotomy procedures, Spinal fusion surgery, Sacroiliac joint fusions, Vertebral corpectomy
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices

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 certain specialty drugs used for long term therapy from CVS Caremark. To speak to a CVS Caremark representative, please call 866-623-1441.

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 800-694-9901 at least two working days 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 that possesses an average knowledge of health and medicines.

  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 800-694-9901. 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, then call us at 800-694-9901. 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 representative, 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 hospital stay, the newborn is considered a patient in their 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.

If your claim is in reference to a contraceptive, call us at 800-694-9901.

- **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 healthcare 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.

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 see your Network provider you pay a copayment of $15 per visit after your calendar year deductible has been met.

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 calendar year deductible is:
  - Network: $2,000 for a Self Only enrollment and $4,000 for a Self Plus One or Self and Family enrollment. The Network deductible applies only to services received from Network providers.
  - Non-Network: $2,000 for a Self Only enrollment and a $4,000 for a 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. Under a Self Plus One or 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 under Traditional Health Coverage. Coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 40% of our allowance 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 an office visit but routinely waives your $15 copayment, the actual charge is $85. We will pay $70 ($15 less than the actual charge of $85).

To help keep your coinsurance out-of-pocket costs to a minimum, we encourage you to call us at 800-694-9901 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 800-694-9901.

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 copayments. Here is an example: You see a Network physician for an office visit who charges $150, but our allowance is $100. If you've already met your deductible, you are only responsible for your copayment. That is, you pay just $15 of our $100 allowance for an office visit. Because of the agreement, your Network physician will not bill you for the $50 difference between our allowance and the 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 an example: You see a Non-Network physician who charges $150 and our allowance is again $100. If you've met your deductible, you are only responsible for your coinsurance, so you pay 40% of our $100 allowance ($40). 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 the bill. For details on how we determine the Plan allowance, please see Section 10.

The following 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 example uses a service for which the physician charges $150 and our allowance is $100. It shows the amount you pay if you have met your calendar year deductible.

EXAMPLE

Network physician
Physician's charge: $150
We set our allowance: $100
We pay: $85
You owe: $15
No Difference up to charge: $0
TOTAL YOU PAY: $15

Non-Network physician
Physician's charge: $150
We set our allowance at: $100
We pay 60% of our allowance: $60
You owe 40% of our allowance: $40
Yes Difference up to charge: $50
TOTAL YOU PAY: $90

Differences between our allowance and the bill

If you have an HSA, you can choose to use funds from your HSA to pay these amounts, or you can pay them out-of-pocket. If you have an HRA, we will withdraw the amount from your HRA if funds are available. After you have exhausted your HSA or HRA, you will be responsible for paying your remaining deductible and also copayments and coinsurance under the Traditional Health Coverage.

Note: We encourage you to use Network providers because it will make the amounts in your HSA or HRA last longer.

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.

You should also see in this section, *Important Notice About Surprise Billing – Know Your Rights* for a description of your protections against surprise billing under the No Surprises Act.

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:

Network benefit: Your catastrophic protection out-of-pocket maximum is $6,000 per person ($12,000 per family) when you use Network providers/facilities and pharmacies. Only eligible expenses for Network providers/facilities and pharmacies count toward this limit. The family limit applies to both Self Plus One and Self and Family enrollments.

Out of pocket expenses for purposes of this benefit are:

- Your annual deductible
- The copayments or coinsurance you pay for covered Network services under the Traditional Health Coverage

Non-Network benefit: Your catastrophic protection out-of-pocket maximum is $7,500 per person ($15,000 per family) when you use Non-Network providers/facilities. Only eligible expenses for Non-Network providers/facilities count toward this limit.

Out of pocket expenses for purposes of this benefit are:

- Your annual deductible
- The 40% coinsurance you pay for covered Non-Network services under the Traditional Health Coverage

After an individual family member reaches the maximum out-of-pocket expenses of $6,000 ($7,500 Non-Network) and the remaining family members reach $12,000 ($15,000 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. Healthcare 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's 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.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for non-network emergency services; non-network non-emergency services provided with respect to a visit to a participating health care facility; and non-network air ambulance services.

A surprise bill is an unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan. Your health plan must comply with the NSA protections that hold you harmless from surprise bills. Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the out-of-network provider based on the median in-network rate or such other data resources or factors as determined by Aetna. Your cost share paid with respect to the items and services will be based on the qualifying payment amount, as defined under the No Surprises Act, and applied toward your in-network deductible (if you have one) and out-of-pocket maximum.

Please note: there are certain circumstances under the law where a provider can give you notice that they are out of network and you can consent to receiving a balance bill. For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.MHBP.com or contact the health plan at 800-694-9901.

The Federal Flexible Spending Account Program-*FSAFEDS*

Healthcare FSA (HCFSA) – Reimburses you for eligible out-of-pocket healthcare 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 5. Consumer Option Benefits

MHBP offers a High-Deductible Health Plan (HDHP) called Consumer Option. The Consumer Option benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

Consumer Option Section 5, which describes the Consumer Option benefits, is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claim filing advice, or more information about your Consumer Option benefits, contact us at 800-694-9901 or visit our website at www.MHBP.com.

See page 16 for how our benefits change this year and page 126 for a benefits summary.

Consumer Option Benefits Overview

MHBP Consumer Option is a High Deductible Health Plan (HDHP) that provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your healthcare benefits.

Consumer Option Section 5, which describes the Consumer Option benefits, is divided into subsections. Please read *Important things you should keep in mind* about these benefits at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 800-694-9901 or visit our website at www.MHBP.com.

When you enroll in the MHBP Consumer Option, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this plan, Network preventive care is covered in full for the listed services. As you receive other non-preventive covered medical care, you must meet the Plan's deductible before we pay Traditional medical coverage benefits. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward the deductible entirely out-of-pocket, allowing your savings to continue to grow.

The MHBP Consumer Option includes five key components: Network preventive care; traditional medical coverage that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

Network preventive care

Consumer Option covers preventive care services such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), prenatal care, routine well-child care, child and adult immunizations, tobacco cessation programs, disease management and wellness programs. These services are covered at 100% if you use a Network provider and are described in Section 5, *Network Preventive Care*. You do not have to meet the deductible to receive these benefits. Non-Network preventive care is not covered.

Traditional medical care

After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. You pay a copayment for Network services and 40% coinsurance for Non-Network services. Covered services include:

- Medical services and supplies provided by physicians and other healthcare professionals
- Surgical and anesthesia services provided by physicians and other healthcare professionals
- Hospital services, other facility or ambulance services
- Emergency services/accidents
- Mental health and substance use disorder benefits
- Prescription drug benefits

Savings

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see the chart beginning on page 35 for more details).

- **Health Savings Accounts (HSA)**

By law, health savings accounts are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, are not covered under their own, or their spouse's FSA, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits within the last three months, and do not have another health plan other than another High-Deductible Health Plan. In 2024, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $100 per month for a Self Only enrollment or $200 per month for a Self Plus One or Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $4,150 for a Self Only enrollment or $8,300 for a Self Plus One or Self and Family enrollment. See maximum contribution information on page 40. You can use funds in your HSA to help pay your Plan deductible. You own your HSA, so the funds can go with you if you happen to change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after-tax out-of-pocket dollars. If you do not deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses. When you calculate the amount of your contribution(s), keep in mind that the Plan also makes monthly contributions to your HSA, and that the combined total of all contributions cannot exceed the limit established by law.

HSA features include:

- The administrator and custodian for your HSA is PayFlex Systems USA, Inc.
- Your contributions to the HSA are tax deductible up to the limit allowed by law
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (e.g., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest on any investment gains through a choice of voluntary investment options
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS Publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable – the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available

Important consideration if you want to participate in a Healthcare Flexible Spending Account (HCFSA): If you are enrolled in the MHBP Consumer Option with a Health Savings Account (HSA) and start or become covered by a HCFSA (such as FSAFEDS offers – see Section 3), the MHBP Consumer Option cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

- **Health Reimbursement Arrangements (HRA)**

If you are not eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will establish and administer an HRA instead. You must notify us that you are not eligible for an HSA.

In 2024, we will give you an HRA credit of up to $1,200 per year for a Self Only enrollment or up to $2,400 for a Self Plus One or Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that do not count toward the deductible. Once we have established an HRA for you, you cannot change to an HSA for the remainder of the calendar year, even if your eligibility for an HSA changes.

HRA Features include:

- Your HRA is administered by MHBP
- Your entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this Plan
- Unused credits carry over from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Healthcare Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

Catastrophic protection for out-of-pocket expenses	When you use network providers, your maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $6,000 for a Self Only enrollment or $12,000 for a Self Plus One or Self and Family enrollment for services from Network providers ($7,500 Self Only or $15,000 Self Plus One or Self and Family for Non-Network providers). However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowance or benefit maximum). Refer to Section 4, *Your catastrophic protection out-of-pocket maximum*, and Consumer Option Section 5, *Traditional medical care* for more details.
Health education resources and account management tools	Consumer Option Section 5(i) describes the health education resources and account management tools available to help you manage your healthcare and your healthcare dollars.

Savings - HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
Administrator	We will establish an HSA for you. The administrator and custodian for your HSA is PayFlex Systems USA, Inc. PayFlex Systems USA, Inc PO Box 3317 Carol Stream, IL 60132-3317 855-288-4507	MHBP is the administrator for your HRA: MHBP PO Box 981106 El Paso, TX 79998-1106 800-694-9901
Fees	Set-up and monthly administrative fees are paid by the MHBP. Returned Deposit Check: $25.00 Insufficient Funds: $25.00 Stop Payment of Check: $25.00 Returned EFT Deposit: $25.00 Account closing: $25.00 Lost/Stolen Debit Card Replacement: None Paper Statement: $1.50	None
Eligibility	You must: • Enroll in the MHBP Consumer Option • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's Federal tax return • Not have received VA (except for veterans with a service-connected disability) or IHS benefits in the last three months • Not be covered by your own, or someone else's Healthcare Flexible Spending Account (HCFSA) • Complete and return all banking paperwork	You must enroll in the MHBP Consumer Option. Eligibility is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.
Funding		Eligibility for the annual credit will be determined on the first day of the month and will be prorated for mid-year enrollment. The entire amount of your HRA will be available to you upon your enrollment.

	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in this Plan. Note: If your effective date in the HSA is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (e. g., Employee Express, MyPay, etc.).	
• **Self Only enrollment**	For 2024, a monthly premium pass through of $100 will be made by this Plan directly into your HSA each month.	For 2024, your HRA annual credit is $1,200 (prorated for mid-year enrollment).
• **Self Plus One enrollment**	For 2024, a monthly premium pass through of $200 will be made by this Plan directly into your HSA each month.	For 2024, your HRA annual credit is $2,400 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2024, a monthly premium pass through of $200 will be made by this Plan directly into your HSA each month.	For 2024, your HRA annual credit is $2,400 (prorated for mid-year enrollment).
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of the Plan's premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $4,150 for a Self Only enrollment and $8,300 for a Self Plus One and Self and Family enrollment. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may roll over funds you have in other HSAs to this Plan's HSA (rollover funds do not affect your annual maximum contribution under this Plan). HSAs can earn tax-free interest (does not affect your annual maximum contribution). Additional contributions are discussed on page 39.	
• Self Only enrollment	You may make an annual maximum contribution of up to $2,950.	You cannot contribute to the HRA.
• Self and Family enrollment	You may make an annual maximum contribution of up to $5,900.	You cannot contribute to the HRA.
• Self Plus One enrollment	You may make an annual maximum contribution of up to $5,900.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit card • Online member portal • Connected claims option – you can elect to have your claims sent directly to your HSA to pay for qualified out-of-pocket expenses. We will alert you that you have a claim and you can choose to pay the provider, pay yourself or archive the claim. • Direct Deposit – Reimbursements can be sent electronically to personal checking or savings accounts. Access this feature from the member portal.	For qualified medical expenses under this Plan, you or your provider will be automatically reimbursed when claims are submitted to the MHBP Consumer Option. For expenses not covered by this Plan, such as orthodontia, you can request a reimbursement form by phone or obtain one on-line at www.MHBP.com.
Distributions/ withdrawals • **Medical expenses**	You can pay the out-of-pocket medical expenses for yourself, your spouse or your dependents (even if they are not covered by this Plan) from the funds available in your HSA. Your HSA is established the first of the month following the effective date of your enrollment. If this Plan is effective on a date other than the first of the month, the earliest date medical expenses will be allowed is the first of the next month.	The available credit in your HRA will be used to pay the out-of-pocket expenses for qualified medical expenses for individuals covered under this Plan. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA.

	If you incur a medical expense between your Plan effective date but before your HSA is effective, you will not be able to use your HSA to reimburse yourself for those expenses. See IRS Publication 502 for a complete list of eligible expenses (www.irs.gov/pub/irs-pdf/p502.pdf).	See IRS Publication 502 for a list of eligible expenses (www.irs.gov/pub/irs-pdf/p502.pdf). Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical expenses**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	If you are under age 65, distributions will not be made for anything other than non-reimbursed qualified medical expenses. When you turn age 65, distributions will not be made for anything other than non-reimbursed qualified medical expenses, except that Medicare premiums are reimbursable.
• **Availability of funds**	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this Plan is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • MHBP receives record of your enrollment and establishes your HSA account and contributes the minimum amount required to establish an HSA. • You can withdraw funds for expenses incurred on or after the date the HSA was initially established.	The entire amount of your HRA will be available to you upon your enrollment in this Plan.
Account owner	FEHB enrollee	MHBP
Portability	You own your HSA and can take it with you when you leave Federal employment, change health plans or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See Section *Savings - HSAs and HRAs under Eligibility* for HSA eligibility.	If you retire and remain in the MHBP Consumer Option, you may continue to use and accumulate credits in your HRA. If you terminate Federal employment or change health plans, only eligible expenses incurred while covered under the MHBP Consumer Option will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions (if available), or you may make lump sum contributions at any time, in any amount not to exceed the annual maximum limit. If you contribute, you can claim the amount contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

  Contact us at 800-694-9901 for more details.

- **Over age 55 additional contributions**

  If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable additional contribution will be $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS website at www.irs.gov or request a copy of IRS Publication 969 by calling 1-800-829-3676.

- **If you die**

  If you have not named a beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, **physician prescribed** over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you have enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although **physician prescribed** over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You can review the activity on your HSA by logging into the secure member portal available at www.MHBP.com. You can also request paper monthly activity statements at an additional charge of $1.50 per month. This fee will be debited from your HSA Cash Account.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

Investment options

Participation in voluntary investment options is entirely optional and neither MHBP nor PayFlex Systems USA, Inc. is or will be acting in the capacity of a registered investment advisor.

Account holders who exceed the minimum required balance of $1,000 in their HSA cash account, will have a number of different investment options to choose from that are offered by different organizations that have been selected by PayFlex Systems USA, Inc. These funds are distributed through BYN Mellon and are not offered or insured by PayFlex Systems USA, Inc. or BYN Mellon. Note: Investment options are subject to change. Balances in these investment options may fluctuate up or down and are not insured by the FDIC or other government agencies.

Contact PayFlex Systems USA at 855-288-4507 for a complete list of the current investment options.

If you have an HRA

- **Why an HRA is established**

If you do not qualify for an HSA when you enroll in this Plan, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

Please review the chart beginning on page 35 which details the differences between an HRA and an HSA. The major differences are:

- You cannot make contributions to an HRA
- Funds are forfeited if you leave this Plan
- An HRA does not earn interest, and
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by this Plan. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Network Preventive Care

Important things you should keep in mind about these benefits:

- Under the Consumer Option, we pay 100% for the preventive care services listed in this Section as long as you use a Network provider. Non-Network preventive care is not covered. For all other covered expenses, please see Traditional medical coverage.
- The Consumer Option calendar year deductible does not apply to Network preventive care 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.

Benefits description	You pay
Preventive care, adult	**Consumer Option**
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 Note: To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Please contact us at 800-694-9901 to obtain information on the specific tests covered under this benefit.	Nothing
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 - Sigmoidoscopy Note: Expenses for anesthesia and outpatient facility services related to covered colorectal cancer screening are covered under this benefit. • Medical nutrition therapy and Intensive Behavioral Therapy, including prevention of obesity related co-morbidities - limited to 26 visits per person per calendar year Note: Visits exceeding the 26 limit maximum will be covered under Section 5(a), Diagnostic and treatment services. • Individual counseling on prevention and reducing health risks • Immunizations such as influenza, human papillomavirus (HPV), Pneumococcal, shingles, and tetanus/Tdap. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/ Note: This benefit covers the immunization only. Note: Some seasonal and non-seasonal vaccines may also be obtained from our Vaccine Network Pharmacy Program. Visit our website, www.MHBP.com or call 866-623-1441 to locate a participating pharmacy. • Prostate cancer screening (PSA) - one per calendar year for men age 40 and 69. • 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 https://shorturl.at/hovHM. • Screening and counseling for prenatal and postpartum depression	Nothing

Preventive care, adult - continued on next page

Benefits description	You pay
Preventive care, adult (cont.)	**Consumer Option**
• Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at www.healthcare.gov/preventive-care-women/ • Routine mammogram Note: For breastfeeding equipment, we limit our benefit for the rental to an amount no greater than what we would have paid if the equipment had been purchased. Call us at 800-694-9901 during your last trimester of pregnancy and submit your physician's order. We can provide additional coverage details and information about Network providers. Note: Brand name oral contraceptive drugs that have a generic equivalent are covered under Section 5(f), Prescription Drug Benefits.	Nothing
Voluntary sterilization for women limited to tubal ligations (including related expenses for anesthesia and outpatient facility services, if necessary)	Nothing
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 drug approved by the FDA to treat nicotine dependence may be obtained from a Network retail pharmacy or through our mail order drug program. 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 recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing
Not covered: • *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*
Preventive care, children	**Consumer Option**
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 • Immunizations such as DTaP/Tdap, 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.htm	Nothing

Preventive care, children - continued on next page

Benefits description	You pay
Preventive care, children (cont.)	**Consumer Option**
Note: To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Some seasonal and non-seasonal vaccines may also be obtained from our Vaccine Network Pharmacy Program. Visit our website, www.MHBP.com or call 866-623-1441 to locate a participating pharmacy. You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://shorturl.at/hovHM. 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 recommended listing of services will be subject to the applicable member copayment, coinsurance and/or deductible.	Nothing
Not covered: • *Routine physical checkups and related tests provided in an urgent care setting* • *Flu vaccines obtained from a non-participating provider* • *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*
Preventive care medications	**Consumer Option**
• CVS Caremark ACA No-Cost Preventive Services List. A complete list is available online at www.caremark.com • 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". A complete list is available online at https://shorturl.at/hovHM. - Aspirin (81 mg) for adults 50-59 and women of childbearing age - Folic acid supplements for women of childbearing age, 400 & 800 mcg Note: Your doctor must write a prescription for these preventive services to be covered by the plan, even if they are listed as over-the-counter. Changes can occur throughout the year.	Nothing

Preventive care medications - continued on next page

Benefits description	You pay
Preventive care medications (cont.)	**Consumer Option**
Contraceptive drugs and devices as listed in the ACA/HRSA site, coverage includes: • Oral contraceptives • Emergency Contraceptives • Injectable Contraceptives • Miscellaneous Contraceptives —Intrauterine Devices, Subdermal Rods & Vaginal Rings • Contraceptive transdermal patches • Barrier Methods- Cervical Caps and Diaphragms • OTC—Contraceptives (requires prescription) • Vaginal pH Modulators Call us at 800-694-9901 for our contraceptive exception process or for information on our reimbursement for OTC contraceptives (prescription required).	Nothing

Traditional Medical Coverage Subject to the Deductible

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.
- Network preventive care is covered at 100% and is not subject to the calendar year deductible.
- The Network deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. There is a separate Non-Network deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. Incurred expenses do not apply toward both limits. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before Traditional medical coverage begins.
- Under Traditional medical coverage, you are responsible for your copayments, coinsurance and amounts in excess of the Plan's allowance for covered medical expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your copayments, coinsurance and deductible total $6,000 for a Self Only enrollment or $12,000 for a Self Plus One or Self and Family enrollment in any calendar year for services from Network providers ($7,500 Self Only or $15,000 Self Plus One or Self and Family for Non-Network providers), you do not have to pay any more for covered services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or, if you use Non-Network providers, amounts in excess of the Plan's allowance).
- The Consumer Option provides coverage for both Network and Non-Network providers. The Non-Network benefits are the regular benefits under the Traditional medical coverage. 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.

Benefits description	You pay After the calendar year deductible...
Traditional Medical Coverage Subject to the Deductible	**You Pay**
The deductible applies to all benefits under Traditional medical coverage. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from Network or Non-Network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the Network or Non-Network deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment.
After you meet the deductible, we pay the allowable charge (less your copayment or coinsurance) until you meet the annual catastrophic out-of-pocket maximum.	Network: After you meet the deductible, you pay the indicated copayments or coinsurance for covered services. You may choose to pay the copayments or coinsurance from your HSA, or you can pay for them out-of-pocket. If you have an HRA, we will withdraw the amount from your HRA if funds are available. Non-Network: After you meet the deductible, you pay the indicated coinsurance based on our Plan's allowance and any difference between our allowance and the billed amount. You may choose to pay the copayments or coinsurance from your HSA, or you can pay for them out-of-pocket. If you have an HRA, we will withdraw the amount from your HRA if funds are available.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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 Network deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. There is a separate Non-Network deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. Incurred expenses do not apply toward both limits. The family deductible can be satisfied by one or more family members.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments or coinsurance for Network services and for coinsurance amounts in excess of the Plan's allowance for Non-Network services.
- 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.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- 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 AND NUCLEAR STRESS TESTS. Please refer to the prior approval procedures in Section 3.

Benefits description	You pay After the calendar year deductible...
Diagnostic and treatment services	**Consumer Option**
Professional services of physicians, including telephonic and video conferencing: • In physician's office (this includes evaluation and management services related to chemotherapy, hemodialysis and radiation therapy) • 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) • Medical nutrition therapy, adult Note: Certain specialty drugs, oncology drugs and growth hormones require prior approval; see Section 3, *Other services* under *You need prior plan approval for certain services*. Note: See Section 10, *Plan allowance* for information on comprehensive and problem-oriented services during the same office visit.	Network: $15 copayment per visit, including testing performed and billed in conjunction with the visit 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 walk-in clinic (except in a MinuteClinic®) including telehealth visits. See walk-in clinic, Section 10, *Definitions* Note: For services related to an accidental injury or medical emergency, see Section 5(d).	Network: $5 copayment per visit 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

Benefits description	You pay After the calendar year deductible...
Diagnostic and treatment services (cont.)	**Consumer Option**
Professional non-emergency services provided in a MinuteClinic®, including telehealth visits. See walk-in clinic, Section 10, *Definitions* Note: For services related to an accidental injury or medical emergency, see Section 5(d).	Network: Nothing Non-Network: All charges
Professional services of physicians: • During a hospital stay • At home visit Note: Outpatient cancer treatment and dialysis services are paid under Section 5(a), *Treatment therapies.* Note: For services related to an accidental injury or medical emergency, see Section 5(d).	Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Routine physical checkups and related tests, except those covered under preventive care* • *Thermography and related visits* • *Orthoptic visits and related services*	*All charges*
TeleHealth Services	**Consumer Option**
TeleHealth consultations are available to members in the 50 United States through our vendor 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 consult only). Note: For Behavioral Health telemedicine consults, see Section 5(e), *TeleHealth services.*	Network: Nothing Non-Network: All charges
Lab, X-ray and other diagnostic tests	**Consumer Option**
Tests, such as: • Blood tests • CT scans, CTA, MRA, MRI, NC, PET, SPECT Note: Prior approval is required. Call us at 800-694-9901. See Section 3, *Other services under You need prior Plan approval for certain services.* • Electrocardiogram and EEG • Hearing exam for non-auditory illness or disease • Non-routine mammograms • Pap tests • Pathology • Unattended or home sleep studies • Ultrasound • Urinalysis • X-rays	Network: $15 copayment per visit 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

Benefits description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests (cont.)	**Consumer Option**
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: $15 copayment per visit 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 800-694-9901. 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: $150 copayment per occurrence 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 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 copayments and coinsurance.	Nothing
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 800-694-9901. 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: $15 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Handling, delivery 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*

Benefits description	You pay After the calendar year deductible...
Maternity care	**Consumer Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Delivery • Anesthesia • Screening and counseling for prenatal and postpartum depression 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. • 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, *You need prior 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. • Hospital services are covered under Section 5(c). • When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. • Maternity benefits will be paid at the termination of pregnancy. 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 the member receives under a surrogacy contract or agreement. Expenses of the new-born 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.* Note: See Section 5, *Network Preventive Care*, for coverage of prenatal care, gestational diabetes screening and breastfeeding counseling and support.	Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Standby doctors* • *Home uterine monitoring devices* • *Services provided to the newborn if the infant is not covered under your Family enrollment*	*All charges*

Benefits description	You pay After the calendar year deductible...
Family planning	**Consumer Option**
Voluntary family planning services, limited to: • Voluntary sterilization (tubal ligations) for women (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) • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptive drugs and devices under Section 5(f), *Prescription Drug Benefits*. Note: We cover voluntary sterilization for men under Section 5(b), *Surgical procedures.*	Network: See Section 5, *Network Preventive Care.* Non-Network: 40% 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*
Infertility services	**Consumer Option**
Infertility is disease or medical condition defined as when a person if unable to conceive or produce conception after 1 year of regular sexual intercourse when the individual attempting conception is under 35 years of age, or after 6 months of regular sexual intercourse when the individual attempting conception is 35 years of age or older. Alternatively, infertility can be established by regular sperm insemination(s) (intrauterine, intracervical, or intravaginal), either with or without ovulation induction medication, when the individual attempting conception is under 35 years of age or regular sperm insemination(s) when the individual attempting conception is 35 years of age or older. This definition applies to all individuals regardless of sexual orientation or the presence/availability of a partner. Infertility may also be established by the demonstration of a disease of the reproductive tract such that regular egg-sperm contact would be ineffective. Diagnosis and treatment of infertility, such as: • Testing for diagnosis and surgical treatment of the underlying medical cause of infertility • Fertility preservation procedures (retrieval of and freezing of eggs or sperm with initial storage) for members facing the possibility of infertility caused by chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or ovary or testicle removal for treatment of disease • Comprehensive Infertility Services: - Artificial insemination (AI) and monitoring of ovulation: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI)	Network: $15 copayment per office visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Infertility services - continued on next page

Benefits description	You pay After the calendar year deductible...
Infertility services (cont.)	**Consumer Option**
- Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries - Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services Note: We limit Artificial Insemination to 6 cycles annually. The Plan defines a "cycle" as: • An attempt at ovulation induction while on injectable medication to stimulate the ovaries with or without artificial insemination • An artificial insemination cycle with or without injectable medication to stimulate the ovaries You are eligible for these covered services if: • You or your partner have been diagnosed with infertility. • You have met the requirement for the number of months trying to conceive through egg and sperm contact. • Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's infertility clinical policy. Note: Fertility preservation procedures and Comprehensive Infertility Services require prior approval, including treatment outside the 50 United States. Note: For Fertility drugs see Section 5(f), Prescription drug coverage. Certain injectable fertility drugs, including but not limited to menotropins, hCG, and GnRH agonists require prior approval. Our National Infertility Unit is staffed with a dedicated team of registered nurses and infertility coordinators. They can help you understanding your benefits and the prior approval process. You can learn more by calling us at 800-575-5999 or visit Www.AetnaInfertilityCare.com.	Network: $15 copayment per office visit 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:* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) program* - *Cryopreserved embryo transfers* - *Gestational carrier cycles* • *Services and supplies related to ART procedures, except as stated above* • *Cost of donor sperm or egg* • *Sperm bank collection fees* • *Surrogacy (host uterus/gestational carrier)* • *Elective fertility preservation, such as egg freezing sought due to natural aging;*	*All charges*

Infertility services - continued on next page

Benefits description	You pay After the calendar year deductible...
Infertility services (cont.)	**Consumer Option**
• *Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy* • *Storage costs, except as stated above* • *Coverage for services received by a spouse or partner who is not a covered member under the plan*	*All charges*
Allergy care	**Consumer Option**
Testing and treatment, including materials	Network: $15 copayment per visit, including testing performed and billed in conjunction with the visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Allergy injections, including allergy serum	Network: $15 copayment per visit 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*
Treatment therapies	**Consumer Option**
• Chemotherapy and radiation therapy for treatment of cancer Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under 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 800-694-9901 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(f), *Prescription Drug Benefits.* Note: Certain specialty drugs, oncology drugs and growth hormones require prior approval; see Section 3, *Other services under You need prior Plan approval for certain services.*	Network: $15 copayment per visit for services provided in a physician's office or clinic; $75 copayment per outpatient hospital visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefits description	You pay After the calendar year deductible...
Treatment therapies (cont.)	**Consumer Option**
• Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy (including TPN) • Respiratory therapy • Inhalation therapy • Growth hormone therapy • Chelation therapy Note: Prior approval may be required. Call us at 800-694-9901 prior to scheduling treatment. See Section 3, *Other services* under Y*ou 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: Certain specialty drugs, oncology drugs and growth hormones require prior approval; see Section 3, *Other services* under *You need prior Plan approval for certain services.* Note: See section 5(e) for coverage of applied behavior analysis therapy.	Network: $15 copayment per office, clinic or home visit; $75 copayment per outpatient hospital visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Rabies shots and related services	Network: $15 copayment per office visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
• Pulmonary rehabilitation therapy- limited to 36 visits per person per calendar year • Cardiac rehabilitation therapy (Phase 1 and 2 only) - limited to 24 visits per person per calendar year	Network: $15 copayment per office, clinic or home visit; $75 copayment per outpatient hospital visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Gene-Based, Cellular and Other Innovative Therapies (GCIT™) Designated Network Program – our program helps patients who have been diagnosed with certain genetic conditions that may be treated with the use of innovative FDA-approved GCIT products. Services related to GCIT include, but not limited to: • Cellular immunotherapies • Genetically modified oncolytic viral therapy • Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions • Human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using: Luxturna® (Voretigene neparvovec), Zolgensma® (Onasemnogene abeparvovec-xioi), Spinraza® (Nusinersen) • Products derived from gene editing technologies, including CRISPR-Cas9 • Oligonucleotide-based therapies including: - Antisense (Example: Spinraza®) - siRNA	GCIT Network: $15 copayment per visit for services provided in a physician's office or clinic; $75 copayment per outpatient hospital visit Non-Network: All Charges

Treatment therapies - continued on next page

Benefits description	You pay After the calendar year deductible...
Treatment therapies (cont.)	**Consumer Option**
To receive the Network level of benefits, you must choose an GCIT facility, and all related services must be received at that facility. Note: Prior approval is required, including treatment outside the 50 United States. Call us at 800-694-9901 prior to scheduling. See Section 3, *Outpatient imaging procedures* under *You need prior Plan approval for certain services* Note: See Section 5(c), *Outpatient hospital* for services provided by a hospital. Note: See Section 5(h), *Aetna Institutes* for travel assistance.	GCIT Network: $15 copayment per visit for services provided in a physician's office or clinic; $75 copayment per outpatient hospital visit Non-Network: All Charges

Treatment therapies - continued on next page

Benefits description	You pay After the calendar year deductible...
Treatment therapies (cont.)	**Consumer Option**
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*	*All charges*
Hearing services (testing, treatment and supplies)	**Consumer Option**
Routine hearing exam and testing Note: For child screening, testing, diagnosis, and treatment, see Section 5(a), *Preventive care, children.* 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: $15 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Physical, occupational and speech therapies	**Consumer Option**
Outpatient physical therapy, speech therapy, and occupational therapy Note: Benefits for combined therapies annual maximum for physical, occupational, speech therapy, chiropractic care and alternative treatments are limited to 40 visits per person per calendar year and 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: $15 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Exercise programs* • *Massage therapy*	*All charges*
Vision services (testing, treatment, and supplies)	**Consumer Option**
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 physicians.* Note: See *Non-FEHB Benefits* section for possible vision discount opportunities.	Network: All charges over $50 for one set of eyeglasses or $100 for contact lenses Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $50 for eyeglasses and $100 for contact lenses

Vision services (testing, treatment, and supplies) - continued on next page

Benefits description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies) (cont.)	**Consumer Option**
Dilated retinal eye exam • Non-routine • For established diabetics	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*
Foot care	**Consumer Option**
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: $15 copayment per office 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*
Orthopedic and prosthetic devices	**Consumer Option**
Orthopedic and prosthetic devices, see Section 10, *Definitions,* when recommended by an MD or DO, 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: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Hearing aid – every five (5) calendar years Note: See *Non-FEHB Benefits section* for possible hearing aid discount opportunities.	All charges over $1,500

Orthopedic and prosthetic devices - continued on next page

Benefits description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	**Consumer Option**
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* • *Orthotics, splints, stents and appliances used to treat TMJ and/or sleep apnea*	*All charges*
Durable medical equipment (DME)	**Consumer Option**
Durable medical equipment (DME) is equipment, supplies or medical foods 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 • Hospital beds • Continuous glucose monitors (CGMs) and supplies • Ostomy supplies (including supplies purchased at a pharmacy) • Medical foods for the treatment of Inborn Errors of Metabolism when administered under the direction of a physician • Home INR (International Normalized Ratio) monitors and testing materials used in conjunction with anticoagulation therapy when provided by a DME vendor • Audible prescription reading devices Note: Prior approval is required for audible prescription reading devices. Call us at 800-694-9901. See Section 3, *Other services* under *You need prior Plan approval for certain services*.	Network: Nothing 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

Benefits description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	**Consumer Option**
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: When Medicare Part B is your primary payor, drugs and diabetic supplies, such as glucose meters and testing materials will be covered under this benefit, even if purchased at a pharmacy. Note: See Section 5(a), *Treatment 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, *Network Preventive Care,* for coverage of breastfeeding equipment.	Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Augmentative and alternative communication (AAC) devices	Network: All charges after the Plan has paid $500 per device Non-Network: All charges after the Plan has paid $500 per device
Not covered: • *Equipment replacements unless medically necessary* • *Safety, hygiene, convenience and exercise equipment* • *Household, vehicle modifications and upgrades, including chair or van lifts, and car seats* • *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 durable medical equipment above* • *Customization or personalization of equipment* • *Desktop and laptop computers, pagers, personal digital assistants (PDAs), computer switchboard, smart phones, and tablet devices (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*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefits description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	**Consumer Option**
• *Home test kits, except as stated above* • *Medical foods that do not require a prescription under Federal law even if your physician or other health care professional prescribes them* • *Medical foods not provided by a DME vendor* • *Nutritional supplements that are not administered by catheter or nasogastric tubes, except for medical foods taken for the treatment of Inborn Errors of Metabolism as stated above*	*All charges*
Home health services – (nursing services)	**Consumer Option**
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 25 visits per person per calendar year.	Network: $15 copayment per visit 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*
Chiropractic	**Consumer Option**
Chiropractic care • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, and vibratory therapy Note: Benefits for combined therapies annual maximum for physical, occupational, speech therapy, chiropractic care and alternative treatments are limited to 40 visits per person per calendar year and includes all covered services and supplies billed for these therapies. When more than one type of therapy, for example chiropractic and acupuncture, are provided on the same day, each will be counted as a separate visit.	Network: $15 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Alternative treatment	**Consumer Option**
Acupuncture Note: Benefits for combined therapies annual maximum for physical, occupational, speech therapy, chiropractic care and alternative treatments are limited to 40 visits per person per calendar year and includes all covered services and supplies billed for these therapies. When more than one type of therapy, for example chiropractic and acupuncture, are provided on the same day, each will be counted as a separate visit.	Network: $15 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Alternative treatment - continued on next page

Benefits description	You pay After the calendar year deductible...
Alternative treatment (cont.)	**Consumer Option**
Not covered: • *Naturopathic and homeopathic services* • *Thermography, biofeedback and related visits* • *Massage therapy, acupressure, hypnotherapy* • *Self care or home management training or programs* • *Nutritional supplements or food*	*All charges*
Educational classes and programs	**Consumer Option**
Individual diabetic education provided by a qualified healthcare professional for members with an established diagnosis of diabetes, including: • Educational supplies • Patient instruction • Medical nutrition therapy Note: Please contact us at 800-694-9901 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: Nothing Non-Network: All charges
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: See Section 5, *Preventive care, adult* for more details. 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 program. See Section 5(f), *Covered medications and supplies.*	Network: See Section 5, Preventive Care Non-Network: Any difference between our allowance and the billed amount
Not covered: • *Self help or self management programs 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*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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 Network deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. There is a separate Non-Network deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. Incurred expenses do not apply toward both limits. The family deductible can be satisfied by one or more family members.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for Network services and for coinsurance and amounts in excess of the Plan's allowance for Non-Network services.
- 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.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- You or your physician must get prior approval for some surgical procedures including but not limited to: Gender affirming surgery, Bariatric surgery, and Organ/Tissue transplants. Please refer to the precertification information shown in Section 3.

Benefits description	You pay After the calendar year deductible...
Surgical procedures	**Consumer Option**
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) • Voluntary sterilization for men (limited to vasectomies) Note: Voluntary sterilization procedures for women, surgically implanted contraceptives and intrauterine devices (IUDs) are covered under Section 5 (a), *Family planning*. • Treatment of severe burns • Correction of amblyopia & strabismus Note: Prior approval is required for all spinal surgeries. Call us at 800-694-9901. See Section 3, *Other services* under *You need prior Plan approval for certain services*.	Network: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefits description	You pay After the calendar year deductible...
Surgical procedures (cont.)	**Consumer Option**
Bariatric Surgery Surgical treatment of severe 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 heart disease, hypertension, hyperlipidemia, obstructive sleep apnea, nonalcoholic steatohepatitis (NASH), 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 an intensive medically supervised weight loss program for 12 or more sessions and occurred within 2 years prior to surgery. The program should be multi-disciplinary by combining diet and nutritional counseling with an exercise program and a behavior modification program Note: Prior approval is required. Call us at 800-694-9901. See Section 3, *Other services* under *You need prior Plan approval for certain services*.	Network: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Subsequent surgery for severe obesity is subject to the following additional pre-surgical requirements: • All criteria listed above for the initial procedure must be met again • Previous severe 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: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in physician's office Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Gender affirming surgery The Plan will provide coverage for the following when all criteria has been met: • Breast removal • Breast augmentation (implants/lipofilling) • Gonadectomy (hysterectomy and oophorectomy or orchiectomy) • Genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, placement of a testicular prosthesis and erectile prosthesis, penectomy, vaginoplasty, labiaplasty, and clitoroplasty) • Medically necessary facial and body contouring Note: All services are subject to medical necessity and are based on our clinical policy bulletin. For more information on coverage details for medically necessary facial and body contouring coverage and criteria, please refer to www.mhbp.com/gender-affirming-care.	Network: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefits description	You pay After the calendar year deductible...
Surgical procedures (cont.)	**Consumer Option**
Note: Prior approval is required, including treatment outside the 50 United States. Call us at 800-694-9901 for coverage details. See Section 3, *Other services* under *You need prior Plan approval for certain services*.	Network: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office 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 musculoskeletal pain through interventional procedures such as nerve blocks Note: Prior approval is required. Call us at 800-694-9901 prior to scheduling treatment. See Section 3, *Other services* under *You need prior Plan approval for certain services*.	Network: Nothing for services performed on an inpatient basis or outpatient hospital /ASC; $15 copayment when performed in a physician's office 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: 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 the tertiary and any other 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: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-Network: 40% of the Plan's allowance 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: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefits description	You pay After the calendar year deductible...
Surgical procedures (cont.)	**Consumer Option**
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: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Multiple of 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* • *Routine treatment of conditions of the foot except for services rendered to members with diabetes See Section 5(a), Foot care* • *Cosmetic surgery, see Section 10, Definitions* • *Radial keratotomy, laser and other refractive surgeries* • *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, Mastopexy, Neck tightening, Pectoral implants, Removal of redundant skin, Rhinoplasty, Voice therapy/voice lessons* • *Reversal of transgender surgeries*	*All charges*
Reconstructive surgery	**Consumer Option**
• 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. 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: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefits description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	**Consumer Option**
Not covered: • *Cosmetic surgery, see Section 10, Definitions* • *Charges for photographs to document physical conditions*	*All charges*
Oral and maxillofacial surgery	**Consumer Option**
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: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office 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*

Benefits description	You pay After the calendar year deductible...
Organ/tissue transplants	**Consumer Option**
Aetna Institutes of Excellence (IOE) Transplant Network Program: • To qualify for this program, you, your representative, the doctor, or the hospital must call us as soon as the possibility of a transplant is discussed. When you call, you will be given information about the program and participating facilities. • All transplant admissions must be precertified. • MHBP must be your primary plan for payment of benefits to use the Aetna IOE Transplant Network Program. • To receive the Network level of benefits, you must choose an Aetna IOE facility, and all transplant-related services must be received at that facility.	IOE Network: Nothing 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

Benefits description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**Consumer Option**
Note: Prior approval is required, call us at 800-694-9901. See Section 3, *Organ/tissue transplants* under *You need prior Plan approval for certain services.* Note: Only transplants performed at hospitals designated as IOE will be considered for Network benefits. Hospitals in our network, but not designated as IOE hospitals, will be covered at the Non-Network benefit level. Note: For travel assistance see Section 5(h), *Aetna Institutes.* Note: See Section 5(c) for coverage of transplant-related services provided by a hospital.	IOE Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
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 Note: Only transplants performed at hospitals designated as IOE will be considered for Network benefits. Hospitals in our network, but not designated as IOE hospitals, will be covered at the Non-Network benefit level.	IOE Network: Nothing 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) Note: Only transplants performed at hospitals designated as IOE will be considered for Network benefits. Hospitals in our network, but not designated as IOE hospitals, will be covered at the Non-Network benefit level.	IOE Network: Nothing 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

Benefits description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**Consumer Option**
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 - 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 (i.e. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (i.e. 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 (i.e. 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 - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma	IOE Network: Nothing 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

Benefits description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**Consumer Option**
- Pineoblastoma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulinemia Note: Only transplants performed at hospitals designated as IOE will be considered for Network benefits. Hospitals in our network, but not designated as IOE hospitals, will be covered at the Non-Network benefit level.	IOE Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Non-myeloblative reduced intensity conditioning (RIC) performed in a clinical trial setting 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 Note: Only transplants performed at hospitals designated as IOE will be considered for Network benefits. Hospitals in our network, but not designated as IOE hospitals, will be covered at the Non-Network benefit level	IOE Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
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 if approved by the Plan's medical director in accordance with the Plan's protocols.	IOE Network: Nothing 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

Benefits description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**Consumer Option**
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, labs test, 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 • Non-myeloablative 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) - 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	IOE Network: Nothing 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

Benefits description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**Consumer Option**
- Advanced non-Hodgkin’s lymphoma - Aggressive non-Hodgkin's 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's lymphoma) - Multiple sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive) - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis Note: Only transplants performed at hospitals designated as IOE will be considered for Network benefits. Hospitals in our network, but not designated as IOE hospitals, will be covered at the Non-Network benefit level	IOE Network: Nothing Non-Network: 40% of the Plan’s allowance and any difference between our allowance and the billed amount
Not covered: • *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* • *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*
Anesthesia	**Consumer Option**
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: Nothing for services performed on an inpatient basis or outpatient hospital /ASC; $15 copayment when performed in a physician’s office 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.
- The Network deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. There is a separate Non-Network deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. Incurred expenses do not apply toward both limits. The family deductible can be satisfied by one or more family members.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for Network services and for coinsurance and amounts in excess of the Plan's allowance for Non-Network services.
- 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.
- 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 under *Outpatient hospital, freestanding ambulatory surgical center or clinic*. 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.

Benefits description	You pay After the calendar year deductible...
Inpatient hospital	**Consumer Option**
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. Note: Hospitals billing an all-inclusive rate will be prorated between room and board and ancillary charges. Note: We waive your copayment for Inpatient hospital care related to maternity care provided by a Network facility.	Network: $75 copayment per day, up to a maximum of $750 per admission Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefits description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	**Consumer Option**
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 CT 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 payment on whether the facility or a healthcare 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 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.	Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Aetna Institutes of Excellence (IOE) Transplant Network Program: • To qualify for this program, you, your representative, the doctor, or the hospital must call us as soon as the possibility of a transplant is discussed. When you call, you will be given information about the program and participating facilities. • All transplant admissions must be precertified. • MHBP must be your primary plan for payment of benefits to use the Aetna IOE Transplant Network Program. • To receive the Network level of benefits, you must choose an Aetna IOE facility, and all transplant-related services must be received at that facility. Note: Prior approval is required, call us at 800-694-9901. See Section 3, *Organ/tissue transplants* under You need prior Plan approval for certain services. Note: Only transplants performed at hospitals designated as Institutes of Excellence (IOE) will be considered for Network benefits. Hospitals in our network, but not designated as IOE hospitals, will be covered at the Non-Network benefit level. Note: See Section 5(b) for transplant-related professional services. 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	IOE Network: $75 copayment per day, up to a maximum of $750 per admission Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefits description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	**Consumer Option**
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* • *A hospital admission, or portion thereof, for services not covered by the Plan* • *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* • *Private inpatient nursing care* • *Institutions that do not meet the definition of covered hospitals* • *All charges for services provided by a Christian Science nursing facility*	*All charges*
Outpatient hospital, freestanding ambulatory surgical center or clinic	**Consumer Option**
Services and supplies, such as: • Operating, recovery, observation, and other treatment rooms • Non-emergency treatment provided in an emergency room • Prescribed drugs and medications • Diagnostic tests, such as X-rays, laboratory, ultrasound and pathology services • CT scans, CTA, MRA, MRI, NC, PET, SPECT provided in the outpatient department of a hospital Note: Prior approval is required. Call us at 800-694-9901 prior to scheduling. See Section 3, Outpatient imaging procedures under You need prior Plan approval for certain services. • 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 • Attended sleep studies Note: Prior approval is required. Call us at 800-694-9901. See Section 3, Other services under You need prior plan approval for certain services.	Network: $75 copayment per occurrence for non-surgical related services; $150 copayment per occurrence for outpatient surgery Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Outpatient hospital, freestanding ambulatory surgical center or clinic - continued on next page

Benefits description	You pay After the calendar year deductible...
Outpatient hospital, freestanding ambulatory surgical center or clinic (cont.)	**Consumer Option**
Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. 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: $75 copayment per occurrence for non-surgical related services; $150 copayment per occurrence for outpatient surgery Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Maternity care, including care at birthing facilities, such as: • Delivery, recovery, and other treatment rooms • Diagnostic tests, limited to X-rays, ultrasound, laboratory and pathology services • Medical supplies, including anesthesia and oxygen • Prescribed drugs and medications	Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
• Pulmonary rehabilitation therapy- limited to 36 visits per person per calendar year • Cardiac rehabilitation therapy (Phase 1 and 2 only) - limited to 24 visits per person per calendar year	Network: $75 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Aetna Institutes of Excellence (IOE) Transplant Network Program: • To qualify for this program, you, your representative, the doctor, or the hospital must call us as soon as the possibility of a transplant is discussed. When you call, you will be given information about the program and participating facilities. • All transplant admissions must be precertified. • MHBP must be your primary plan for payment of benefits to use the Aetna IOE Transplant Network Program. • To receive the Network level of benefits, you must choose an Aetna IOE facility, and all transplant-related services must be received at that facility. Note: Prior approval is required, call us at 800-694-9901. See Section 3, *Outpatient imaging procedures* under *You need prior Plan approval for certain services*. Note: Only transplants performed at hospitals designated as Institutes of Excellence (IOE) will be considered for Network benefits. Hospitals in our network, but not designated as IOE hospitals, will be covered at the Non-Network benefit level Note: Section 5(b) for transplant-related professional services. Network: $150 copayment per occurrence for outpatient surgery Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount 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.*	IOE Network: $150 copayment per occurrence for outpatient surgery Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Outpatient hospital, freestanding ambulatory surgical center or clinic - continued on next page

Benefits description	You pay After the calendar year deductible...
Outpatient hospital, freestanding ambulatory surgical center or clinic (cont.)	**Consumer Option**
Services and supplies related to Gene-Based Cellular and other Innovative Therapies (GCIT). such as: • Cellular immunotherapies • Genetically modified oncolytic viral therapy • Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions • Human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using: Luxturna® (Voretigene neparvovec), Zolgensma® (Onasemnogene abeparvovec-xioi), Spinraza® (Nusinersen) • Products derived from gene editing technologies, including CRISPR-Cas9 • Oligonucleotide-based therapies including: - Antisense (Example: Spinraza®) - siRNA To receive the Network level of benefits, you must choose an GCIT facility, and all related services must be received at that facility. Note: Prior approval is required, including treatment outside the 50 United States. Call us at 800-694-9901 prior to scheduling. See Section 3, *Outpatient imaging procedures* under *You need prior Plan approval for certain services.*	GCIT Network: $75 copayment per occurrence for non-surgical related services; $150 copayment per occurrence for outpatient surgery Non-Network: All Charges
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 Healthcare (AAAHC), or which do not have Medicare certification as an ASC facility*	*All charges*
Extended care benefits/skilled nursing care facility benefits	**Consumer Option**
Semiprivate room, board, services and supplies provided in a skilled nursing facility (SNF) when you are admitted directly from a covered inpatient hospital stay. Note: Prior approval is required. Call us at 800-694-9901. 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 28 days per person per calendar year. When another plan, including Medicare, is the primary payor, these benefits are not payable.	Network: $75 copayment per day, up to a maximum of $750 per admission including copayments already applied to the inpatient hospital confinement Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care, see Section 10, Definitions*	*All charges*

Benefits description	You pay After the calendar year deductible...
Hospice care	**Consumer Option**
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. Note: See Section 5(h), *Compassionate Care program,* for information about additional programs to support end-of-life care.	Network: $5 copayment per day Non-Network: 10% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Homemaker services*	*All charges*
Ambulance	**Consumer Option**
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 800-694-9901. See Section 3, *Other services* under *You need prior Plan approval for certain services.*	Network: Nothing Non-Network: Any difference between our allowance and the billed amount
Not covered: • *Transportation to other than a hospital, hospice, skilled nursing facility 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*

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 benefits under this Plan for emergency treatment of accidental injuries and medical emergencies.
- The Network deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. There is a separate Non-Network deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. Incurred expenses do not apply toward both limits. The family deductible can be satisfied by one or more family members.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for Network services and for coinsurance and amounts in excess of the Plan's allowance for Non-Network services.
- 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.

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. 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. Masticating (chewing) incidents are not considered to be accidental injuries.

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.

Benefits description	You pay
Note: The calendar year deductible applies to all benefits in this Section.	
Accidental injury/medical emergency	**Consumer Option**
If you receive outpatient care for your accidental injury or medical emergency in a hospital emergency room or urgent care center, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services Note: We pay inpatient hospital benefits and waive the copayment if you are admitted. Note: If the stay is greater than 24 hours, you need to precertify the admission. See Section 5(c), *Inpatient hospital.*	Network: $50 copayment per occurrence Non-Network: $50 copayment per occurrence and any difference between our allowance and the billed amount
Non-surgical physician services provided in a doctor's office for your accidental injury or medical emergency	Network: $15 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Benefits description	You pay
Ambulance	**Consumer Option**
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 800-694-9901. See Section 3, *Other services* under *You need prior Plan approval for certain services*.	Network: Nothing Non-Network: Any difference between our allowance and the billed amount
Not covered: • *Transportation to other than a hospital, hospice, skilled nursing facility 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*

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

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 benefits under this Plan for services related to treatment of mental health and substance use disorder.
- The Network deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. There is a separate Non-Network deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. Incurred expenses do not apply toward both limits. The family deductible can be satisfied by one or more family members.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for Network services and for coinsurance and amounts in excess of the Plan's allowance for Non-Network services.
- 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...
Professional services	**Consumer Option**
We cover professional services by licensed professional mental health and substance use disorder treatment 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.
Diagnostic and treatment services: • Psychiatric office visits • Outpatient visits, including individual or group therapy • Telehealth consultations	Network: $15 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
• Inpatient professional services	Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
TeleHealth services	**Consumer Option**
TeleHealth consultations are available to members in the 50 United States through our vendor 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 consult only).	Network: Nothing Non-Network: All charges

Benefits description	You pay After the calendar year deductible...
AbleTo Program	**Consumer Option**
An 8-week personalized web-based video conferencing 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 • diabetes • chronic pain • bereavement and • post-partum care The program also provides support for behavioral health conditions such as: depression, anxiety and panic, stress and alcohol/substance abuse. Note: See Section 5(h), *Wellness and Other Special Features,* for additional information about the AbleTo Program.	Network: Nothing Non-Network: All charges
Diagnostics	**Consumer Option**
Outpatient lab, X-ray and other diagnostic tests, including psychological and neuropsychological testing	Network: $15 copayment per visit 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 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
Treatment therapy	**Consumer Option**
Applied behavior analysis (ABA) therapy when provided by: • Licensed clinicians with a Doctorate or Master's degree trained to treat ASD • Board Certified Behavior 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 800-694-9901 prior to scheduling. See Section 3, *Other services* under *You need prior Plan approval for certain services.*	Network: $15 copayment per occurrence 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...
Inpatient hospital	**Consumer Option**
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 approved residential treatment center Note: Prior approval is required. Call us at 800-694-9901 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, our benefit will be based on the hospital's average charge for semiprivate accommodations.	Network: $75 copayment per day, up to a maximum of $750 per admission Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Behavioral health outpatient/all other services	**Consumer Option**
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* • Intensive outpatient treatment, see Section 10, *Definitions* • Substance use disorder detoxification • Medication evaluation and management (pharmacotherapy) • Observation care • Vagus Nerve Stimulation (VNS) • Physical, occupational and speech therapy for autism and developmental delays Note: Prior approval may be required. Call us at 800-694-9901 prior to scheduling. See Section 3, *Other services* under *You need prior Plan approval for certain services.*	Network: $15 copayment per occurrence Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Psychiatric home healthcare	**Consumer Option**
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: $15 copayment per occurrence 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	**Consumer Option**
• *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* • *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

Section 5(f). Prescription Drug Benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in this section.
- 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.
- Your prescribers must obtain prior authorizations for certain prescription drugs and supplies before coverage applies. Prior authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The Network deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. There is a separate Non-Network deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment.
- Incurred expenses do not apply toward both limits. The family deductible can be satisfied by one or more family members.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Prescription drug benefits are available only when you obtain your covered medications from a Network retail pharmacy or through our mail order drug program.
- You must get prior authorization 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. Prior authorizations must be renewed periodically. For more information about prior authorization, please call us at 800-694-9901 or visit our website, 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.
- If you are covered by Medicare and Medicare Part A or B is primary, we will automatically enroll you in our SilverScript Employer Prescription Drug Plan (PDP) under Medicare Part D. This plan enhances your FEHB coverage by offering lower cost sharing on covered drugs. You can find more details about this plan and the opt out process in Section 9, *Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP).* The PDP is subject to Medicare rules.

There are important features about your prescription drug program you should be aware of. These include:

- **Who can write your prescription?** A licensed physician or dentist, and in states allowing it, licensed or certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where can you obtain them?** You may fill the prescription at a Network pharmacy or by mail for certain drugs. Benefits are not available when you use a non-network pharmacy.
  - **Network pharmacy** – Present your Plan identification card at a network pharmacy to purchase your prescription and have the claim filed electronically for you. Call us at 800-694-9901 or check the electronic directory via www.MHBP.com to locate the nearest network pharmacy.
  - **Non-network pharmacy** – Not covered.
  - **Mail order** – To obtain more information about the mail order drug program, order refills, check order status and request additional mail services envelopes and claim forms, or to ask questions about eligibility, copayments or other issues, call us at 800-694-9901 or visit our website at 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).

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 800-694-9901 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 800-694-9901 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. MHBP offers a Maintenance Choice Program that allows members to get up to 90-day refills at a CVS retail pharmacy or our mail order drug program for the same cost-share as mail order.
- **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 whether 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 CVS Caremark at 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.
  - **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 drugs will be authorized.**
  - **Certain specialty drugs must be obtained from CVS Caremark Specialty Pharmacy**

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.

- **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. A medical 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 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 us in advance at 800-694-9901 to request the accommodation.
- **The Plan conducts Drug Utilization Review (DUR).** When you fill your prescription at a network pharmacy or through the mail order drug 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 800-694-9901.
- **When you have to file a claim.** If you purchase prescriptions at a network pharmacy and you forget your MHBP ID card or the pharmacy is unable to file your claim electronically, mail your CVS Caremark claim form and prescription receipts to: CVS Caremark, Attn: Claims Department, PO 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 drugstore and NDC number (included on the bill).

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

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 us at 800-694-9901.

- **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 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.

If your primary plan does not provide for electronic claims handling, purchase your prescription from the pharmacy and submit the bill 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.

Medicare Part B coverage: When Medicare Part B is your primary payor, 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. MHBP's prescription drug benefits exclude coverage for Part B drugs and supplies, your prescriptions will be coordinated with Medicare and our medical benefits.

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.

Benefits description	You pay
Note: The calendar year deductible applies to all benefits in this Section.	
Covered medications and supplies	**Consumer Option**
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 • Drugs to treat gender dysphoria Note: Certain drugs to treat gender dysphoria are considered Specialty drugs, see *Specialty drugs* section. • Fertility drugs- limited to three (3) cycles Note: Certain drugs to treat fertility are considered Specialty drugs, see Specialty drugs section. 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: For continuous glucose monitors (CGMs) and supplies see Section 5(a), *Durable medical equipmen*t (DME). For questions about the prescription drug program, or to obtain a copy of our current formulary, please call 800-694-9901 or visit our website at www.MHBP.com. 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 800-694-9901 for instructions on how to obtain a brand exception. Note: Physician-prescribed over-the-counter or prescription drugs approved by the FDA to treat nicotine dependence are covered under Section 5, *Network Preventive care* under *Preventive care, adult.* Note: We offer discounts for certain additional drugs. See Discount drug program under Section 5(h), Wellness and Other Special Features.	Network pharmacies, up to a 30-day supply: • Generic: $10 copayment per prescription • Preferred brand name (formulary): 30% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained, 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 pharmacies, up to a 90-day supply: • 30% of the billed charges, limited to $200 per prescription Non-network pharmacies: All charges Mail order drug program, 31-day up to a 90-day supply: • Generic: $20 copayment per prescription • Preferred brand name (formulary): $80 copayment per prescription 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

Covered medications and supplies - continued on next page

Benefits description	You pay
Covered medications and supplies (cont.)	**Consumer Option**
Specialty drugs: • are used to treat chronic complex conditions and require special handling and close monitoring, and • must be obtained from CVS Caremark Specialty Pharmacy Note: Preauthorization for specialty drugs is required. Call us at 800-694-9901 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.	CVS Caremark Specialty Pharmacy, 30-day supply: • Generic/Preferred brand name: 30% of the Plan's allowance; limited to $225 per prescription • Non-Preferred brand name: 30% of the Plan's allowance; limited to $275 per prescription CVS Caremark Specialty Pharmacy, 90-day supply: • Generic/Preferred brand name: 30% of the Plan's allowance; limited to $425 per prescription • Non-Preferred brand name: 30% of the Plan's allowance; limited to $500 per prescription
Not Covered	**Consumer Option**
• *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, except as noted under Section 5(a), Treatment therapies* • *Continuous glucose monitors (CGMs) and supplies, except as noted under Section 5(a), Durable Medical Equipment* • *Over-the-counter medications even if prescribed by a physician, unless otherwise stated in this section.* • *Topical analgesics, including patches, lotions and creams* • *Erectile dysfunction drugs* • *Drugs and supplies when Medicare Part B is primary payor. For Part B drugs, diabetic continuous glucose meters and testing materials, see Section 5 (a), Durable medical equipment* • *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 network retail pharmacy in excess of a 30-day supply* • *Drugs obtained from a foreign pharmacy in excess of a 90-day supply* • *Home test kits*	*All charges*

Section 5(g). Dental Benefits

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.
- 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 Network deductible is $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. There is a separate Non-Network deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. Incurred expenses do not apply toward both limits. The family deductible can be satisfied by one or more family members.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for Network services and for coinsurance and amounts in excess of the Plan's allowance for Non-Network services.
- 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.

Note: We cover hospitalization for dental procedures only when a non-dental impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5(c) for Inpatient hospital benefits.

Benefits description	You pay After the calendar year deductible...
Accidental injury benefit	**Consumer Option**
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 were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	See Section 5(d), *Accidental injury*
Oral surgery	**Consumer Option**
Removal of impacted teeth	See Section 5(b), *Oral and maxillofacial surgery*
Dental benefits	**Consumer Option**
We have no other dental benefits	All charges

Section 5(h). Wellness and Other Special Features

Special feature	Description
Care Management Program	MHBP offers several types of Care Management Programs that assist you with your care coordination for your acute or chronic condition. The program provides education, clinical support, and access to digital support and well-being tools to help you better manage your health. The Care Management Program offers: • One-on-one personalized nurse support • Group coaching • Digital support • Customized health action plans based on your needs and preferences To start using our digital support tools, log in to your Aetna member website from www.MHBP.com and then go to your health dashboard. New users will need to register first. We're committed to giving you all the support you deserve. That's why we offer digital support, nurse support, and group coaching so you can move easily between the services. We offer several 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 healthcare and treatment options. • Digital Coaching programs – find dynamic health coaching programs that give you personalized support. • Health Dashboard – view your health information, and find entry points to health and wellness programs and resources. Our Care Management Program includes the following list of services. If you would like to contact the Plan for more information about our program or services, please call 800-694-9901. We are available to assist you Monday-Friday from 6:00 a.m. - 5:00 p.m. Mountain Time (MT).
• **Back & Joint Care**	Provides support for members dealing with musculoskeletal (MSK) issues, acute and chronic pain, and either taking opioids or trying to avoid opioids. The program helps you improve your quality of life by helping you manage and reduce your chronic MSK pain, without surgery or drugs. If MHBP identifies that there is an opportunity to help you improve your care, you will be invited to participate. Eligible participants will receive access to exercise therapy, motivational coaching, one-on-one support and education that is tailored to the participant's specific needs.
• **Behavioral Health Support**	MHBP provides resources and support to help you address mental health or behavioral health conditions like anxiety, depression, substance use disorders, domestic violence and more. Our team will work with you, help you understand your benefits and guide you through the wellness programs we offer. We are here to support you, get you connected with a clinical social worker, psychologist or other behavior health professional to obtain the right treatment, the best services and resources to manage the daily obstacles that may be keeping you from achieving a healthier happy life.
• **Cancer Support**	Provides dedicated proactive support to individuals along their cancer journey. We understand that a cancer diagnosis is life changing and can be overwhelming and we are here to help you. Through our program individuals will better understand their benefits, have the ability to locate the right provider for their specific need and get certain services approved. Individuals will also receive care management support for holistic care, treatment side effects, and medication management.

Special feature	Description
• **Compassionate Care**	Offers service and support to members or a family member that have a serious illness or face imminent end-of-life decisions. The program 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.
• **Healing Better**	Provides support and educational resources for total knee or hip replacement surgery. The program gives you the tools and resources you need to prepare for a successful surgery and healthy recovery. It provides you access to benefit information specific to joint services, holistic overview of pain management options, digital, personalized education on recovery resources, mental and physical health tips and more.
• **Social Work**	Is designed to assist you in improving your quality of life by taking steps to help you locate the right resources. Social workers can help connect you with community resources that can provide you services in times of need. Some examples include: • Local food pantries • Utility or rental assistance programs • Home-delivered meal services • Support groups • Counseling services • Federal and state programs 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.
• **Transform Diabetes Care**	Helps members keep their diabetes and hypertension under control. The program uses medical claims, pharmacy claims, biometric screening data, and lab results to identify opportunities to help members improve their health. Members are provided personal guidance in five areas of focus, medication adherence, taking the right medication, self-monitoring of blood glucose and blood pressure, lifestyle and comorbidity management and recommended screenings, all are based on the member's specific needs. You do not need to enroll in this program. If MHBP identifies that there is an opportunity to help you improve your care, we will contact you by phone, letter, email, or even in person by a CVS pharmacist, or MinuteClinic provider.
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 a 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 to 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 treatment of pain such as, but not limited to: injections, 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 LLC at 866-533-1410 or go to www.myactivehealth.com/MHBP. Our Health Coaches are available Monday through Friday from 8 am - 8 pm Eastern Time (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. From www.MHBP.com, click on Aetna member website 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 • Check HSA balance 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.

Special feature	Description
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 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 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 healthcare. Access the PHR through the secure member portal at www.MHBP.com.
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 Heath Assessment. 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.
Biometric Screening	Complete a biometric screening through Quest Diagnostics one of three ways. • Make an appointment for your biometric screening at a Quest Diagnostics Patient Service Center (PSC). • 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. • Or complete your biometric wellness screening using at-home collections materials from Quest Diagnostics. To register for your screening at a PSC, to order your at-home collections materials or to download your physician form, call 855.6.BE.WELL (855-623-9355) or visit www.My.QuestforHealth.com and enter the registration key: mhbp Once your biometric screening is complete, your results will be available online at www.My.QuestforHealth.com. If you have any questions or would like more information about the program, please call us at 800-694-9901.

Special feature	Description
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 providers, 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 provider. 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 800-694-9901.
24-Hour Nurse 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 800-556-1555. 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.
Discount Drug Program	MHBP members can receive a discount on certain drugs prescribed for cosmetic purposes and impotency. You pay 100% of the discounted price at a network retail pharmacy. Call CVS Caremark at 866-623-1441 to determine if your drug qualifies for a discounted price.
Round-the-Clock Member Support	We provide integrated health benefit services including a national Network, clinical management services, a national transplant program, Care Management 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 healthcare information • Have your questions about healthcare issues answered This 24/7 service is a benefit to you, allowing you to be informed about your healthcare 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 800-694-9901, 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 • Pulmonary Arterial Hypertension (PAH) • 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.
Enhanced Maternity Program with family-building support powered by Maven	Our Enhanced Maternity program, provides trusted information and guidance about family planning, maternity support and postpartum care. With this program, you will also have access to the following resources: • Nurses who are trained in obstetrics and high-risk pregnancy conditions • Behavioral health support, including referrals to resources to deal with stress, depression, and anxiety • Postpartum depression screening and support • Resources and educational materials through our Maternity Support Program • Guided medically appropriate genetic counseling and testing • Preeclampsia prevention – If you are identified as high-risk, you will receive educational materials about preeclampsia risk factors, and the benefits of aspirin therapy • Fertility advocate to help you throughout your infertility journey, fertility preservation, same-sex conception needs, and more. The advocate will also provide support and guidance during fertility treatment and provide support if you become pregnant. For direct access to a fertility advocate, call 833-415-1709 No matter where you are on your journey, our nurses and experts are here to support you along the way. Participation in this program is voluntary and available at no cost to you. The participant and their physician or healthcare provider remain in charge of the participant's treatment plan. If you would like more information or would like to enroll in the Enhanced Maternity Program, call toll-free 855-282-6344 between 8 am and 9 pm ET. Via the Enhanced Maternity Program, you and your partner also get 24/7 access to Maven's digital health platform and quality providers via unlimited video appointments, messaging, and classes. Your Maven membership includes support on Adoption, Surrogacy, fertility, maternity, and postpartum care: • A personal Care Advocate who serves as a trusted guide to help you navigate the Maven platform and connect you with providers throughout your journey

	• Unlimited video chat and messaging with doctors, nurses, and coaches across 35+ specialties, including fertility, mental health, Doulas, Sleep coaches, and pediatrics and more • Provider-led virtual classes and vetted articles—tailored to your journey • Counseling and expert guidance via Maven Adoption and surrogacy Coaches through different adoption and surrogacy pathways and key considerations in the process You can activate your no-cost membership at www.mavenclinic.com/join/aetnafamily-OP or download the Maven Clinic app.
Diabetes Incentive Program	MHBP offers a wellness incentive program for members with diabetes. The program will reward members with a $75 credit towards your calendar year deductible in the following calendar year if you re-enroll in the MHBP Consumer Option Plan. If you are identified as having diabetes, we will 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 A1C is greater than or equal to 8 percent, you will receive the incentive if one of the following is completed by December 1st of the calendar year: • Lifestyle and Condition Coaching (LCC) Program (complete four personal coaching or group coaching sessions). You may enroll online at www.myactivehealth.com/MHBP or call LCC at 866-533-1410 to complete your coaching sessions. • Diabetic Education or Training (see Section 5(a), *Educational classes and programs*) • Transform Diabetes Care Program (if identified by the Plan and qualify, you will need to check your blood glucose four times per month for four continuous months in the calendar year). Your A1C laboratory results must be submitted to the Plan at the address noted below by December 31st of the calendar year. MHBP PO Box 981106 El Paso, TX 79998-1106 If you would like to contact the Plan for more information about the Diabetes Incentive Program, please call 800-694-9901. We are available to assist you Monday – Friday from 6:00am to 5:00pm Mountain Time (MT).
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 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 Program	AbleTo is a 8-week personalized web-based video conferencing treatment support program designed to address the unique emotional and behavioral health needs of individuals learning to live with conditions such as heart disease, diabetes, cancer, pain management, digestive health, infertility, and respiratory. The program also provides support for behavioral health conditions such as: depression, anxiety and panic, stress, and alcohol/substance abuse. Additionally, the program assists members with life challenges such as post-partum, bereavement, military transitions, and caregiving. 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/Aetna, 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 800-694-9901.
Aetna Institutes	Aetna Institutes of Excellence (IOE) Transplant Network Program The Plan participates in the IOE Transplant Network program. The Plan has special arrangements with facilities to provide services for tissue and organ transplants only. The transplant network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplants. Because transplantation is a highly specialized area, not all Network hospitals are part of the Aetna Institutes of Excellence program. See Section 5(b), *Organ/tissue transplants* for the Plan's Organ/Tissue transplants benefit. 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. Gene-Based, Cellular and Other Innovative Therapies (GCIT™) Designated Network Program The Plan participates in the GCIT Designated Network Program. The Plan has special arrangements with facilities to provide services for members who have been diagnosed with certain genetic conditions. See Section 5(a), *Treatment therapies* for the Plan's GCIT benefit. Travel Benefit: If the Aetna IOE Transplant or GCIT Designated facility needed is more than 100 miles from the patient's residence, certain Travel & Lodging expenses for the patient and one companion may be reimbursed if pre-authorized by Aetna. Members who use the Aetna IOE Transplant Program or GCIT Designated Network program, may be approved 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. Note: The Plan must be the primary payor for health benefits to be eligible for the travel benefit. If you have any questions or would like more information about the program, please call us at 800-694-9901.

Section 5(i). Health Education Resources and Account Management Tools

Health education resources	MHBP takes the health and safety of its members seriously. Visit www.MHBP.com and select Health Education for online resources which include: • Take Charge of your Health and Wellness: Link to articles covering disease prevention, nutrition and fitness, home care, safety and more • The Medical Library: Link to articles about treatment options, common symptoms and their causes and child development • Health Risk Assessment: Members can assess their overall health profile using a comprehensive evaluation tool • Patient safety information
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through our website: www.MHBP.com • Your balance will also be shown on your explanation of benefits (EOB) form • You will receive an EOB each time we process a claim HSA members may also contact Member Services to review account transactions and balances and where appropriate, be connected with PayFlex Systems USA, Inc. to receive information on additional services, such as reporting lost or stolen cards, or making changes to investment options. If you have an **HRA,** • Your HRA balance will be available through www.MHBP.com • Your balance will also be shown on your EOB form
Consumer choice information	As a member of MHBP Consumer Option, you may choose any healthcare provider. However, you will receive discounts when you see a Network provider and when you use a CVS Caremark network pharmacy. Directories are available online at www.MHBP.com.

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 800-694-9901 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're brought to you by the MHBP, but you do not have to be an MHBP member to get them. A single annual $52 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 healthcare 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 35% 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 27,000 providers at over 110,00 locations including optometrists, ophthalmologists, opticians and leading optical retailers such as: LensCrafters, Target Optical, participating Pearle Vision locations, and many independent providers. 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.

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 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.
- "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.
- Services supplied by healthcare provider such as: membership or concierge service fees, handling or administrative charges (medical records and missed appointments), telehealth transmission fees or physician standby services.
- Services or supplies we are prohibited from covering under the Federal Law.
- Services and/or supplies not listed as covered.

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 800-694-9901, 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 800-694-9901.

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 physician’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 healthcare 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 ten percent (10%) 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 healthcare 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 800-694-9901.

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 healthcare 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 their 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.

Disagreements between you and PayFlex Systems USA, Inc regarding the administration of your HSA, and between you and the Plan regarding the administration of your HRA, are not subject to the disputed claims process.

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; and 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 healthcare 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 or notify you of the status of OPM's review within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, 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 800-694-9901. 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 family member 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 healthcare 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 processes the benefit, 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 healthcare 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 or employing 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**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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.

- **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 or employing 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 incurred up to and including the date of settlement or judgement, 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@estprs.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 Www.BENEFEDS.com, 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 115 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 800-694-9901 or see our website at www.MHBP.com.

We waive some costs if the Original Medicare Plan is your primary payor and your Consumer Option enrollment is accompanied by a health reimbursement account – We will waive applicable deductibles, copayments and coinsurance.

We will only waive these when the member has both Medicare Part A and Part B – not Medicare Part A or Part B.

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

- **HRA Cost Share**

Please review the following information. 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.

Medicare Coverage: Deductible
Consumer Option HRA: You pay without Medicare: Network: 2,000/4,000
Consumer Option HRA: You pay without Medicare: Out-of-Network: 2,000/4,000
Consumer Option HRA: You pay with Medicare Part A & B: Network: 2,000/4,000 applied to prescription drugs only
Consumer Option HRA: You pay with Medicare Part A & B: Out-of-Network: 2,000/4,000 applied to prescription drugs only

Medicare Coverage: Catastrophic Protection Out-of-pocket maximum
Consumer Option HRA: You pay without Medicare: Network: 6,000/12,000
Consumer Option HRA: You pay without Medicare: Out-of-Network: 7,500/15,000
Consumer Option HRA: You pay with Medicare Part A & B: Network: 6,000/12,000
Consumer Option HRA: You pay with Medicare Part A & B: Out-of-Network: 7,500/15,000

Medicare Coverage: Part B premium reimbursement offered
Consumer Option HRA: You pay without Medicare: Network: N/A
Consumer Option HRA: You pay without Medicare: Out-of-Network: N/A
Consumer Option HRA: You pay with Medicare Part A & B: Network: N/A
Consumer Option HRA: You pay with Medicare Part A & B: Out-of-Network: N/A

Medicare Coverage: Primary care provider
Consumer Option HRA: You pay without Medicare: Network: $15 copay after deductible
Consumer Option HRA: You pay without Medicare: Out-of-Network: 40% of Plan allowance and any difference after deductible
Consumer Option HRA: You pay with Medicare Part A & B: Network: Nothing
Consumer Option HRA: You pay with Medicare Part A & B: Out-of-Network: Nothing

Medicare Coverage: Specialist
Consumer Option HRA: You pay without Medicare: Network: $15 copay after deductible
Consumer Option HRA: You pay without Medicare: Out-of-Network: 40% of Plan allowance and any difference after deductible
Consumer Option HRA: You pay with Medicare Part A & B: Network: Nothing
Consumer Option HRA: You pay with Medicare Part A & B: Out-of-Network: Nothing

Medicare Coverage: Inpatient hospital
Consumer Option HRA: You pay without Medicare: Network: $75 copayment per day/max $750 after deductible
Consumer Option HRA: You pay without Medicare: Out-of-Network: 40% of Plan allowance and any difference after deductible
Consumer Option HRA: You pay with Medicare Part A & B: Network: Nothing
Consumer Option HRA: You pay with Medicare Part A & B: Out-of-Network: Nothing

Medicare Coverage: Outpatient hospital
Consumer Option HRA: You pay without Medicare: Network: $75 copayment per occurrence after deductible
Consumer Option HRA: You pay without Medicare: Out-of-Network: 40% of Plan allowance and any difference after deductible
Consumer Option HRA: You pay with Medicare Part A & B: Network: Nothing
Consumer Option HRA: You pay with Medicare Part A & B: Out-of-Network: Nothing

Medicare Coverage: Incentives offered
Consumer Option HRA: You pay without Medicare: Network: N/A
Consumer Option HRA: You pay without Medicare: Out-of-Network: N/A
Consumer Option HRA: You pay with Medicare Part A & B: Network: N/A
Consumer Option HRA: You pay with Medicare Part A & B: Out-of-Network: N/A

Call us at 800-694-9901 or visit our website, 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 healthcare 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.

Individual Medicare Part D coverage: If you are currently enrolled in an individual Medicare Part D plan, auto-enrollment into the SilverScript PDP for MHBP will result in your disenrollment from that plan. You cannot be covered under two Part D plans at the same time. If you elect to opt out of the SilverScript PDP for MHBP and remain in your individual Medicare Part D plan, your FEHB prescription drug coverage will be secondary to your individual Medicare Part D Plan. In that circumstance, the Plan will supplement the coverage you get under your Medicare Part D prescription drug plan. We will not waive any copayments or coinsurance when you have Medicare Part D as your primary payor. 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.

Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)

If you are enrolled in Medicare, and are not enrolled in a Medicare Advantage Plan (Part C), you will be automatically enrolled in the Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). The PDP EGWP is a prescription drug benefit for FEHB covered annuitants and their FEHB covered family members who are eligible for Medicare. This allows you to receive benefits that will never be less than your coverage that is available to members with only FEHB but more often you will receive benefits that are better than members with only FEHB.

This Plan and our PDP EGWP: You will be automatically enrolled in our PDP EGWP and continue to remain enrolled in our FEHB Plan. Participation in the PDP EGWP is voluntary, and **you have the choice to opt out of this enrollment at any time.**

In the case of those with higher incomes you may have a separate premium payment for your PDP EGWP benefit. Please refer to the Part D-Income-Related Monthly Adjustment Amount (IRMAA) section of the Medicare website: www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

We offer a SilverScript Employer Prescription Drug Plan (PDP) for MHBP, a Medicare Employer Group Waiver Plan (EGWP), to Medicare-eligible annuitants and Medicare eligible family members covered under the Plan. The PDP is a Medicare Part D plan and the copays/coinsurance are equal to or better than the MHBP Consumer Option prescription drug benefits, which means you will pay less for prescription drugs than Consumer Option members without Medicare Part D coverage. You will generally receive better benefits than members with only FEHB coverage. Covered drugs will be subject to the formulary approved by the Centers for Medicare and Medicaid Services.

If you are an annuitant or an annuitant's family member who is enrolled in either Medicare Part A or B or Parts A and B, you will be automatically enrolled in SilverScript effective January 1, 2024, or later upon becoming Medicare-eligible. There is no need for you or your eligible dependent to take action to enroll. If you do not wish to enroll in the SilverScript Employer PDP, you may "opt out" of the enrollment by following the instructions mailed to you or by calling us at 833-825-6755. Declining coverage or "opting out" will place you back into your FEHB prescription drug coverage. You can opt out at any time.

Participants who enroll in SilverScript Employer PDP for MHBP will receive a separate SilverScript prescription ID card to use for filling prescriptions. The following are your enhanced prescription benefits:

- No prescription deductible
- Catastrophic Protection Out-of-Pocket Maximum of $2,000 per person annually (included in the Plan's integrated medical and prescription drug overall out of pocket maximum.)
- **Consumer Option 30-day prescription supplies:**
  - Generic - $8 copay
  - Preferred Brand - $45 copay
  - Non-Preferred Brand - $70 copay
  - Specialty - 25% coinsurance up to $225 maximum
- **Consumer Option 90-day prescription supplies:**
  - Generic - $15 copay
  - Preferred brand - $70 copay
  - Non-Preferred brand - $110 copay
  - Specialty - 25% coinsurance up to $425 maximum

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		✓*
9) Are a Federal employee receiving 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 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 participates with Medicare or accepts Medicare assignment for the claim and is a member of our Network, then you are responsible for your deductibles, coinsurance, and copayments.

If your physician participates with Medicare and is not in our Network, then you are responsible for your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.

If your physician does not participate with Medicare, then you are responsible for your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

If your physician does not participate with Medicare and is not a member of our Network, then you are responsible for your non-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount.

If your physician opts-out of Medicare via private contract, then you are responsible for 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 they have 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 800-694-9901.

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 Parts A and B and Medicare is primary and your Consumer Option enrollment is accompanied by a health reimbursement arrangement (HRA), we will waive your deductibles, copayments and coinsurance

- We will only waive deductibles, copayments and coinsurance when you have both Medicare Part A and Part B.
- We will not waive any applicable deductibles, copayments or coinsurance for prescription drugs.

When you have Medicare Part B as your primary coverage but do not have Medicare Part A, and your Consumer Option enrollment is accompanied by a health reimbursement arrangement (HRA), 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:

- If your physician accepts Medicare assignment:
  - You pay nothing if you have unused credit available under your HRA to pay the difference between the Medicare approved amount and Medicare's payment.
  - After your HRA is exhausted and your deductible has been met, you pay either the difference between the Medicare approved amount and Medicare's payment or your copayment amount, whichever is less.
- If your physician does not accept Medicare assignment:
  - You pay nothing if you have unused credit available under your HRA to pay the difference between Medicare's "limiting charge" and Medicare's payment.
  - After your HRA is exhausted and your deductible has been met, you pay either 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: 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 you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

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.

Copayment

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

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.

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

Healthcare 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 healthcare 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.

Healthcare professional

A physician or other healthcare 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

Infertility is disease or medical condition defined as when a person if unable to conceive or produce conception after 1 year of regular sexual intercourse when the individual attempting conception is under 35 years of age, or after 6 months of regular sexual intercourse when the individual attempting conception is 35 years of age or older. Alternatively, infertility can be established by regular sperm insemination(s) (intrauterine, intracervical, or intravaginal), either with or without ovulation induction medication, when the individual attempting conception is under 35 years of age or regular sperm insemination(s) when the individual attempting conception is 35 years of age or older. This definition applies to all individuals regardless of sexual orientation or the presence/availability of a partner. Infertility may also be established by the demonstration of a disease of the reproductive tract such that regular egg-sperm contact would be ineffective.

See our medical clinical policy bulletin under Section 10, *Definitions of Terms We Use in This Brochure - Medical Necessity* definition for additional details on Aetna's Infertility Clinical Policy.

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 foods

The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medical necessity

Services, drugs, supplies, or equipment provided by a hospital or covered provider of healthcare services that the Plan determines are appropriate to diagnose or treat your condition, illness, or injury and that:

1. are consistent with standards of good medical practice in the United States;
2. are clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms;
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.

Note: When a medical necessity determination is made utilizing the Aetna Clinical Policy Bulletins (CBPs), you may obtain a copy of Aetna's CPB through the following website: www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html.

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.

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 considered 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.

If you receive a comprehensive preventive evaluation and management (E/M) service and a problem-oriented E/M service during the same office visit, the Plan's allowance for the problem-oriented service will be 50% of the normal Plan allowance, unless the provider's Network contract provides for a different amount.

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

If you receive a comprehensive preventive evaluation and management (E/M) service and a problem-oriented E/M service during the same office visit, the Plan's allowance for the problem-oriented service will be 50% of the normal Plan allowance.

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 on 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 800-694-9901 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 healthcare 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 800-694-9901 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*.

You should also see Section 4, *Important Notice About Surprise Billing – Know Your Rights* for a description of your protections against surprise billing under the No Surprises Act.

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.

Severe obesity

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. Eligible members must be age 18 or older.

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.

Subrogation

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.

Surprise bill

An unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Urgent care center

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

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 800-694-9901. 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 the Mail Handlers Benefit Plan (MHBP).

Walk-in clinic

A medical facility that accepts patients on a walk-in basis; no appointment is required. Provides non-emergency, basic healthcare services on a walk-in basis. Examples include MinuteClinic® at CVS Pharmacy locations and Healthcare Clinics at Walgreens pharmacy locations. Urgent care centers are not considered walk-in clinics (See Urgent care center in this section.)

You

You refers to the enrollee and each covered family member.

Index

Summary of MHBP Consumer Option Benefits – 2024

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.

In 2024, for each month you are eligible for the HSA, the Plan will deposit $100 per month for a Self Only enrollment or $200 per month for a Self Plus One or Self and Family enrollment to your HSA. If you are not eligible for an HSA, the Plan will establish an HRA for you.

Traditional medical coverage (other than Network preventive care) is subject to the Consumer Option calendar year deductible of $2,000 for a Self Only enrollment or $4,000 for a Self Plus One or Self and Family enrollment. You can choose to use the funds in your HSA to pay your deductible, or you can pay your deductible out-of-pocket. If you have an HRA, we will withdraw the amount from your HRA if funds are available. After you meet the deductible, you pay the indicated copayments or coinsurance for covered services up to the annual catastrophic protection maximum for out-of-pocket expenses. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an Non-Network provider.

Consumer Option benefits	You pay	Page(s)
Network Preventive care (see specific services)	Network: Nothing (No deductible) Non-Network: All charges	41
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Network: • Physician's office services: $15 copayment per office visit • Diagnostic X-rays and laboratory services: $15 copayment per visit • Surgery, maternity and hospital visits: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount	46
Services provided by a hospital: Inpatient	Network: $75 copayment per day, up to maximum of $750 per admission Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount	71
Services provided by a hospital: Outpatient (Non-surgical)	Network: $75 copayment per occurrence for outpatient hospital services Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount	73
Services provided by a hospital: Outpatient (Surgical)	Network: $150 copayment per occurrence for outpatient surgery Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount	73
Emergency benefits: Accidental injury/Medical emergency	Network: $50 copayment per occurrence Non-Network: $50 copayment per occurrence and any difference between our allowance and the billed amount	77
Mental health and substance use disorder treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	79
Prescription drugs	Network Retail:	83

	• Generic: $10 copayment per prescription • Preferred brand name: 30% coinsurance • Non-Preferred brand name: 50% coinsurance Mail order drug program: • Generic: $20 copayment per prescription • Preferred brand name: $80 copayment per prescription • Non-Preferred brand name: $120 copayment per prescription Non-Network Retail: All charges Specialty Drugs: • 30% of the Plan’s allowance for Generic/Preferred brand name, limited to $225 per prescription for a 30-day supply; 30% of the Plan's allowance for Non-Preferred brand name, limited to $275 per prescription for a 30-day supply • 30% of the Plan’s allowance for Generic/Preferred brand name, limited to $425 per prescription for a 90-day supply; 30% of the Plan's allowance for Non-Preferred brand name, limited to $500 per prescription for a 90-day supply	
Dental care	Accidental injury; Oral surgery	89
Special features	Care Management Program; Flexible Benefits Option; Compassionate Care program; Diabetes incentive program; Health Risk Assessment; Health risk assessment; Biometric Screening; Pain Management program; Lifestyle and Condition Coaching Program; Personal Health Record; Enhanced Maternity Program with family-building support powered by Maven; Discount Drug program; Round-the-clock Member Support	90
Protection against catastrophic costs (out-of-pocket maximum)	Network: Nothing after your covered expenses total $6,000 for a Self Only enrollment ($12,000 Self and Family) per calendar year for Network providers/facilities Non-Network: Nothing after your covered expenses total $7,500 for a Self Only enrollment ($15,000 Self and Family) per calendar year for Non-Network providers/facilities Some costs do not count toward this protection.	27

2024 Rate Information for MHBP Consumer Option

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**.**

Premiums for Tribal employees are shown under the Monthly Premium Rate. 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	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Nationwide					
HDHP Option Self Only	481	$236.08	$78.69	$511.50	$170.50
HDHP Option Self Plus One	483	$522.43	$174.14	$1,131.93	$377.31
HDHP Option Self and Family	482	$548.54	$182.85	$1,188.51	$396.17