MOST UTILIZED HEALTH PLANS 2018 RATES AND ENROLLMENT CODES

Attached are some of the top Federal Health Plans utilized by DCRB annuitants. For your convenience, we have enclosed information about the 2018 premiums and enrollment codes.

Below are the specific links to the plan information provided in this mailing.

Blue Cross & Blue Shield
https://www.fepblue.org/en/benefit-plans/benefit-plans-brochures-and-forms/#

Kaiser Foundation HP - The Mid Atlantic
http://healthplans.kaiserpermanente.org/federalemployees/virginia-washington-dc-maryland/shop-and-enroll

Government Employees Hospital Association
https://www.geha.com/enroll/plan-brochures

Aetna Open Access
http://www.aetnafeds.com/brochures.php

Mail Handlers Benefit Plan
http://www.mhbp.com/health-plans/official-plan-brochures/index.htm

M.D. IPA: The Quality Care HP
https://www.uhcfeds.com/static/pdf/mdipa/73-100_COC_JP_2018_FINAL_op.pdf

Capital Care, Inc. (CareFirst Blue Choice)
http://www.carefirst.com/fedhmo/

For access to these and other complete plan brochures you may either visit the plan provider's web page or OPM's health plan web page at https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/.

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2018

A fee-for-service plan (standard and basic option) with a preferred provider organization

IMPORTANT:

- Rates: Back Cover
- Changes for 2018: Pages 16-18
- Summary of benefits: Pages 160-163

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See pages 5 and 10 for details. This Plan is accredited. See page 14.

Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees, Tribal employees, and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program

Enrollment codes for this Plan:

104 Standard Option - Self Only
106 Standard Option - Self Plus One
105 Standard Option - Self and Family
111 Basic Option - Self Only
113 Basic Option - Self Plus One
112 Basic Option - Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
www.opm.gov/healthcare-insurance

RI 71-005

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2018

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

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.

Basic Option does not provide benefits when you use Non-Preferred providers. For a list of the exceptions to this requirement, see page 21. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; $30 per office visit for primary care physicians and other healthcare professionals; $40 per office visit for specialists Non-PPO: You pay all charges	38-40 41-48
Telehealth services	PPO: $15 Non-PPO: You pay all charges	39, 98
Services provided by a hospital:		
• Inpatient	PPO: $175 per day up to $875 per admission Non-PPO: You pay all charges	80-81
• Outpatient	PPO: $100 per day per facility Non-PPO: You pay all charges	82-85
Emergency benefits:		
• Accidental injury	PPO: $35 copayment for urgent care; $125 copayment for emergency room care Non-PPO: $125 copayment for emergency room care; you pay all charges for care in settings other than the emergency room Ambulance transport services: $100 per day for ground ambulance; $150 per day for air or sea ambulance	94-95
• Medical emergency	Same as for accidental injury	93, 95-96
Mental health and substance use treatment	PPO: Regular cost-sharing, such as $30 office visit copayment; $175 per day up to $875 per inpatient admission Non-PPO: You pay all charges	97-100

Basic Option Summary – continued on next page

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2018 *(continued)*

Prescription drugs	Retail Pharmacy Program: • PPO: $10 generic/$50 Preferred brand-name per prescription ($45 if you have primary Medicare Part B)/60% coinsurance ($75 minimum) for non-preferred brand-name drugs (50% ($60 minimum) if you have primary Medicare Part B) • Non-PPO: You pay all charges Specialty Drug Pharmacy Program: • See inside for details Mail Service Prescription Drug Program (for primary Medicare Part B Members only): $20 generic/$90 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply	111-113
Dental care	PPO: $30 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $30 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	70, 116, 119
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor & Hospital Finder℠; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		120-124
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $5,500 (PPO) per contract per year • Self Plus One: Nothing after $11,000 (PPO) per contract per year • Self and Family: Nothing after $11,000 (PPO) per contract per year; nothing after $5,500 (PPO) per individual per year Note: Some costs do not count toward this protection. Note: When one covered family member (Self Plus One and Self and Family contracts) reaches the Self Only maximum during the calendar year, that member's claims will no longer be subject to associated Member cost-share amounts for the remainder of the year. All remaining family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.	32

2018 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

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

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

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, NPPN, and NRLCA.

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

Non-Postal rates apply to all career non-bargaining unit Postal Service employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: 877-477-3273, option 5, TTY: 866-260-7507

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career Postal employees.

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Enrollment Code	Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Standard Option Self Only	104	$229.25	$113.16	$496.71	$245.18	$106.79	$100.43
Standard Option Self Plus One	106	$491.00	$257.81	$1,063.83	$558.59	$244.17	$230.53
Standard Option Self and Family	105	$521.58	$271.95	$1,130.09	$589.23	$257.46	$242.97
Basic Option Self Only	111	$221.18	$73.72	$479.21	$159.74	$67.09	$61.19
Basic Option Self Plus One	113	$491.00	$171.84	$1,063.83	$372.32	$158.20	$144.56
Basic Option Self and Family	112	$521.58	$180.98	$1,130.09	$392.12	$166.49	$152.00

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

www.kp.org/feds

Member Services 877-KP4-FEDS (877-574-3337) (TTY: 711)

2018

A Health Maintenance Organization (High, Standard and Basic Options)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 27.

Serving: *Washington, DC, Northern Virginia, and Metropolitan Baltimore, Maryland Area*

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 12 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 15
- Summary of benefits: Page 103

Enrollment codes for this Plan:

E31 High Option - Self Only
E33 High Option - Self Plus One
E32 High Option - Self and Family

E34 Standard Option - Self Only
E36 Standard Option - Self Plus One
E35 Standard Option - Self and Family

T71 Basic Option - Self Only
T73 Basic Option - Self Plus One
T72 Basic Option - Self and Family

Authorized for distribution by the:

United States Office of Personnel Management

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

RI 73-047

Summary of benefits for the High Option of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- 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.
- We only cover services provided or arranged by Medical Group physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$10 per primary care office visit (nothing from infancy through age 4); $20 per specialty care office visit	29
Services provided by a hospital:		
• Inpatient	$100 per admission	58
• Outpatient	$75 per visit	59
Emergency benefits:		
• In-area and Out-of-area	$100 per visit	63
Mental health and substance misuse treatment:	Regular cost-sharing	65
Prescription drugs:		
• Plan pharmacy	$7 generic; $30 preferred brand-name; $45 non-preferred brand-name; $100 specialty	69
• Affiliated network pharmacy	$17 generic; $50 preferred brand-name; $65 non-preferred brand-name; $150 specialty.	69
• Mail service delivery	$5 generic; $28 preferred brand-name; $43 non-preferred brand-name; $100 specialty.	69
Dental care:	Various copayments based on procedure rendered	73
Vision care:	$10 per office visit (one visit at no charge for children through the end of the month they turn age 19).	40
Special features: Flexible benefits option; Options for care; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards		77
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $2,250/Self Only or $4,500/ Family enrollment per year. Some costs do not count toward this protection.	23

Summary of benefits for the Standard Option of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- 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.
- We only cover services provided or arranged by Medical Group physicians, except in emergencies.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$20 per primary care office visit (nothing from infancy through age 17); $30 per specialty care office visit	29
Services provided by a hospital:		
• Inpatient	$500 per admission	58
• Outpatient	$150 per visit	59
Emergency benefits:		
• In-area and Out-of-area	$150 per visit	63
Mental health and substance misuse treatment:	Regular cost-sharing	65
Prescription drugs:		
• Plan pharmacy	$10 generic; $40 preferred brand-name; $60 non-preferred brand-name; $150 specialty.	69
• Affiliated network pharmacy	$20 generic; $60 preferred brand-name; $80 non-preferred brand-name; $200 specialty.	69
• Mail service delivery	$8 generic; $38 preferred brand-name; $58 non-preferred brand-name; $150 specialty.	69
Dental care:	Various copayments based on procedure rendered	73
Vision care:	$20 per office visit (one visit at no charge for children through the end of the month they turn age 19).	40
Special features: Flexible benefits option; Options for care; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards		77
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $3,500/Self Only or $7,000/ Family enrollment per year. Some costs do not count toward this protection.	23

Summary of benefits for the Basic Option of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.-2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- 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.
- We only cover services provided or arranged by Medical Group physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the calendar year medical deductible.

Basic Option Benefits	You Pay	Page
Deductible:		
• Covered services	$100 per person and $200 per family	23
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$30 per primary care office visit (nothing from infancy through age 17); $40 per specialty care office visit	29
Services provided by a hospital:		
• Inpatient	$750 per admission*	58
• Outpatient	$300 per visit*	59
Emergency benefits:		
• In-area and Out-of-area	$150 per visit*	63
Mental health and substance misuse treatment:	Regular cost-sharing	65
Prescription drugs:		
• Plan pharmacy	$10 generic; $45 preferred brand-name; $65 non-preferred brand-name; $200 specialty.	69
• Affiliated network pharmacy	$20 generic; $65 preferred brand-name; $85 non-preferred brand-name; $250 specialty	69
• Mail service delivery	$8 generic; $43 preferred brand-name; $63 non-preferred brand-name; $200 specialty.	69
Dental care:	Various copayments based on procedure rendered	73
Vision care:	$30 per office visit (one visit at no charge for children through the end of the month they turn age 19).	40
Special features: Flexible benefits option; Options for care; Centers of Excellence; Services for the deaf, hard of hearing or speech impaired; Services from other Kaiser Permanente or allied plans; Travel benefit; Rewards		77
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $4,000/Self Only or $8,000/ Family enrollment per year. Some costs do not count toward this protection.	23

2018 Rate Information for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

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

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

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, NPPN and NRLCA.

Postal Category 2 rates apply to career bargaining unit employees who are represented by the following agreements: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: 877-477-3273, option 5, (TTY: 866-260-7507)

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career Postal employees.

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contributions 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.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Enrollment Code	Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	E31	$228.59	$76.19	$495.27	$165.09	$69.34	$63.24
High Option Self Plus One	E33	$491.00	$210.00	$1,063.83	$455.00	$196.36	$182.72
High Option Self and Family	E32	$521.58	$179.42	$1,130.09	$388.74	$164.93	$150.44
Standard Option Self Only	E34	$174.80	$58.26	$378.72	$126.24	$53.02	$48.36
Standard Option Self Plus One	E36	$402.05	$134.02	$871.12	$290.37	$121.96	$111.23
Standard Option Self and Family	E35	$402.05	$134.02	$871.12	$290.37	$121.96	$111.23
Basic Option Self Only	T71	$159.24	$53.08	$345.02	$115.01	$48.30	$44.06
Basic Option Self Plus One	T73	$348.31	$116.10	$754.67	$251.55	$105.65	$96.37
Basic Option Self and Family	T72	$382.33	$127.44	$828.38	$276.12	$115.97	$105.78

GEHA Benefit Plan

www.geha.com

800-821-6136

2018

A fee-for-service (High and Standard options) health plan with a preferred provider organization

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 page 13.

IMPORTANT

- Rates: Back Cover
- Changes for 2018: Page 15
- Summary of benefits: Page 123

Sponsored and administered by:
Government Employees Health Association, Inc.

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program may become members of GEHA. You must be, or must become a member of Government Employees Health Association, Inc.

To become a member: You join simply by signing a completed Standard Form 2809, Health Benefits Registration Form, evidencing your enrollment in the Plan.

Membership dues: There are no membership dues for the Year 2018.

Enrollment codes for this Plan:

311 High Option - Self Only
313 High Option - Self Plus One
312 High Option - Self and Family
314 Standard Option - Self Only
316 Standard Option - Self Plus One
315 Standard Option - Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 71-006

Summary of benefits for the High Option of the Government Employees Health Association, Inc. 2018

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

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

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $20 copay per covered office visit and 10%* of the covered professional services including X-ray and lab Non-PPO: 25%* of covered professional services	33
Services provided by a hospital:		
• Inpatient	PPO: 10% of room and board and other hospital charges, inpatient $100 per admission copayment applies Non PPO: 25% of room and board and other hospital charges, inpatient $300 per admission copayment applies	63
• Outpatient	PPO: 10%* of other hospital charges Non PPO: 25%* of other hospital charges	65
Emergency benefits:		
• Accidental injury	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident	68
• Medical emergency	Regular benefits*	69
Mental health and substance misuse disorder treatment:	Regular cost-sharing*	71
Prescription drugs:		
• Retail pharmacy	Network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/25% preferred drugs for up to a maximum of $150 for up to a 30-day supply/40% non-preferred drugs for up to a maximum of $200 for up to a 30-day supply/$10 plus the difference in cost between the brand name and the generic for up to a 30-day supply for the initial fill and first refill. For subsequent refills, you pay the greater of 50% or the amount described above (except for Maintenance Choice).	81

High Option Benefits	You pay	Page
• Retail pharmacy	Non-network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/25% preferred drugs for up to a maximum of $150 for up to a 30-day supply/40% non-preferred drugs for up to a maximum of $200 for up to a 30-day supply /$10 plus the difference in cost between the brand name and the generic for up to a 30-day supply for the initial fill and first refill. For subsequent refills you pay the greater of 50% or the amount described above and any difference between our allowance and the cost of the drug. Copayments and coinsurance go toward a $5,500 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic.	81
• Mail order	Member pays lesser of $20 or the cost of the drug for generic drugs/25% preferred drugs for up to a maximum of $350 for up to a 90-day supply/40% non-preferred drugs for up to a maximum of $500 for up to a 90-day supply /$20 plus the difference in cost between the brand name and the generic for up to a 90-day supply. Copayments and coinsurance go toward a $5,500 annual PPO out-of-pocket except for the difference in cost between the brand name and the generic.	81
Dental care:	Charges in excess of the scheduled amounts for diagnostic and preventive service, restorations, and extractions	88
Wellness and other special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, Health Advice Line, Health Assessment and Personal Health Record	90
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $5,500 Self Only ($7,000 Self Plus One or Self and Family) per year for PPO providers Nothing after $7,500 Self Only ($9,000 Self Plus One or Self and Family) per year for non-PPO providers Some costs do not count toward this protection	28

Summary of benefits for the Standard Option of the Government Employees Health Association, Inc. 2018

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

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

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

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $15 copay primary care physician; $30 copay specialist for covered office visits and 15%* of other covered professional services including X-ray and lab Non-PPO: 35%* of covered professional services	33
Services provided by a hospital:		
• Inpatient	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	63
• Outpatient	PPO: 15%* of covered hospital charges Non PPO: 35%* of covered hospital charges	65
Emergency benefits:		
• Accidental injury	Nothing up to Plan allowance of covered charges incurred within 72 hours of an accident	68
• Medical emergency	Regular benefits*	69
Mental health and substance misuse disorder treatment:	Regular cost-sharing*	71
Prescription drugs:		
• Retail pharmacy	Network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/50% brand name for up to a maximum of $200 for up to a 30-day supply Non-network pharmacy: Member pays lesser of $10 or pharmacy's usual and customary cost for generic drugs/50% brand name for up to a maximum of $200 for up to a 30-day supply and any difference between our allowance and the cost of the drug. Copayments and coinsurance for prescription drugs go toward a $6,000 annual out-of-pocket limit except for the difference in cost between the brand name and the generic.	81

Standard Option Benefits	You pay	Page
• Mail order	Member pays lesser of $20 or the cost of the drug for generic drugs/50% brand name for up to a maximum of $500 for up to a 90-day supply Copayments and coinsurance for prescription drugs go toward a $6,000 annual out-of-pocket limit except for the difference in cost between the brand name and the generic.	81
Dental care:	50% up to Plan allowance for diagnostic and preventive services and charges in excess of the scheduled amounts for restorations and extractions	88
Wellness and other special features:	Flexible benefits options, online customer and claims services, Services for deaf and hearing impaired, High risk pregnancies, Lab Card Program, Health Advice Line, Health Assessment and Personal Health Record	90
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):	Nothing after $6,000 Self Only ($7,500 Self Plus One or Self and Family) per year for PPO providers Nothing after $8,000 Self Only ($9,500 Self Plus One or Self and Family) per year for Non-PPO providers Some costs do not count toward this protection	28

2018 Rate Information for Government Employees Health Association, Inc. (GEHA) Benefit Plan

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

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

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, NPPN and NRLCA.

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

Non-Postal rates apply to all career non-bargaining unit Postal Service employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
877-477-3273, option 5
TTY: 866-260-7507

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career Postal employees.

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	311	$229.25	$103.57	$496.71	$224.40	$97.20	$90.84
High Option Self Plus One	313	$491.00	$241.21	$1,063.83	$522.63	$227.57	$213.93
High Option Self and Family	312	$521.58	$269.25	$1,130.09	$583.38	$254.76	$240.27
Standard Option Self Only	314	$164.81	$54.94	$357.10	$119.03	$49.99	$45.60
Standard Option Self Plus One	316	$354.35	$118.12	$767.77	$255.92	$107.49	$98.04
Standard Option Self and Family	315	$389.78	$129.92	$844.52	$281.50	$118.23	$107.84

Aetna Open Access®

www.aetnafeds.com
Customer Service 800-537-9384

2018

A Health Maintenance Organization (High and Basic option)

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 page 13.

Serving: All of Washington, D.C., Northern/Central/Southern Maryland, and Northern Virginia Areas.

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 17 for requirements.

Enrollment code for this Plan:
JN1 High Option - Self Only
JN3 High Option - Self Plus One
JN2 High Option - Self and Family

JN4 Basic Option - Self Only
JN6 Basic Option - Self Plus One
JN5 Basic Option - Self and Family

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 18
- Summary of benefits: Page 104

Note: The Plan will reduce its service area for the Central/Richmond service area for 2018. See Section 2 for impacted counties.

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-052

Summary of benefits for the High Option of the Aetna Open Access Plan - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $30 specialist	31
Services provided by a hospital:		
• **Inpatient**	$150 per day up to a maximum of $450 per admission	59
• **Outpatient**	$150 per visit	60
Emergency benefits:		
• **In-area**	$125 per visit	63
• **Out-of-area**	$125 per visit	63
Mental health and substance misuse disorder treatment:	Regular cost-sharing	66
Prescription drugs: You may fill non-emergency prescriptions at a participating Plan retail pharmacy or by mail order for up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay, and a 31-day up to a 90-day supply of medication for two copays. In no event will the copay exceed the cost of the prescription drug.	**For up to a 30-day supply**: $3 per generic formulary; $35 per brand name formulary; 50% up to $200 maximum per non-formulary (generic or brand name); Preferred Specialty 50% up to $350 maximum; Non-preferred Specialty 50% up to $700 maximum. For a 31-day up to a 90-day supply: Two (2) copays (Not available for Specialty Drugs)	69
Dental care:	Various copays, coinsurance, reduced fees or deductibles	75
Vision care:	$30 copay per visit. All charges over $100 for eyeglasses or contacts per 24-month period	41
Special features: Flexible benefits option, Aetna Navigator, Services for the deaf and hearing-impaired, Informed Health Line, Maternity Management Program, National Medical Excellence Program, and Reciprocity benefit.	Contact Plan at 800-537-9384	78
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,000/Self Only enrollment or $6,850/ Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection.	26

Summary of benefits for the Basic Option of the Aetna Open Access Plan - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Basic Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $45 specialist	31
Services provided by a hospital:		
• Inpatient	$200 per day up to a maximum of $1,000 per admission	59
• Outpatient	$175 per visit	60
Emergency benefits:		
• In-area	$175 per visit	63
• Out-of-area	$175 per visit	63
Mental health and substance misuse disorder treatment:	Regular cost-sharing	66
Prescription drugs: You may fill non-emergency prescriptions at a participating Plan retail pharmacy or by mail order for up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay, and a 31-day up to a 90-day supply of medication for two copays. In no event will the copay exceed the cost of the prescription drug.	**For up to a 30-day supply:** $5 per generic formulary; $50 per brand name formulary; 50% up to $200 maximum per non-formulary (generic or brand name); Preferred Specialty 50% up to $350 maximum; Non-preferred Specialty 50% up to $700 maximum. For a 31-day up to a 90-day supply: Two (2) copays (Not available for Specialty Drugs)	69
Dental care:	Various copays, coinsurance, reduced fees or deductibles	75
Vision care:	$45 copay per visit. All charges over $100 for eyeglasses or contacts per 24-month period	41
Special features: Flexible benefits option, Aetna Navigator, Services for the deaf and hearing-impaired, Informed Health Line, Maternity Management Program, National Medical Excellence Program, and Reciprocity benefit.	Contact Plan at 800-537-9384	78
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/Self Only enrollment or $6,850/ Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection.	26

2018 Rate Information for the Aetna Open Access Plan

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

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

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, NPPN and NRLCA.

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

Non-Postal rates apply to all career non-bargaining unit Postal Service employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: 877-477-3273, option 5, TTY: 866-260-7507

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career Postal employees.

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	JN1	$229.25	$279.87	$496.71	$606.38	$273.50	$267.14
High Option Self Plus One	JN3	$491.00	$642.25	$1,063.83	$1,391.55	$628.61	$614.97
High Option Self and Family	JN2	$521.58	$623.01	$1,130.09	$1,349.86	$608.52	$594.03
Basic Option Self Only	JN4	$229.25	$76.68	$496.71	$166.14	$70.31	$63.95
Basic Option Self Plus One	JN6	$482.19	$160.73	$1,044.74	$348.25	$146.26	$133.41
Basic Option Self and Family	JN5	$521.58	$178.55	$1,130.09	$386.86	$164.06	$149.57

MHBP

www.MHBP.com

Customer Service - 800.410.7778

2018

A fee for service plan (Standard Option and Value Plan) with a provider network

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See *How this plan works*, Section 1.

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

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

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

IMPORTANT:

- Rates: Back Cover
- Changes for 2018: Page 14
- Summary of benefits: Pages 118-121

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

Enrollment codes for this Plan:

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

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

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 71-007

Summary of MHBP Standard Option benefits – 2018

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

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

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

Standard Option Benefits	You pay	Page(s)
Medical services provided by physicians		
• Diagnostic and treatment services provided in the office	Network: • Primary care physician: $20 copayment per office visit for adults; $10 copayment per office visit for dependent children through age 21; • Specialty physician: $30 copayment per visit • Diagnostic X-rays, laboratory services and other professional services: 10%* of the Plan's allowance Non-Network: • Primary care physician and Specialty physician: 30%* of the Plan's allowance and any difference between our allowance and the billed amount • Diagnostic X-rays, laboratory services and other professional services: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	30
Services provided by a hospital		
• Inpatient	Network: $200 copayment per admission and 10% of the Plan's allowance for hospital ancillary services (No deductible) Non-Network: $500 copayment per admission; 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	61-63
• Outpatient	Network: 10%* of the Plan's allowance Non-Network: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	63-64
Emergency benefits		
• Accidental injury	Network: • Emergency room: $200 copayment per occurrence • Urgent care center: $50 copayment per occurrence Non-Network: • Emergency room: $200 copayment per occurrence and any difference between our allowance and the billed amount • Urgent care center: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	68

Summary of Standard Option benefits – continued on next page

Standard Option Benefits *(continued)*	You pay	Page(s)
• Medical emergency	Network: • Emergency room: $200 copayment* per occurrence • Urgent care center: $50 copayment* per occurrence Non-Network: • Emergency room: $200 copayment* per occurrence and any difference between our allowance and the billed amount • Urgent care center: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	70
Mental health and substance misuse disorder treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	72-75
Prescription drugs	Network retail: • Generic: $5 copayment per prescription • Preferred brand name: 30% of the Plan's allowance (25% when enrolled in Medicare Part B) and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained, limited to $200 per prescription • Non-Preferred brand name: 50% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained, limited to $200 per prescription Non-network retail: • Generic: $5 copayment per prescription and any difference between our allowance and the billed amount • Preferred brand name: 30% of the Plan's allowance (25% when enrolled in Medicare Part B) and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained • Non-Preferred brand name: 50% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained Mail order drug program: • Generic: $10 copayment per prescription • Preferred brand name: $80 copayment ($60 copayment when enrollment in Medicare Part B) 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: $120 copayment per prescription and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained Specialty drugs: • 15% of the Plan's allowance, limited to $200 per prescription for a 30-day supply; 15% of the Plan's allowance, limited to $425 per prescription for a 90-day supply	76-83

Summary of Standard Option benefits – continued on next page

Standard Option Benefits *(continued)*	You pay	Page(s)
Dental care	Accidental injury; Oral surgery	84
Special features: Case Management program; Flexible Benefits Option; Disease Management program; Diabetes Management incentive program; Advanced illness program; Health Risk Assessment; Health risk assessment reward; Biometric Screening reward; Health Coaching programs; Personal Health Record; ExtraCare® Health Card; Discount Drug program; Round-the-clock Member Support		85-91
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after your covered medical and prescription drug expenses total: • $6,000/person ($12,000/family) per calendar year, for services, drugs and supplies of Network providers/facilities and pharmacies, combined. • $9,000/person ($18,000/family) for services, drugs and supplies of Non-Network providers/facilities and pharmacies, combined Some costs do not count toward this protection.	26

Summary of MHBP Value Plan benefits – 2018

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

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

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

Value Plan Benefits	You pay	Page(s)
Medical services provided by physicians		
• Diagnostic and treatment services provided in the office	Network: • Primary care physician: $30 copayment per office visit for adults; $10 copayment per office visit for dependent children through age 21 • Specialty physician: $50 copayment* per office visit • Diagnostic X-rays, laboratory services and other professional services: 20%* of the Plan's allowance Non-Network: • Primary care physician and Specialty physician: 40%* of the Plan's allowance and any difference between our allowance and the billed amount • Diagnostic X-rays, laboratory services and other professional services: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	30
Services provided by a hospital		
• Inpatient	Network: 20%* of the Plan's allowance Non-Network: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	61-63
• Outpatient (Non-Surgical)	Network: 20%* of the Plan's allowance Non-Network: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	64
• Outpatient (Surgical)	Network: 20%* of the Plan's allowance Non-Network: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	63
Emergency benefits		
Accidental injury/Medical emergency	Network: • Emergency room: 20%* of the Plan's allowance • Urgent care center: 20% of the Plan's allowance for an accidental injury; 20%* of the Plan's allowance for a medical emergency Non-Network: • Emergency room: 20%* of the Plan's allowance and any difference between our allowance and the billed amount • Urgent care center: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	68-70

Summary of Value Plan benefits – continued on next page

Summary of MHBP Value Plan benefits *(continued)*

Value Plan Benefits *(continued)*	You pay	Page(s)
Mental health and substance misuse disorder treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	72-75
Prescription drugs	Network retail: • Generic: $10 copayment per prescription • Preferred brand name: 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained • Non-Preferred brand name: 75% of the Plan's allowance, and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained Non-network retail: • All charges Mail order drug program: • Generic: $30 copayment per prescription • Preferred brand name: 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained • Non-Preferred brand name: 75% of the Plan's allowance, and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained Specialty drugs: • 50% of the Plan's allowance	76-82
Dental care	Accidental injury; Oral surgery	84
Special features: Case Management program; Flexible Benefits Option; Disease Management program; Diabetes Management incentive program; Advanced illness program; Health Risk Assessment; Health risk assessment reward; Biometric Screening reward; Health Coaching programs; Personal Health Record; ExtraCare® Health Card; Discount Drug program; Round-the-clock Member Support		85-91
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after your covered medical and prescription drug expenses total: • $6,600/ person ($13,200/family) per calendar year, for services, drugs and supplies of Network providers/facilities and pharmacies, combined • $10,000/person ($20,000/family) for services of Non-Network providers/facilities Some costs do not count toward this protection.	26

P.O. Box 8402
London, KY 40742

2018 MHBP Standard Option and Value Plan Rate Information

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

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

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, NPPN, and NRLCA.

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

For further assistance, Postal Service employees should call: Human Resources Shared Service Center: 877-477-3273, option 5, TTY: 866-260-7507

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career Postal employees.

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Value Plan Self Only	414	$172.06	$57.35	$372.80	$124.26	$52.19	$47.60
Value Plan Self Plus One	416	$407.67	$135.89	$883.28	$294.43	$123.66	$112.79
Value Plan Self and Family	415	$415.82	$138.60	$900.93	$300.31	$126.13	$115.04
Standard Option Self Only	454	$201.62	$67.20	$436.83	$145.61	$61.16	$55.78
Standard Option Self Plus One	456	$464.09	$154.69	$1,005.52	$335.17	$140.77	$128.40
Standard Option Self and Family	455	$468.54	$156.18	$1,015.17	$338.39	$142.12	$129.63

MD-Individual Practice Association, Inc.

http://www.uhcfeds.com

Customer Service 877-835-9861

2018

A Health Maintenance Organization and a Individual Practice Plan - High Option

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details. This plan is accredited. See page 12.

Serving: Washington, D.C., Maryland and Northern Virginia

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Enrollment code for this Plan:

JP1 High Option -Self Only

JP3 High Option - Self Plus One

JP2 High Option - Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2018: Page 15
- Summary of benefits: Page 91

Authorized for distribution by the:

United States
Office of Personnel Management

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

Summary of benefits for the High Option of M.D. IPA - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Routine preventive care	Nothing	29
Diagnostic and treatment services provided in the office	Office visit copay: $25 primary care physician ages 18 and older; $0 under age 18; $40 specialist	28
Services provided by a hospital:		50
• Inpatient	$150 per day for up to 3 days per admission	50
• Outpatient Surgical	$200 per visit at hospital facility; $100 per visit at approved free-standing surgical center	51
• Outpatient Non-Surgical	$50 per visit	51
Emergency benefits:		53
• **In-area or out-of-area**	$75 per urgent care center visit $125 per emergency room visit	53
Mental health and substance abuse treatment:	Regular cost-sharing	50
Prescription drugs:		53
Plan Retail Pharmacy and Specialty Pharmaceuticals	Up to 30-day supply: Tier 1 - $7 Tier 2 - $35 Tier 3 - $65 Tier 4 - $100	60
Plan mail order for up to a 90-day fill	Tier 1: $21 Tier 2: $105 Tier 3: $195 Tier 4: $300	60
Dental care:	Discount plan	63

High Option Benefits	You pay	Page
Vision care:	$40 copayment for eye refraction exam	35
Wellness and other Special features:	Health4Me, Rally, Healthy Pregnancy Program, Health and Wellness Information, Health Risk Assessment, Clinical Programs	67
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after: $5,000 for Self Only, $10,000 Self Plus One or $10,000 for Family enrollment per year Some costs do not count toward this protection	23

Rate Information for MD IPA

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

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

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, NPPN and NRLCA.

Postal Category 2 rates apply to all career bargaining unit employees who are represented by the following agreements: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: 877-477-3273, option 5, TTY: 866-260-7507

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career Postal employees.

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
District of Columbia, Maryland and Northern Virginia							
High Option Self Only	JP1	$229.25	$102.03	$496.71	$221.06	$95.66	$89.30
High Option Self Plus One	JP3	$485.24	$161.75	$1,051.36	$350.45	$147.19	$134.25
High Option Self and Family	JP2	$521.58	$407.34	$1,130.09	$882.57	$392.85	$378.36

CareFirst BlueChoice, Inc.

www.carefirst.com/fedhmo

Member Services
888-789-9065

2018

A Health Maintenance Organization (high and standard option) and a high deductible health plan

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 page 13.

Serving: Maryland, the Northern Virginia area and Washington, DC

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 16 for requirements.

IMPORTANT

- Rates: Back Cover
- Changes for 2018: Page 18
- Summary of benefits: Page 167

Enrollment Codes for this Plan:

2G1 High Option Open Access - Self Only
2G3 High Option Open Access - Self Plus One
2G2 High Option Open Access - Self & Family
2G4 Standard HealthyBlue - Self Only
2G6 Standard HealthyBlue - Self Plus One
2G5 Standard HealthyBlue - Self & Family
B61 HealthyBlue Advantage HDHP - Self Only
B63 HealthyBlue Advantage HDHP - Self Plus One
B62 HealthyBlue Advantage HDHP - Self & Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-718

Summary of Benefits - High Option Open Access for 2018

Do not rely on this chart alone.

All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

- 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.
- High Option Open Access has an in-network $500 deductible per Self Only enrollment and $1,000 per Self Plus One and Self and Family enrollment.

High Option Open Access Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	**In-network**: No copay for preventive care; $30 Primary Care Physician and $40 Specialist **Out-of-network**: You pay all charges	31
Services provided by a hospital:		
• **Inpatient**	**In-network**: Deductible applies, $300 per admission copay **Out-of-network**: You pay all charges	63
• **Outpatient**	**In-network**: $55 for Ambulatory Surgical Center for surgical services Deductible applies, $100 copay for medical $200 for Hospital outpatient care associated with surgical services **Out-of-network**: You pay all charges	64
Emergency benefits:		
• **In-area**	$100 per emergency room visit	67
• **Out-of-area**	$100 per emergency room visit	67
Mental health and substance misuse treatment:	Regular cost-sharing	69
Prescription drugs:	*If a drug is available in generic, and your doctor specifies that you are not to take the generic, you pay only the copay. If your doctor does not specify, and you get the brand name drug, you will pay the cost difference between the brand and the generic as well as the copay.* ***Out-of-Network:*** *Members will be responsible for all charges for Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	72

<table>
<tr><th>High Option Open Access Benefits</th><th>You pay</th><th>Page</th></tr>
<tr><td>Retail</td><td>For up to a 34-day supply:
Tier 1 - No copay (generic drugs)
Tier 2 - $35 preferred brand name drug copay
Tier 3 - $65 copay for non-preferred brand name drug
Tier 4 - $150 for preferred specialty drugs
Tier 5 - $150 for non-preferred specialty drugs
For 35-day through 90-day supply, two (2) copays apply for all tiers.</td><td>73</td></tr>
<tr><td>Mail order</td><td>Maintenance drugs: for up to a 34-day supply:
Tier 1 - No copay (generic drugs)
Tier 2 - $35 preferred brand name drug copay
Tier 3 - $65 copay for non-preferred brand name drug
Tier 4 - $150 for preferred specialty drugs
Tier 5 - $150 for non-preferred specialty drugs
For 35-day through 90-day supply, two (2) copays apply for all tiers.</td><td>73</td></tr>
<tr><td>Dental care:</td><td>No benefit except for services related to an accidental injury</td><td>78</td></tr>
<tr><td>Vision care:</td><td>In-network: Davis network providers: $10 per visit copay for routine eye exams
All other providers: You pay all charges</td><td>43</td></tr>
<tr><td>Special features: 24 hr. nurse line; Care team program; Guest membership program</td><td>No additional cost</td><td>79</td></tr>
<tr><td>Protection against catastrophic costs (out-of-pocket maximum):</td><td>Nothing after $2,500/Self Only or $5,000/Self Plus One and Family enrollment per year
Some costs do not count toward this protection</td><td>26</td></tr>
</table>

Summary of Benefits - Standard HealthyBlue for 2018

Do not rely on this chart alone.

All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

•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.

•Standard HealthyBlue has a calendar year in-network deductible of $500 per Self-Only contract and $1,000 per Self Plus One and Self and Family contract, and an out-of-network deductible of $3,000 for Self-Only contract and $6,000 for Self Plus One and Self and Family contract. The in-network deductible is included in the out-of-network total.

•We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard HealthyBlue	You pay	Page
Medical services provided by a physician		
Diagnostic and treatment services provided in the office	**In-network**: No deductible or copay for primary care provider and $40 for a specialist **Out-of-network**: After calendar year deductible, $80 copay	31
Services provided in a hospital:		
• **Inpatient**	**In-network**: After calendar year deductible, $300 per admission copay **Out-of-network**: After calendar year deductible, $500 per admission copay	63
• **Outpatient**	**In-network**: After deductible: • $40 copay for medical care • Ambulatory Surgical Center copay is $40 for surgical care • Outpatient Hospital copay is $150 for surgical care **Out-of-network**: After calendar year deductible: • $80 copay for medical care • Ambulatory Surgical Center copay is $80 for surgical care • Outpatient Hospital copay is $200 for surgical care	64
Emergency Benefits:		
• **In-area**	$200 per emergency room visit	67
• **Out-of-area**	$200 per emergency room visit	67
Mental health and substance misuse treatment:	Regular cost sharing	69

Standard HealthyBlue	You pay	Page
Prescription drugs:	*If a drug is available in generic, and the brand name drug is dispensed, you are responsible for the difference between price of the brand and the generic in addition to the appropriate copay.* ***Out-of-Network:** Members will be responsible for all charges for Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	72
• Retail	For up to a 34-day supply: • Tier 1 - No copay (generic drugs) • Tier 2 - $35 preferred brand name drug copay • Tier 3 - $65 copay for non-preferred brand name drug • Tier 4 - $150 for preferred specialty drugs • Tier 5 - $150 for non-preferred specialty drugs For 35-day through 90-day supply, two (2) copays apply for all tiers.	73
• Mail order	Maintenance Drugs: for up to a 34-day supply: • Tier 1 - No copay (generic drugs) • Tier 2 - $35 preferred brand name drug copay • Tier 3 - $65 copay for non-preferred brand name drug • Tier 4 - $150 for preferred specialty drugs • Tier 5 - $150 for non-preferred specialty drugs For 35-day through 90-day supply, two (2) copays apply for all tiers.	73
Dental care:	No benefit except for services related to an accidental injury	78
Vision care:	Davis network providers: $10 per visit copay for routine eye exams.	43
Special features: 24-hour nurse line; Care team program; Guest membership. Care plans, Blue Rewards.	No additional cost	79
Protection against catastrophic costs (out-of-pocket maximum)	**In-network**: Nothing after $2,500 Self only, $5,000 Self Plus One and $5,000 for Self and Family for per year based on contract, not members	26

	Out-of-network: After $4,500 Self only, $9,000 Self Plus One and $9,000 for Self and Family per year based on contract, the member is liable for charges in excess of our allowed benefit. Some costs do not count toward this protection	

Summary of Benefits - HealthyBlue Advantage HDHP for 2018

Do not rely on this chart alone.

All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. 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 2016 for each month you are eligible for the Health Savings Account, HealthyBlue Advantage HDHP will deposit $37.50 per month for Self-Only enrollment, $75 for Self Plus One enrollment, or $75 per month for Self and Family enrollment to your HSA. For the HSA you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $1,400 in-network and $2,800 out of network for Self-Only and $3,000 in-network and $6,000 out-of-network for Self Plus One and Self and Family. Once you satisfy your calendar year deductible, traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $37.50 per month for Self-Only enrollment and $75 for Self Plus One and Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, traditional medical coverage begins.

The deductible is $1,400 per Self Only enrollment or $2,800 per Self Plus One and Self and Family enrollment for in-network services and $3,000 per Self Only enrollment and $6,000 per Self Plus One and Self and Family enrollment for out-of-network care each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits unless we indicate differently in Sections 5(a) through 5(g) of this brochure.

Under HealthyBlue Advantage, you may earn a medical expense debit card to help pay for qualified medical expenses of $250 per Self Only enrollment and up to $500 per Self Plus One and Self and Family enrollment.

HealthyBlue Advantage HDHP	You pay	Page
Medical services provider by a physician		
Diagnostic and treatment services provided in the office	**In-network**: Preventive Care and Women's Health: No copay All other office care: After deductible, No copay for PCP and $35 for a specialist **Out-of-network**: After deductible, $80 copay	99
Services provided in a hospital:		
• **Inpatient**	**In-network**: After deductible, $400 per admission **Out-of-network**: After deductible, $500 per admission	121
• **Outpatient**	**In-network**: • Medical care: After deductible, $200 per admission in hospital and ambulatory surgical center • Surgical care: After deductible, $100 in an ambulatory surgical center and $300 in the outpatient department of a hospital. **Out-of-network**: • Medical care: After deductible, $500 per admission in hospital and ambulatory surgical center	122

	• Surgical care: After deductible, $500 in an ambulatory surgical center and in the outpatient department of a hospital.	
Emergency Benefits:		
• **In area**	After the deductible: • $50 copay for Urgent care center • $50 copay for Ambulance services • $300 copay for Emergency Room services	125
• **Out-of-area**	After the deductible: • $50 copay for urgent care center • $50 copay for ambulance services • $300 copay for emergency room services	125
Mental health and substance misuse treatment:	Regular cost sharing	127
Prescription drugs:	*If a drug is available in generic, and your doctor specifies that you are not to take the generic, you pay only the copay. If your doctor does not specify, and you get the brand name drug, you will pay the cost difference between the brand and the generic as well as the copay.* ***Out-of-Network:*** *Members will be responsible for all charges for Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	130
• Retail	No Deductible for generic drugs for the treatment of asthma, blood pressure, cholesterol, depression and diabetes After deductible: • Tier 1 - Generic drugs - $0 copay • Tier 2 - Preferred brand named drugs - $30 copay for up to 34-day supply; $60 for 35-day to 90-day supply • Tier 3 - Other brand named drugs - $60 copay for up to 34-day supply; $120 copay for 35-day to 90-day supply • Tier 4 - Preferred Specialty Drugs- $150 copay for up to 34-day-supply; $300 copay for 35-day to 90-day supply • Tier 5 - Non-Preferred Specialty Drugs- $150 copay for up to 34-day-supply; $300 copay for 35-day to 90-day supply	130
• Mail order	Benefit is designed for maintenance drugs only.	131

	No Deductible for selected generic drugs for the treatment of asthma, blood pressure, cholesterol, depression and diabetes After deductible: • Tier 1 - Generic drugs - $0 copay • Tier 2 - Preferred brand named drugs - $30 copay for up to 34-day supply; $60 for 35-day to 90-day supply • Tier 3 - Other brand named drugs - $60 copay for up to 34-day supply; $120 copay for 35-day to 90-day supply • Tier 4 - Preferred Specialty Drugs - $150 copay for up to 34-day-supply; $300 copay for 35-day to 90-day supply • Tier 5 - Non-Preferred Specialty Drugs - $150 copay for up to 34-day-supply; $300 copay for 35-day to 90-day supply	
Dental care:	No benefit except for services related to an accidental injury	135
Vision	**In-network**: $10 for routine eye exams **Out-of-network**: You pay all charges Discount program is available for lenses, frames and contacts	107
Special features: 24 nurse line; Care team program; Guest membership; Care plans; Blue Rewards	No additional costs	136
Protection against catastrophic costs (out-of-pocket maximum):	**In-network**: Nothing after $4,000 under a Self-Only enrollment, $6,500 for Self Plus One and $6,500 for Self and Family enrollment per year. **Out-of-network**: After $6,000 on a Self-Only enrollment, $12,000 for Self Plus One and $12,000 for Self and Family enrollment. The member remains liable for charges in excess of our allowed benefit. Some costs do not count toward this protection.	26

2018 Rate Information for CareFirst BlueChoice,Inc.

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

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment. Postal rates apply to United States Postal Service employees. Postal Category 1 rates apply to career bargaining unit employees who are represented by the APWU (including IT/ASC, MDC, OS, and NPPN employees) and NRLCA.

Postal Category 2 rates apply to career bargaining unit employees who are represented by the NALC, NPMHU and PPO. Non-postal rates apply to all career non-bargaining unit Postal Service employees. For further assistance, Postal Service employees should call: Human Resources Shared Service Center: 877-477-3273, option 5, TTY: 866-260-7507. Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees.

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	2G1	229.25	165.40	496.71	358.37	159.03	152.67
High Option Self Plus One	2G3	491.00	298.29	1,063.83	646.30	284.65	271.01
High Option Self and Family	2G2	521.58	416.08	1,130.09	901.51	401.59	387.10
Standard Option Self Only	2G4	229.25	90.88	496.71	196.91	84.51	78.15
Standard Option Self Plus One	2G6	480.20	160.07	1,040.44	346.81	145.66	132.86
Standard Option Self and Family	2G5	521.58	239.06	1,130.09	517.96	224.57	210.08
HDHP Option Self Only	B61	211.06	70.35	457.29	152.43	64.02	58.39
HDHP Option Self Plus One	B63	422.12	140.70	914.58	304.86	128.04	116.79
HDHP Option Self and Family	B62	501.47	167.15	1,086.51	362.17	152.11	138.74