



# MHBP HEALTH PLANS

THREE PLANS, ONE MISSION.  
A HEALTHIER YOU.

**MHBP**<sup>SM</sup>  
Open to all federal employees



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**They've treated us like family.  
It's just been the right fit for us.**

— John G., MHBP member

”

# PLANS THAT FIT YOU.

**That's you, federal employees. Regardless of what job you do in the service of the U.S. public, this plan is your plan.**

**MHBP** provides plans with:



Outstanding plan satisfaction, per **OPM.gov** Consumer Satisfaction Survey Results.

**If you aren't happy, we aren't happy.**



A large, nationwide network of over 1.6 million capable care providers and hospitals.

**When you need care, it's never too far.**



No referrals required to see a specialist.

**No jumping through hoops to see the right doctor.**



Even more, MHBP is backed by Aetna®, a CVS Health® company — **a name you know and trust.**

## CONNECT WITH MHBP

To attend or register for a webinar or to schedule a one-on-one phone consultation, go to **MHBP.com** and click on 'Connect with Us Live' at the top of the page.



# STANDARD OPTION



## Overview

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Low rates,  
rich benefits.

## Benefits

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- **\$350** in wellness rewards
- **No cost** MinuteClinic® visits at a CVS Pharmacy®\*
- **No cost** for telehealth services through Teladoc®
- **No out-of-pocket costs** for maternity care
- **40** alternative care visits per year for chiropractic care and acupuncture combined
- **No cost** for Lab Savings Program

# STANDARD OPTION

## BENEFITS AT-A-GLANCE

These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to the FEHB Program website or contact the agency or Tribal Employer which maintains your health benefits enrollment.

Plan Types	Federal Employees (biweekly)	Annuitants (monthly)
<b>Self Only</b> CODE 454	<b>\$80.61</b>	<b>\$174.65</b>
<b>Self Plus One</b> CODE 456	<b>\$185.54</b>	<b>\$402.01</b>
<b>Self and Family</b> CODE 455	<b>\$187.33</b>	<b>\$405.88</b>

DO NOT RELY ON THIS CHART ALONE. All benefits are fully described in the official Plan Brochure (RI 71-007).

Network Benefits	Cost	
<b>Preventive Care</b> Annual physical exam, routine screenings, well-child care, women's preventive care, immunizations and more	<b>You pay nothing</b>	
<b>Primary Care Doctor Office Visits</b>	<b>\$20</b> copay ( <b>\$10</b> copay for dependents through age 21)	
<b>Specialist Visits</b>	<b>\$30</b> copay	
<b>Walk-in Clinic Visits</b>	<b>\$5</b> copay	
<b>MinuteClinic® Visits</b>	<b>You pay nothing</b>	
<b>Alternative Care</b> (40-visit combined maximum)		
Chiropractic	<b>\$20</b> copay per visit	
Acupuncture	<b>10%</b> of Plan allowance	
<b>Lab Savings Program</b>	<b>You pay nothing</b> for covered lab tests with the Lab Savings Program when LabCorp® or Quest Diagnostics™ performs the testing	
<b>Prescription Drugs at Retail Mail order and specialty pharmacy are available. Out-of-pocket costs may vary. (30-day supply)</b>	Generic	<b>\$5</b> copay
	Preferred Brand <sup>†</sup>	<b>30%</b> of Plan allowance, limited to <b>\$200</b> per prescription
	Non-preferred Brand <sup>†</sup>	<b>50%</b> of Plan allowance, limited to <b>\$200</b> per prescription
<b>Emergency Room Visits</b>	<b>\$200</b> copay* No deductible for accidental injury. Copay is waived if admitted to the hospital	
<b>Urgent Care Center Visits</b>	<b>\$50</b> copay per visit	
<b>Hospital Inpatient</b>	<b>\$200</b> copay per admission and <b>10%</b> of Plan allowance for ancillary services	
<b>Maternity</b>	<b>You pay nothing</b>	
<b>Calendar Year Deductible</b>	<b>\$350</b> per person, limited to <b>\$700</b> per Self Plus One or Self and Family enrollment	
<b>Out-of-pocket Limits</b> There are separate limits for Non-Network out-of-pocket expenses	<b>\$6,000</b> per person, limited to <b>\$12,000</b> per Self Plus One or Self and Family enrollment	

<sup>†</sup> You will pay the copay or coinsurance amount and the difference in cost between our allowance for the generic and brand-name drugs when a generic is available, unless a brand exception is obtained.

\* The calendar year deductible applies and must be met before benefits begin.

# CONSUMER OPTION (HDHP)



## Overview

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Part health plan, part savings account that's there when you need it.

## Benefits

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- **Low copays** for services after deductible is met\*
- **No cost** for telehealth through Teladoc®\*
- **No cost** MinuteClinic® visits at a CVS Pharmacy®\*
- **40** alternative care visits per year for chiropractic care and acupuncture combined\*
- **No cost** for Lab Savings Program\*

# CONSUMER OPTION (HDHP)

## BENEFITS AT-A-GLANCE

These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to the FEHB Program website or contact the agency or Tribal Employer which maintains your health benefits enrollment.

Plan Types	Federal Employees (biweekly)	Annuitants (monthly)
<b>Self Only</b> CODE 481	<b>\$78.69</b>	<b>\$170.50</b>
<b>Self Plus One</b> CODE 483	<b>\$174.14</b>	<b>\$377.31</b>
<b>Self and Family</b> CODE 482	<b>\$182.85</b>	<b>\$396.17</b>

DO NOT RELY ON THIS CHART ALONE. All benefits are fully described in the official Plan Brochure (RI 71-016).

Network Benefits	Cost
<b>Plan contribution to your HSA</b>	<b>\$1,200</b> Self Only; <b>\$2,400</b> Self Plus One or Self and Family
<b>Preventive Care</b> Annual physical exam, routine screenings, well-child care, women's preventive care, immunizations and more	<b>You pay nothing</b>
<b>Primary Care Doctor Office Visits</b>	<b>\$15</b> copay*
<b>Specialist Visits</b>	<b>\$15</b> copay*
<b>Walk-in Clinic Visits</b>	<b>\$5</b> copay*
<b>MinuteClinic® Visits</b>	<b>You pay nothing*</b>
<b>Alternative Care (Chiropractic and Acupuncture)</b>	<b>\$15</b> copay* per visit 40-visit combined maximum
<b>Lab Savings Program</b>	<b>You pay nothing*</b> for covered lab tests with the Lab Savings Program when LabCorp® or Quest Diagnostics™ performs the testing
<b>Prescription Drugs at Retail Mail order and specialty pharmacy are available. Out-of-pocket costs may vary. (30-day supply)</b>	<b>Generic*</b> <b>\$10</b> copay*
	<b>Preferred Brand††</b> <b>30%</b> of Plan allowance,†† limited to <b>\$200</b> per prescription*
	<b>Non-preferred Brand††</b> <b>50%</b> of Plan allowance,†† limited to <b>\$200</b> per prescription*
<b>Emergency Room Visits</b>	<b>\$50</b> copay* is waived if you are admitted to the hospital
<b>Urgent Care Center Visits</b>	<b>\$50</b> copay*
<b>Hospital Inpatient</b>	<b>\$75</b> copay per day <b>\$750</b> max. per admission*
<b>Maternity</b>	<b>You pay nothing*</b>
<b>Calendar Year Deductible</b>	<b>\$2,000</b> per Self Only enrollment; <b>\$4,000</b> per Self Plus One or Self and Family enrollment
<b>Out-of-pocket Limits</b> There are separate limits for Non-Network out-of-pocket expenses	<b>\$6,000</b> per person, limited to <b>\$12,000</b> per Self Plus One or Self and Family enrollment

\* The calendar year deductible applies and must be met before benefits begin.

\*\* Deductible applies to both preferred and non-preferred brand drugs

† You will pay the copay or coinsurance amount and the difference in cost between our allowance for the generic and brand-name drugs when a generic is available, unless a brand exception is obtained.

# PLAN VALUE



## Overview

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Simple, affordable coverage to protect you from the unexpected.

## Benefits

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- **\$300** in wellness rewards
- **No out-of-pocket costs** for maternity care
- **No cost** for telehealth through Teladoc®
- **No cost** MinuteClinic® visits at a CVS Pharmacy®\*
- **40** alternative care visits per year for chiropractic care and acupuncture combined
- **No cost** for Lab Savings Program



# VALUE PLAN

## BENEFITS AT-A-GLANCE

These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to the FEHB Program website or contact the agency or Tribal Employer which maintains your health benefits enrollment.

Plan Types	Federal Employees (biweekly)	Annuitants (monthly)
<b>Self Only</b> CODE 414	<b>\$58.20</b>	<b>\$126.11</b>
<b>Self Plus One</b> CODE 416	<b>\$137.91</b>	<b>\$298.81</b>
<b>Self and Family</b> CODE 415	<b>\$140.66</b>	<b>\$304.77</b>

DO NOT RELY ON THIS CHART ALONE. All benefits are fully described in the official Plan Brochure (RI 71-007).

Network Benefits	Cost
<b>Preventive Care</b> Annual physical exam, routine screenings, well-child care, women's preventive care, immunizations and more	<b>You pay nothing</b>
<b>Primary Care Doctor Office Visits</b>	<b>\$30</b> copay ( <b>\$10</b> copay for dependents through age 21)
<b>Specialist Visits</b>	<b>\$50</b> copay*
<b>Walk-in Clinic Visits</b>	<b>\$15</b> copay ( <b>\$5</b> copay for dependents through age 21)
<b>MinuteClinic® Visits</b>	<b>You pay nothing</b>
<b>Alternative Care (Chiropractic and Acupuncture)</b>	<b>20%</b> of the Plan allowance 40-visit maximum
<b>Lab Savings Program</b>	<b>You pay nothing</b> for covered lab tests with the Lab Savings Program when LabCorp® or Quest Diagnostics™ performs the testing
<b>Prescription Drugs at Retail Mail order and specialty pharmacy are available. Out-of-pocket costs may vary. (30-day supply)</b>	<b>Generic</b> <b>45%</b> of Plan allowance, limited to <b>\$500</b> per prescription
	<b>Preferred Brand<sup>†</sup></b> <b>45%</b> of Plan allowance
	<b>Non-preferred Brand<sup>†</sup></b> <b>75%</b> of Plan allowance, limited to <b>\$700</b> per prescription
<b>Emergency Room Visits</b> Copay is waived if you are admitted to the hospital	<b>20%</b> of Plan allowance*
<b>Urgent Care Center Visits</b>	<b>20%</b> of Plan allowance
<b>Hospital Inpatient</b>	<b>20%</b> of Plan allowance*
<b>Maternity</b>	<b>You pay nothing</b>
<b>Calendar Year Deductible</b>	<b>\$600</b> per person, limited to <b>\$1,200</b> per Self Plus One or Self and Family enrollment
<b>Out-of-pocket Limits</b> There are separate limits for Non-Network out-of-pocket expenses	<b>\$6,600</b> Self Only, <b>\$13,200</b> Self Plus One or Self and Family enrollment

\* The calendar year deductible applies and must be met before benefits begin.

† You will pay the copay or coinsurance amount and the difference in cost between our allowance for the generic and brand-name drugs when a generic is available, unless a brand exception is obtained.

# MHBP DENTAL AND VISION PLANS.

It's easy to enhance your medical coverage with a dental and/or vision plan. All FEHBP members are eligible to add this optional coverage at affordable group rates.\* In fact, you can add a Dental and/or Vision plan even if you're not enrolled in an MHBP health plan. Enroll anytime — not just during Open Season.

## MHBP Dental Plan

### Your dental benefits include:

- Preventive Care covered 100% twice a year
- Basic Services,\*\* such as fillings and extractions, covered at 70% for the first 12 months and 80% thereafter
- Major Services,\*\* such as root canals and crowns, covered at 50% starting at the 13th month
- Orthodontic benefits\*\* for members age 18 and under begin the 25th month of coverage

## MHBP Vision Plan

**Get affordable vision coverage for low monthly premiums: \$8.60 for Self Only and \$16.00 for Self and Family.**

- Eye exams and lenses every 12 months for just a \$10 copay each
- \$120 for frames (every 24 months) or contact lenses (every 12 months)
- Nationwide coverage for eye exams, frames and lenses, contacts, laser vision correction discounts and more

**Call 1-800-254-0227 (TTY: 711) or visit [MHBP.com](https://www.mhbp.com) to learn more and enroll.**

**ENROLL IN DENTAL AND VISION PLANS ANYTIME!**

You don't need MHBP medical coverage to sign up.

Learn more at [MHBP.com](https://www.mhbp.com)

\* Dental and vision coverage provided by First Health Life & Health Insurance Company. These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all FEHBP enrollees and their covered family members. You cannot file an FEHBP disputed claim about them. The premiums and fees you pay for these services do not count toward FEHBP deductibles or out-of-pocket maximums.

\*\* For dental coverage, the annual deductible applies (\$50 per person, \$150 per family) and the annual benefit maximum is \$2,000 per person per calendar year. Orthodontic benefits are limited to \$1,000 per person per lifetime. After the first year, premiums are subject to change with 60 days' notice. Coverage will not begin without payment of premium, and it is renewable as long as your premiums are paid, the Master Group Policy remains in force, and you remain eligible for this coverage. The dental PPO network is made available by Guardian Life Insurance Company of America. Benefits are not provided for services rendered outside the 50 United States and the District of Columbia.

# Benefits you'll actually use.

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We're raising quality standards, while keeping comparably low rates. It's what federal employees deserve, after all.

**NO COST\***

Telehealth visits through Teladoc®

**\$300-\$350\*\***

in wellness rewards

**NO COST\***

lab work with Quest Diagnostics™ or LabCorp®

**ADDITIONAL ALTERNATIVE CARE VISITS\***

40 chiropractic and acupuncture visits combined

**READY TO TALK?**

visit [MHBP.com/Live](https://www.mhbp.com/Live) to schedule your consultation or call **1-800-410-7778** (TTY: 711)

**WORLDWIDE COVERAGE**

Access to care with providers all over the globe

**NO COST**

Nurseline services

**DEDICATED CUSTOMER SERVICE TEAM**

exclusively to MHBP members

**100%\***

coverage for network maternity care

\* Consumer Option must meet their deductible first.

\*\* Does not apply to Consumer Option.



## Shop. Compare. Choose MHP.

How do you select a plan for you and your family? Choice is good a thing, but choosing isn't always easy. And you want to make the right decision. So start by determining what's most important to you:

- What kind of medical services will I need this year?
- Do my current benefits meet my medical needs?
- Are there upcoming life events that could impact my coverage?
- Does my plan's selection of Network providers meet my needs?
- Are my total out-of-pocket costs (premium, deductibles, copay and coinsurance) manageable?
- Does my plan's customer service meet my expectations?

Now that you have a feel for what you need for the coming year, use this guide to compare an MHP plan to your current plan or to another health plan. Fill in the blanks for your current health plan — and for any other plans you may be considering. Add in other features that are important to you. Then compare the results. See which plan is the best fit for your health needs.

### Retiring soon?

Check out how MHP can work for retirees at [MHBP.com/Retiree](https://www.mhbp.com/Retiree).

If you have questions about MHP, call **1-800-410-7778 (TTY: 711)**, 24 hours a day, 7 days a week except major holidays.



SCAN ME

# STANDARD OPTION

## COMPARISON CHART

These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to the FEHB Program website or contact the agency or Tribal Employer which maintains your health benefits enrollment.

Plan features to compare		MHBP Plan	Your current plan
2023 Premium (Biweekly)*	Self Only	\$80.61	
	Self Plus One	\$185.54	
	Self and Family	\$187.33	
Deductible		\$350 Self/\$700 Self Plus One or Self and Family	
<b>Network benefits</b>			
Primary Care Visits		\$20 copay (\$10 copay for dependents through age 21)	
Specialist Visits		\$30 copay	
Referral needed for Specialist Visit		No	
Preventive Care		You Pay Nothing	
Maternity Care		You Pay Nothing	
Walk-In Clinic Visits		\$5 copay	
MinuteClinic® Visits		You Pay Nothing	
Generic Prescriptions		\$5 copay	
Surgical Procedures		10% of the Plan's allowance**	
<b>Service and special features</b>			
Wellness Rewards		Up to \$350/year	
Nationwide network with the doctors and hospitals I need		Over 1.6 million providers nationwide plus worldwide coverage	
Non-Network benefits also available		Yes	
Customer Service available 24 hours a day, 7 days a week except major holidays		Yes	
<b>Other features (add what's important to you)</b>			

\* Other rates available at [MHBP.com](http://MHBP.com)

\*\* The calendar year deductible applies and must be met before benefits begin.

# CONSUMER OPTION (HDHP)

## COMPARISON CHART

These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to the FEHB Program website or contact the agency or Tribal Employer which maintains your health benefits enrollment.

Plan features to compare		MHBP Plan	Your current plan
2023 Premium (Biweekly)*	Self Only	\$78.69	
	Self Plus One	\$174.14	
	Self and Family	\$182.85	
Plan contribution to HSA		\$1,200 Self Only, \$2,400 Self Plus One and Self Plus Family	
Deductible		\$2,000 Self and \$4,000 Self Plus One or Self Plus Family	
<b>Network benefits**</b>			
Primary Care Visits		\$15 copay	
Specialist Visits		\$15 copay	
Referral needed for Specialist Visit		No	
Preventive Care (not subject to deductible)		You Pay Nothing	
Maternity Care		You Pay nothing	
Walk-In Clinic Visits		\$5 copay	
MinuteClinic® Visits		You Pay nothing	
Generic Prescription		\$10 copay	
Surgical Procedures		\$150 copay per occurrence	
<b>Service and special features</b>			
Diabetic Incentive Program		\$75	
Nationwide network with the doctors and hospitals I need		Over 1.6 million providers nationwide plus worldwide coverage	
Non-Network benefits also available		Yes	
Customer Service available 24 hours a day, 7 days a week except major holidays		Yes	
<b>Other features (add what's important to you)</b>			

\* Other rates available at [MHBP.com](http://MHBP.com)

\*\* The calendar year deductible applies and must be met before benefits begin.

# VALUE PLAN COMPARISON CHART

These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to the FEHB Program website or contact the agency or Tribal Employer which maintains your health benefits enrollment.

Plan features to compare		MHBP Plan	Your current plan
2023 Premium (Biweekly)*	Self Only	<b>\$58.20</b>	
	Self Plus One	<b>\$137.91</b>	
	Self and Family	<b>\$140.66</b>	
Deductible		<b>\$600</b> Self Only and <b>\$1,200</b> Self Plus One or Self and Family	
<b>Network benefits</b>			
Primary Care Visits		<b>\$30</b> copay for adults	
Specialist Visits		<b>\$50</b> copay**	
Referral needed for Specialist Visit		<b>No</b>	
Preventive Care		<b>You Pay Nothing</b>	
Maternity Care		<b>You Pay Nothing</b>	
Walk-In Clinic Visits		<b>\$15</b> copay for adults <b>\$5</b> copay for dependents through age 21	
MinuteClinic® Visits		<b>You Pay Nothing</b>	
Generic Prescriptions		<b>\$10</b> copay	
Surgical Procedures		<b>20%</b> of the Plan's allowance**	
<b>Service and special features</b>			
Wellness Rewards		<b>\$300</b>	
Nationwide network with the doctors and hospitals I need		Over <b>1.6 million</b> providers nationwide plus worldwide coverage	
Non-Network benefits also available		<b>Yes</b>	
Customer Service available 24 hours a day, 7 days a week except major holidays		<b>Yes</b>	
<b>Other features (add what's important to you)</b>			

\* Other rates available at [MHBP.com](http://MHBP.com)

\*\* The calendar year deductible applies and must be met before benefits begin.

**HIGH STANDARDS.**  
**LOW RATES.**

## Retiring soon?

Check out how MHPB can work for retirees at [MHPB.com/Retiree](https://MHPB.com/Retiree)

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**You can't put a clock on your needs for health care and for answers. So, I can reach out at any time during the day and get the service that I need.**

— Michael H., MHPB member

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SCAN ME

Call **1-800-410-7778 (TTY: 711)**, or visit **MHPB.com/Live** for one-on-one consultations, live chat and webinars.

Providers are independent contractors and are not agents of Aetna®. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Includes select MinuteClinic services. Not all MinuteClinic services are covered. Please consult benefit documents to confirm which services are included. Members enrolled in qualified high-deductible health plans must meet their deductible before receiving covered non-preventive MinuteClinic services on a cost-share. However, such services are covered at negotiated contract rates. This benefit is not available in all states and on indemnity plans.

Teladoc® is not available to all members. Teladoc and Teladoc physicians are independent contractors and are not agents of Aetna. Visit [Teladoc.com/Aetna](https://Teladoc.com/Aetna) for a complete description of the limitations of Teladoc services. Teladoc, Teladoc Health and the Teladoc Health logo are registered trademarks of Teladoc Health, Inc.

Information is accurate as of the production date but may change.

This is a brief description of the features of the MHPB Plans. Before making a final decision, please read the official Plan Brochures (RI 71-007 or RI 71-016). All benefits are subject to the definitions, limitations and exclusions set forth in the 2023 official Plan Brochures. A single annual \$52 associate membership fee makes all MHPB plans available to you.

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