The **2012**

Guide To Benefits

For Postal Career Executive Service Employees

Visit us at: www.opm.gov/insure

Healthcare and Insurance

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Revised November 2011

Key Information – Please Read

- Make sure your plan code has not been discontinued!
- If your plan is not a national plan (such as an HMO), **make sure it covers your County or State**.
- **Check for premium rate changes**; you may wish to elect a different plan or option!
- Self and Family plan codes end in 5 or 2; Self Only codes end in 4 or 1 -- is your code correct? **Plan codes do not change to Self Only automatically when your last dependent turns 26 years old -- YOU MUST CHANGE through HRSSC or at Open Season. Paying for coverage you can't use is a waste of your money.**
- In *PostalEASE*, changes to "View/Update Dependents" DO NOT result in a plan code/option change. Therefore, removing all dependents does not change your enrollment from Self and Family to Self Only.
- DO NOT WAIT until the last day of Open Season to make your election!
- Know your USPS PIN.
- *PostalEASE* Web is preferred to the phone for ease of use.
- **Keep clicking** on UPDATE and SUBMIT until you get a CONFIRMATION NUMBER! Until you have one, your transaction has **not** processed.
- CAUTION: **Do not click** on CANCEL to exit *PostalEASE*; this will cancel your FEHB enrollment entirely.
- CAUTION: **Do not click** on DELETE PENDING unless you no longer wish to make the change; DELETE PENDING does not exit the application.
- DO NOT elect a plan code for "Specific Groups" unless you are a member of that group.
- If you plan to retire or separate before the Open Season effective date in January 2012, DO NOT use *PostalEASE*; submit OPM 2809 to the H.R. Shared Service Center with your retirement application for processing.
- Before cancelling your FEHB coverage, read and understand the 5-year requirement for continuing FEHB into retirement (see p. 6).
- If you are on OWCP rolls and having health benefits deducted from compensation checks, DO NOT use *PostalEASE* for FEHB changes, contact Department of Labor, Office of Workers' Compensation Programs (OWCP).
- Retirees access OPM'S Open Season Online at www.opm.gov/retire/fehb or call Open Season Express at 1-800-332-9798.

Summary Information

	New Hires Can Enroll	Open Season	How to Enroll	Program Website
FEHB	Within 60 days from new hire date	Annual – November 14 to December 13, 2011 5 p.m. Central Time	*PostalEASE* https://liteblue.usps.gov 1-877-477-3273, option 1	**www.opm.gov/insure/health**
FEDVIP	Within 60 days from new hire date	Annual – November 14 to December 12, 2011 11:59 p.m. Eastern Time	Go to www.BENEFEDS.com or call 1-877-888-3337	**www.opm.gov/insure/dental** **www.opm.gov/insure/vision**
FSA	During 26th or 27th pay period after career appointment	Annual – November 7 to December 25, 2011 5 p.m. Central Time	*PostalEASE*	**https://liteblue.usps.gov**
FEGLI	Within 60 days from new hire date for optional insurance; automatically enrolled in Basic insurance until you take action to cancel	No annual Open Season	Via SF 2817 for new hires Others provide medical information on SF 2822	**www.opm.gov/insure/life**
FLTCIP	Apply (not necessarily enroll) within 60 days from new hire date with abbreviated underwriting	No annual Open Season	Go to www.LTCFEDS.com/usps or call 1-800-582-3337	**www.opm.gov/insure/ltc**

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Introduction to Benefits and This Guide

As a U.S. Postal Service employee, the benefits available to you represent a significant piece of your compensation package. They may provide important insurance coverage to protect you and your family and, in some cases, offer tax advantages that reduce the burden in paying for some health products and services, or dependent or elder care services.

The purpose of this Guide is to provide you basic information about the benefits offered to you as a Postal Service employee, and assist you in making informed choices about these benefits as you move through your career and prepare for retirement.

Benefits Programs included in this Guide

In addition to your Civil Service or Federal Employees Retirement System benefits and the Thrift Savings Plan, the Postal Service offers five benefits programs to eligible employees. This Guide includes information on the five programs:

- Federal Employees Health Benefits Program
- Federal Employees Dental and Vision Insurance Program
- USPS Flexible Spending Accounts Program
- Federal Employees' Group Life Insurance Program
- Federal Long Term Care Insurance Program

If you are a new Postal Service employee or have recently become eligible for benefits, this Guide will walk you through the benefits offered, and provide information on how and when to make your choices. If you are a current employee, it will provide the most current information regarding the benefit programs, and will support you as you make decisions during the annual Open Season, or experience life events that cause you to reconsider previous choices.

This Guide also contains some tips on what to consider as you make your decisions. For instance, did you know that the Federal Employees Health Benefits (FEHB) Program, the Federal Employees Dental and Vision Insurance Program (FEDVIP) and the Flexible Spending Accounts Program (FSA) can potentially provide you with greater benefits without costing you much more? As a Postal Service employee, you can choose to pay the FEDVIP and FEHB premiums with pre-tax dollars and you can use pre-tax FSA dollars to pay for eligible expenses, including FEDVIP and FEHB copays and deductibles. Dental and vision care are also eligible FSA expenses, whether combined with FEDVIP coverage or not. Please take a moment to review the information in this Guide and decide upon the right choices for you.

Additional Information

You will find references throughout this Guide to websites or other locations to obtain more detailed information than is available here. We encourage you to access these sites to become a more educated decision-maker and consumer of Postal Service benefit programs.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY: 1-866-561-1604).

Benefits Snapshot

New or Newly Eligible Employees

As a new or newly eligible employee, you may have the opportunity to enroll in the benefit programs noted below. Use this chart to assist you with the decision-making process of selecting and enrolling in the benefit programs below that meet your needs. The chart gives you things to consider as you make your decisions.

FEHB	1. See page 9 for general information on FEHB (including eligibility) and for guidance on choosing a plan; 2. If you decide to enroll, examine the 2012 brochure of each plan you consider to ensure the benefits and premiums meet your needs and the plan is available in your area; 3. Complete the *PostalEASE* FEHB Worksheet and enroll via *PostalEASE*. For assistance or additional information, contact the Human Resources Shared Service Center (HRSSC) on 1-877-477-3273, option 5.
FEDVIP	1. See page 20 for general information on FEDVIP (including eligibility) for guidance on choosing a FEDVIP dental plan and/or vision plan; 2. If you decide to enroll, examine the 2012 brochure of each plan you consider to ensure the benefits and premiums meet your needs and the plan is available in your area; 3. See the 2012 FEDVIP Guide for USPS Employees for complete information.
FSA	1. See page 24 for general information on FSA (including eligibility) and for guidance on making a decision whether to participate; 2. See the USPS FSA brochure (November 2011) for complete information.
FEGLI	1. See page 28 for general information on FEGLI (including eligibility) and for guidance on making a decision whether to select optional insurance (Basic FEGLI is automatic); 2. See page 30 for information on how to enroll.
FLTCIP	1. See page 31 for general information on FLTCIP (including eligibility) and for guidance on making a decision whether to apply; 2. See page 32 for information on how to apply for coverage.

Open Season Snapshot

Current Employees

During Open Season, you have the opportunity to make changes in the Federal Employees Health Benefits (FEHB) Program, the Federal Employees Dental and Vision Insurance Program (FEDVIP) and the Flexible Spending Accounts Program (FSA). You can use this chart to assist you with the decision-making process of selecting plans and enrolling in these benefit programs.

	If Currently Enrolled in the Program	If Not Enrolled in the Program
FEHB	1. Check your plan's 2012 premiums and satisfaction survey results in Appendix F; 2. Examine your plan's 2012 brochure for benefit and enrollment/service area changes; 3. Check Appendix F for any new plans and plan options available to you; 4. If satisfied with your plan's rates, survey results and benefits for 2012, **do nothing** – your enrollment will continue automatically; 5. If **not** satisfied with your current plan for 2012, see Appendix B for guidance on choosing another plan. 6. See page 6 for information on FEHB and retirement.	1. See page 9 for general information on FEHB (including eligibility) and Appendix B for guidance on choosing a plan; 2. If you decide to enroll, examine the 2012 brochure of each plan you consider to ensure the benefits and premiums meet your needs and the plan is available in your area; 3. Complete the *PostalEASE* FEHB Worksheet on pages 41 and 43 and enroll via *PostalEASE*. 4. Contact the Human Resources Shared Service Center (HRSSC), 1-877-477-3273, option 5, if you require assistance.
FEDVIP	1. Check your plan's 2012 premiums in the FEDVIP Guide and examine your plan's 2012 brochure for benefit and enrollment/service area changes; 2. If also enrolled in FEHB, check your 2012 FEHB brochure for any changes in dental and/or vision benefits; 3. If satisfied with your plan's rates and benefits for 2012, **do nothing** – your enrollment will continue automatically; 4. If **not** satisfied with your current plan for 2012, see the FEDVIP Guide for guidance on choosing another plan and for information on how to change your enrollment; 5. If you no longer want FEDVIP, you must cancel during Open Season by contacting BENEFEDS. After Open Season you cannot cancel; see the FEDVIP Guide for details. 6. See page 7 for information on FEDVIP and retirement.	1. See page 20 for general information on FEDVIP (including eligibility) and for guidance on choosing a FEDVIP plan; 2. If you decide to enroll, examine the 2012 brochure of the plans in which you are interested to ensure the benefits and premiums meet your needs and the plan is available in your area; 3. If enrolled in FEHB, check your 2012 FEHB brochure for any changes in dental and/or vision benefits. 4. See page 22 and the 2012 FEDVIP Guide for information on how to enroll.
FSA	1. If you want to participate in 2012, **you must make a new election**. Keep in mind your election and enrollment do **not** carry over from year to year; see page 25 for information on how to enroll; 2. Check your 2012 FEHB and 2012 FEDVIP plan brochures to see how any benefit changes may affect your out-of-pocket health care expenses; 3. See the USPS FSA brochure for any updated information about the Program. 4. See page 7 for information on FSA and retirement.	1. See page 24 for general information on FSA (including eligibility) and for guidance on making a decision whether to participate; 2. See page 25 and the USPS FSA brochure (November 2011) for information on how to enroll.

Benefits Facts

FEHB

- When you retire, you are eligible to continue health benefits coverage if you meet all of the following requirements:
  - you are entitled to retire on an immediate annuity under a retirement system for civilian employees (including the Federal Employees Retirement System (FERS) Minimum Retirement Age (MRA) + 10 retirement); and
  - you have been continuously enrolled (or covered as a family member) in any FEHB plan(s) for the 5 years of service immediately before the date your annuity starts, or for the full period(s) of service since your first opportunity to enroll (if less than 5 years).
- The 5 year requirement period can include the following:
  - the time you are covered as a family member under another person's FEHB enrollment; or
  - the time you are covered under the Uniformed Services Health Benefits Program (also known as TRICARE) as long as you are covered under an FEHB enrollment at the time of your retirement.
- As an annuitant, you are entitled to the same benefits and Government contributions as Federal employees enrolled in the same plan.
- The event of retirement is not a qualifying life event (QLE); however, there are other opportunities to change FEHB enrollment including during Open Season or when you experience a QLE.
- If you retire with a Self Only enrollment and later want to cover eligible family members, you can change to a Self and Family enrollment during the annual Open Season or when you experience certain QLEs.
- If you are not enrolled in FEHB (or covered as a family member) at the time of your retirement, you cannot enroll when you retire.
- If you are enrolled in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) at the time of your retirement, you can still contribute to your HSA provided you have no other insurance coverage other than those specifically allowed, and are not claimed as a dependent on someone else's tax return. Some examples of other coverage that would cause ineligibility are: Medicare, TRICARE, other non-high deductible health insurance, or having received VA benefits within the previous three months. If you don't qualify for an HSA, your plan will enroll you in a Health Reimbursement Arrangement (HRA).
- If you cancel your FEHB enrollment as an annuitant, you will never be able to re-enroll in FEHB **unless** you had suspended your FEHB enrollment because you had become covered by a Medicare Advantage plan, TRICARE or CHAMPVA, Medicaid or similar State-sponsored program of medical assistance, or Peace Corps volunteer coverage.
- If you want your surviving family members to continue your health benefits enrollment after your death, you must be enrolled for Self and Family at the time of your death, and at least one family member must be entitled to an annuity as your survivor.
- Consider whether you need to sign up for Medicare when you become eligible.

Benefits Facts *continued*

FEDVIP

- There is no 5 year requirement for continuing FEDVIP coverage into retirement.
- Your coverage will continue as a retiree. Retirees may also enroll during the annual Federal Benefits Open Season or when you experience a qualifying life event (QLE). Keep in mind that **retirement is not a QLE.**
- In most cases, changing from payroll deduction to annuity deduction is automatic, but may take one to three months to occur. You will pay premiums on an after-tax, not pre-tax basis. It is advised that you contact BENEFEDS at 1-877-888-3337 prior to retirement in order to eliminate any suspension in coverage.
- BENEFEDS cannot deduct premiums from your annuity while you are receiving "special" or "interim" pay. Once your annuity is finalized, premium deductions will begin. If you miss one or more premium payments before your annuity is final, BENEFEDS will make double deductions until any balance due is paid. They will notify you before deducting this additional premium amount. Once there is no past due balance, the amount of premium deducted will return to the regular monthly premium.

FSA

- You may request payment only for the expenses of services or items received up to and including your retirement date.
- Exception: if you retire on December 31, you are eligible for the FSA Grace Period, so you may request payment for expenses through the following March 15.
- Your FSA claims will be processed if they are received by September 30 of the year following the plan year.
- You cannot continue your FSA coverage after you retire.
- You must pay a full period contribution for any pay period during which you are on Postal Service rolls, even if it is only the first day of the pay period. (The payroll system does not prorate your FSA contribution.)
- The collection of FSA contributions (including the collection of missed contributions) relates strictly to the amount of the contributions you were scheduled to make each pay period while you were an FSA participant.
- What you actually claim, whether it is more or less than what you were scheduled to contribute each pay period while you were an FSA participant, does not affect what you must pay in contributions.
- If you missed contributions you were scheduled to make from your paychecks because you were on Leave Without Pay (LWOP) or had low pay, you must make up the missed contributions.
- If you missed contributions, you cannot reduce what you owe by not filing claims. These rules apply to any type of retirement, including a disability retirement.
- Refer to brochure FSA BK1, *Flexible Spending Accounts* (November 2011), which is being mailed to all career employees for the FSA open season, for the details.

Benefits Facts *continued*

FEGLI

- When you retire, you are eligible to continue your FEGLI life insurance coverage(s) if you retire on an immediate annuity and had the coverage for:
  - the five years of service immediately before the starting date of your annuity or, for annuitants retiring under FERS who postpone receiving their annuity, the five years immediately before their separation date for annuity purposes, or
  - all period(s) of service during which that coverage was available to you if it is less than five years, and
  - you (or your assignees) do not convert the coverage to a private policy.
- If you are eligible, you will choose via Standard Form (SF) 2818 how you wish your coverage(s) to continue during your retirement.
- If you are not enrolled in FEGLI at the time of your retirement, you cannot enroll when you retire.
- You cannot newly elect or increase existing coverage after you retire. You may only reduce or cancel coverage.
- Your premiums are subject to change in the future. Your premium could change based on your age and the experience of the Program. You will be notified if there is any change in your deductions from your annuity.

FLTCIP

- Your coverage continues into retirement provided you continue to pay premiums.
- If you pay premiums via payroll deduction, then shortly before you retire, you should notify Long Term Care Partners (LTCP) at 1-800-582-3337 to make other arrangements for premium payment.
- You may elect annuity deduction if you desire. LTCP cannot deduct your premium from "special" or "interim" pay. LTCP will send you a direct bill during this time. Premium deduction will begin from your annuity once it is finalized.

Federal Employees Health Benefits (FEHB) Program

Overview

The United States Postal Service (USPS) provides health benefits to its career employees by participating in the Federal Employees Health Benefits (FEHB) Program, which is administered by the U.S. Office of Personnel Management (OPM), Office of Healthcare and Insurance. It is the largest employer-sponsored health insurance program in the world. OPM interprets health insurance laws and writes regulations for the FEHB Program. It gives advice and guidance to the USPS and other participating agencies to process your enrollment changes and to deduct your premiums. OPM also contracts with and monitors all of the plans participating in the FEHB Program.

While FEHB eligibility, enrollment requirements and the plans available for 2012 are the same for federal and USPS employees alike, the Postal Service pays a higher percentage contribution towards career Postal employee premium rates than the rest of the federal government. All employee premium rates are calculated using the "Fair Share Formula."

What does this program offer?

The FEHB Program offers a wide variety of plans and coverage to help you meet your health care needs. It is group coverage available to employees, retirees and their eligible family members. If you continuously maintain your FEHB enrollment, or are covered by another FEHB enrollment as a family member, or a combination of both, for the five years of service immediately preceding your retirement, and you retire on an immediate annuity, you can continue to participate in the FEHB Program after retirement. The benefits you receive as a retiree are the same coverage Federal employees receive and at the same cost. If you leave government employment before retiring, the Program offers temporary continuation of coverage (TCC) and an opportunity to convert your enrollment to non-group (private) coverage.

Appendix F includes a comparison chart of all the plans in the FEHB Program with information comparing basic benefits and costs.

Key FEHB Facts

- The FEHB Program is part of the annual Open Season.
- FEHB coverage continues each year. You do not need to re-enroll each year. If you are happy with your current coverage, do nothing. **Please note that your premiums and benefits may change. Also, if your plan is not a national plan, the service area may change.**
- You can choose from Consumer-Driven and High Deductible plans that offer catastrophic risk protection with higher deductibles, health savings/reimbursement accounts and lower premiums, or Health Maintenance Organizations or Fee-for-Service plans with comprehensive coverage and higher premiums.
- There are no waiting periods and no pre-existing condition limitations, even if you change plans.
- If you are an active Postal employee, you can use your Health Care Flexible Spending Account or Limited Health Care Flexible Spending Account with your FEHB plan.
- If you participate in Pre-tax Payment of Premiums, enrollment changes can only be made during Open Season or if you experience a qualifying life event (QLE).
- All nationwide FEHB plans offer international coverage.
- There are separate and/or different provider networks for each plan.
- Utilizing an in-network provider will reduce your out-of-pocket costs.

Federal Employees Health Benefits (FEHB) Program

Coverage

What enrollment types are available?

- Self Only, which covers only the enrolled employee.
- Self and Family, which covers the enrolled employee and all eligible family members.

How much does it cost?

The premiums for your enrollment are shared by you and the Postal Service. The Postal Service pays the lesser of 91% of the average premium of all plans weighted by the number of enrollees in each plan but not more than 94.75% of the total premium for any individual plan. If you are a career employee, you automatically pay your share of the premium through a payroll deduction using pre-tax dollars unless you waive this treatment and pay your premiums with after-tax money. The charts in Appendix F provide cost information for all plans in the FEHB Program.

Am I eligible to enroll?

All career employees are eligible to enroll in FEHB. Non-career employees are eligible if they meet the eligibility requirements. If you have an appointment other than career and you have not received information about enrollment, you should contact the Human Resources Shared Service Center (HRSSC) on 1-877-477-3273, option 5 for more information.

When you retire, you are eligible to continue health benefits coverage if you retire on an immediate annuity under a retirement system for civilian employees (including FERS MRA + 10 retirements) and you have been continuously enrolled (or covered as a family member) in any FEHB plan(s) for the 5 years of service immediately before the date your annuity starts, or for the full period(s) of service since your first opportunity to enroll (if less than 5 years).

If you suspend your FEHB coverage as a retiree because you are covered by TRICARE or CHAMPVA, a Medicare Advantage Plan, Medicaid, or Peace Corps volunteer coverage you may reenroll under certain conditions. (You should contact OPM for information on your eligibility.) **If you are not enrolled in or covered as a family member under FEHB when you retire, you will not be able to enroll after retirement.**

When Can I Enroll?

New Employees – New employees have the opportunity to select a health plan within 60 days of being hired.

Current Employees – Current employees have an opportunity to select or change plans:

- During Open Season
- When certain life events occur (see table on pages 46 through 49 of this Guide) **NOTE: These elections MUST be made within certain time limits as specified in the table.**

For new or newly eligible employees who elect to enroll, coverage will be effective on the first day of the first pay period that begins after the Postal Service receives your enrollment. An Open Season enrollment or change is effective on the first day of the first full pay period that begins in January.

Which family members are eligible?

Family members covered under your Self and Family enrollment are:

- Your Spouse (including a valid common law marriage); and
- Your Children under age 26, including legally adopted children, recognized natural (born out of wedlock) children and stepchildren.

Foster children are included if they meet certain requirements. A child age 26 or over that is incapable of self-support because of a mental or physical disability that existed before age 26 is also an eligible family member.

In determining whether the child is a covered family member, the HRSSC will look at the child's relationship to you as an enrollee.

Ineligible Members – Even though the following family members may live with and/or be dependent upon the enrollee, they are NOT ELIGIBLE for coverage under the enrollee's "Self and Family" FEHB Program enrollment:

- Parents and other relatives
- Former spouses

NOTE: Falsifying or misrepresenting family member eligibility or enrollment is a violation of federal law and may subject an employee to fine, imprisonment and/or disciplinary action.

Loss of Coverage – When an event occurs that causes you or your family member to lose coverage, the FEHB Program offers a continuation of coverage feature, either temporarily or by permanent conversion to a private sector policy. Such events include but are not limited to:

- Child reaching age 26
- Retirement
- Application for Spouse Equity
- Relocation
- Separation
- Divorce
- Death
- LWOP Status*

*Leave Without Pay Status – FEHB Program regulations state that you may continue your FEHB coverage for up to 365 days while you are in a Leave Without Pay (LWOP) status, provided that you pay the employee share of the premium, either while on LWOP or when you return to a pay status.

The 365 days of continued enrollment during leave without pay status is not considered to be broken by any period(s) in pay status of less than 4 consecutive months. If you are in a pay status during any part of a pay period, the entire pay period is not counted toward the 365-day limit.

If you return to pay status for at least 4 consecutive months during which you are paid for at least part of each pay period, you are entitled to begin a new 365-day period of continued enrollment while in leave without pay status.

The Postal Service will invoice you for our share of the premium unless you complete and submit to the Human Resources Shared Service Center (HRSSC) PS Form 3111, *FEHB Coverage or Termination While in Leave Without Pay (LWOP) Status*, to terminate coverage. At 365 days in LWOP status, your FEHB coverage terminates.

If you do not pay your FEHB premiums while in an LWOP status, when you return to a pay status the amount owed for unpaid premiums may be significant.

If there are FEHB past-due premiums (from one to four unpaid FEHB premiums), up to the entire amount due will be deducted from your salary. In addition, if there are sufficient monies available, the premium for the current pay period will be deducted from your pay. When an accounts receivable account has been created for unpaid FEHB premiums and that receivable is over 45 days old, Payroll automatically takes 15 percent of your disposable net pay per pay period until that accounts receivable account is paid off. This means that an employee who returns to pay status could possibly pay all of these amounts at the same time – the past due FEHB premiums (maximum of four unpaid FEHB premiums), the current FEHB premium, and up to 15 percent of disposable net pay towards payment of any accounts receivables for unpaid FEHB premiums.

It is your responsibility to report life events that may cause you or your family member to lose eligibility. It is also your responsibility to complete and submit any required paperwork to change your enrollment and/or apply for any continuation of coverage, if eligible, within the time limits specified in the Table of Permissible Changes on pages 46 through 49 of this Guide. If you have questions, contact the HRSSC on 1-877-477-3273, option 5.

If you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB plan to cover you. If not, the plan must give you one on request. This certificate may be important to qualify for benefits if you join a non-FEHB plan.

FEHB Open Season

Each year you have the opportunity to enroll or change enrollment during an Open Season. **The 2011 Open Season is from November 14 through December 13 at 5:00 p.m. Central Time.** Employees may make any one – or a combination – of the following changes:

- Enroll if not enrolled
- Change from one option to another
- Change from Self Only to Self and Family
- Change from Self and Family to Self Only
- Change from pre-tax to post tax premium deductions or vice versa (see pages 17 through 19 of this Guide)
- Cancel enrollment

If you decide to do any of the above actions, you MUST follow the instructions on the *PostalEASE* FEHB Worksheet contained in this Guide and enter your election in *PostalEASE* by 5:00 p.m. Central Time on December 13, 2011. It is critical that this be done timely.

Please do not wait until late in the open season to enter your change via *PostalEASE*.

Your new enrollment or any changes that you make to your existing coverage will take effect on January 14, 2012, and the change in premium rate deductions will be seen on your February 3, 2012, earnings statement.

If you decide NOT to change your enrollment, DO NOTHING, and your present enrollment will continue automatically unless your plan is not participating in 2012. If your plan is not participating in 2012 you MUST choose another plan during Open Season or you will not have FEHB coverage.

If you decide to cancel your coverage during Open Season, you must cancel your enrollment in *PostalEASE*, which includes a confirmation by you that you clearly accept the consequences of canceling. The cancellation will become effective on January 13, 2012.

If you pay premium contributions on a pre-tax basis (which most career employees do) you will not be able to cancel or reduce (change from Self and Family to Self Only) coverage outside of open season unless you experience a qualifying life event (QLE) and your election is in keeping with the change. See pages 17 through 19 of this Guide on Pre-tax Payment of Premium Contributions and the Table of Permissible Changes on pages 46 through 49 of this Guide.

You, as an employee, are responsible for being informed about your health benefits. You should thoroughly read this Guide, the brochures of plans that interest you, and the bulletin board notices on health benefits topics. These include family member eligibility, the option to continue or terminate an enrollment during periods of non-pay status or insufficient pay, dual enrollment prohibition, coverage for former spouses, and discontinued health insurance plans. Be sure to read the section on the pre-tax payment of health insurance premium contributions, which specifies Internal Revenue Service (IRS) restrictions for reducing or canceling coverage (see pages 17 through 19 of this Guide). Also be sure to refer to the Table of Permissible Changes on pages 46 through 49 of this Guide.

Federal Employees Health Benefits (FEHB) Program

You can go to https://liteblue.usps.gov and download all of the Benefits Guides including the Guide for Non-APWU Career USPS Employees, the Guide for APWU Career Postal Employees, the Guide for United States Postal Service Inspectors and Office of Inspector General Employees, the Guide for Postal Career Executive Service Employees, the Guide for Certain Temporary (Non-career) USPS Employees, and the Guide for TCC and Former Spouse Enrollees. Plan brochures that include benefits, cost, and other major features of each health plan are available at www.opm.gov/insure/health.

After referring to these sources, if you still have questions regarding eligibility, enrollment criteria, continued coverage after certain life events, or on any other FEHB policies, or if you need assistance making your choice in *PostalEASE*, contact the HRSSC on 1-877-477-3273, option 5.

How do I enroll?

- Complete the *PostalEASE* FEHB Worksheet on pages 41 and 43.
- Access *PostalEASE* on the Internet (https://liteblue.usps.gov), at an Employee Self-Service Kiosk (available in some facilities), on the Intranet (from the Blue page), or by calling the Employee Service Line toll-free on 1-877-477-3273, option 1.

How do I get more information about this Program?

Visit the FEHB Program online at www.opm.gov/insure/health for information including:

- How to compare and choose among health plans
- Health plan websites and plan brochures
- How to file a disputed claim request
- Getting quality healthcare
- Medicare and FEHB

Did You Know… Health Information Technology can improve your health!

What is Health Information Technology? Health Information Technology (HIT) allows doctors and hospitals to manage medical information and to securely exchange information among patients and providers. In a variety of ways, HIT has a demonstrated benefit in improving health care quality, preventing medical errors, reducing costs, and decreasing paperwork.

What are examples of HIT at work?

- You can go online to review your medical, pharmacy, and laboratory claims information;
- If you complete a Health Risk Assessment (HRA), your health plan can identify you as a candidate for case management or disease management and offer suggestions on healthy lifestyle strategies and how to reduce or eliminate health risks. Health plans can provide you with tips and educational material about good health habits, and information about routine care that is age and gender appropriate;
- Physicians can have the very best clinical guidelines at their fingertips for managing and treating diseases;
- While with a patient, a physician can enter a prescription on a computer where potential allergies and adverse reactions are shown immediately;
- Computer alerts are sent to physicians to remind them of a patient's preventive care needs and to track referrals and test results.

One feature of HIT is the **Personal Health Record (PHR)**. The electronic version of your medical records allows you to maintain and manage health information for yourself and your family in a private and secure electronic environment. Some health plans include your medical claims data in your PHR, which gives a more complete picture of your health status and history.

You can also find a PHR on OPM's website at www.opm.gov/insure/health/phr/tools.asp. This PHR is a fillable and downloadable form that you complete yourself and save on your home computer. We encourage you to take a look at this PHR option and, if you determine it will fulfill your record-keeping needs, take advantage of this opportunity.

Price/cost transparency is another element of health information technology. For example, many health plans allow you to use online tools that will show what the plan will pay on average for a specific procedure or for a specific prescription drug. You can also review healthcare quality indicators for physician and hospital services.

The health plans listed on our HIT website at www.opm.gov/insure/health/reference/hittransparency.asp have taken steps to help you become a better consumer of health care and have met OPM's HIT, quality and price/cost transparency standards.

No one is more responsible for your health care than you – HIT tools can help.

FEHB and *PostalEASE*

The United States Postal Service uses *PostalEASE* to enter Federal Employees Health Benefits (FEHB) Program Open Season enrollments and changes. By using *PostalEASE* for health benefits, and by sending information to health insurance companies electronically instead of via paper forms as in past open seasons, the Postal Service expects that employees who make health benefits changes will get their new insurance cards more quickly. All the information you need for using *PostalEASE* is included in the FEHB *PostalEASE* Worksheet found on pages 38 - 44 of this Guide. Just follow the instructions to:

- Enroll
- Change Enrollment
- Cancel Enrollment
- Review or change your pending open season transaction
- Review or update your dependent information
- Review your current enrollment information
- Receive a copy of a health benefits election that was processed using *PostalEASE*

If you want to make a change for the 2012 plan year, you may do so during the annual FEHB Open Season, which is from November 14 through December 13, 2011, at 5:00 PM Central Time. If you currently have an FEHB enrollment and you do not want to make any changes, *do nothing*. Your coverage will continue automatically.

Please do not wait until late in the open season to enter your choice via *PostalEASE*. If you select Self and Family coverage, then you'll need to enter information about your eligible family members. Although this will take extra time, providing this information is required under FEHB regulations. Just complete the FEHB *PostalEASE* Worksheet and follow the instructions carefully.

All open season Self Only enrollments, changes to Self Only coverage, and cancellations, should be entered as employee "self service" transactions using *PostalEASE*. Since dependent information is not required, such transactions are simple. Most Self and Family enrollments can also be completed as employee self service transactions, although they require additional information. The easiest way to do this is via the *PostalEASE* Employee Web, which is available through the LiteBlue page, Blue page, or on a kiosk. Many Self and Family transactions can also be completed by telephone. If you are unable to enter eligible family members information via the telephone, the *PostalEASE* system will refer you to the Web, a kiosk, or the Human Resources Shared Service Center (HRSSC). *PostalEASE* provides the enrollment date, processing date, and effective date when you complete your transaction. You may delete or change a pending transaction until it is processed. If you are newly eligible for FEHB as a career employee, you may also use *PostalEASE* during the first 60 days after your date of appointment.

This Guide contains important FEHB policy information that used to be provided to you as part of the SF 2809 *Health Benefits Election Form*. Be sure you understand how your health benefits work, including information on which family members are eligible, how you pay for your health benefits premiums using pre-tax dollars, and the limitations on making a health benefits change outside of open season. As a reminder, to continue health benefits coverage during retirement, you must have had five consecutive years of FEHB coverage immediately prior to your retirement. If you need help understanding any of this information, or you need help using *PostalEASE*, you should contact the HRSSC for assistance on 1-877-477-3273, option 5. TTY 1-866-260-7507.

Pre-Tax Payment of Premium Contributions

The Postal Service has established the pre-tax payment of health insurance premium contributions as a tax-saving benefit feature for its employees. This feature has been sponsored by the Postal Service since 1994. Payment of premiums on a pre-tax basis prohibits enrollees from reducing coverage unless they qualify as described in the section "Reducing Coverage" below.

Pre-Tax Withholding

If you are a career employee, your premium contributions will automatically be withheld from pay as "pre-tax money," which means the premium amount is not subject to income, Social Security, or Medicare taxes.

Premiums are collected on a pre-tax basis automatically, unless you waive this treatment. Once you begin to pay FEHB premiums with pre-tax money, this method continues each year.

Although you are automatically enrolled to pay premium contributions with pre-tax money, you do have an opportunity during FEHB Open Season, or if you have a qualifying life event, to waive this treatment and pay your premiums with "after-tax money." This means you give up the tax savings of paying with pre-tax money.

There are two possible disadvantages of paying your premiums with pre-tax money that you should balance against the tax savings you receive.

First, when you retire, if you begin to collect Social Security (normally this occurs at age 62 at the earliest), you may receive a slightly lower Social Security benefit. Paying your FEHB premiums with pre-tax money reduces the earnings reported to the Social Security Administration. (Your Medicare, life insurance, retirement plan, and Thrift Savings Plan benefits are not affected.)

Second, there are some restrictions on reducing or canceling your coverage outside FEHB Open Season that apply if you pay your premium contributions with pre-tax money. These are explained in the section "Reducing Coverage" below.

Most employees prefer paying their premiums with pre-tax money because they save on taxes. Nevertheless, if for any reason you do not want this method of payment, and instead wish to have premiums paid with after-tax money, you must submit a form that is available from the Human Resources Shared Service Center (HRSSC) to waive the pre-tax treatment. For more information, see the section "How to Waive or Restore Pre-Tax Payment" on page 19 of this Guide.

Reducing Coverage

When your premium contributions are withheld on a pre-tax basis, certain Internal Revenue Service (IRS) guidelines affect your ability to change coverage. You may elect to reduce your coverage, that is, to cancel your FEHB enrollment, or to go from Self and Family to Self Only coverage, only during an FEHB Open Season, unless you have a qualifying life event. These are shown in the chart on pages 46 to 49 of this Guide titled "USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment." Refer to the column labeled "FEHB Enrollment Change That May Be Permitted" and the header "Cancel or Change to Self Only." You also must satisfy the time limits shown in the column labeled "Time Limits in Which Change May Be Permitted."

If you are the only person left in your Self and Family enrollment as a result of a qualifying life event in marital or family status, you must elect to reduce the enrollment (elect Self Only coverage or cancel coverage) by submitting the FEHB *PostalEASE* Worksheet to the HRSSC within the time limit shown in the column labeled "Time Limits in Which Change May Be Permitted" in the chart on pages 46 to 49 of this Guide. Otherwise, your Self and Family enrollment will continue until another event (that is, a qualifying life event or FEHB Open Season) occurs that allows you to elect to reduce coverage.

Reducing your FEHB coverage outside of FEHB Open Season must be in keeping with, or on account of, your qualifying life event. For example, if you have a new baby, you usually would not change from Self and Family to a Self Only enrollment, or cancel coverage.

To reduce your FEHB coverage outside of FEHB Open Season, submit an FEHB *PostalEASE* Worksheet to the Human Resources Shared Services Center (HRSSC) within the time limits shown in the column labeled "Time Limits in Which Change May be Permitted" in the table on pages 46 to 49 of this Guide. You must provide any supporting documentation requested by the HRSSC. The effective date of a change from Self and Family to Self Only will be the first day of the pay period that follows the pay period in which your Worksheet is received by the HRSSC. The effective date of a cancellation will be the last day of the pay period in which your Worksheet is received by the HRSSC, if received within the specified time limits.

It is your responsibility to notify and submit necessary forms to the HRSSC on time when you are the only person left on your enrollment.

Retirement is NOT a qualifying life event that allows cancellation prior to the date of your retirement. If you wish to cancel an enrollment at retirement, the HRSSC will accept your completed OPM 2809 and forward it to OPM for processing after separation from the Postal Service. (Annuitants' FEHB premium contributions are not withheld as a pre-tax payment, thus once you are an annuitant, reduction in coverage is allowed at any time.)

During periods of non-pay status or insufficient pay, you may terminate your FEHB enrollment. The effective date of termination is retroactive to the end of the last pay period in which a premium contribution was withheld from pay. Contact the HRSSC for more information about how termination during periods of non-pay status or insufficient pay affects FEHB enrollment.

Pre-Tax Payment of Premium Contributions

How to Waive or Restore Pre-Tax Payments

If you pay premiums with after-tax money, you will not be affected by the IRS guidelines described above that restrict reductions in coverage. You may reduce your level of FEHB coverage at any time of year without having a qualifying life event. You will give up the tax savings from paying your premium contributions with pre-tax money.

If you wish to pay your premiums with after-tax money, you must contact the HRSSC and ask for Postal Service (PS) Form 8201, *Pre-tax Health Insurance Premium Waiver/Restoration Form*. During Open Season, complete the form and return it to the HRSSC by close of business December 13, 2011. If this is your initial opportunity to enroll in FEHB, you have 60 days to submit your election to the HRSSC. You also may make such an election when you have a qualifying life event which is shown in the chart on pages 46 to 49 of this Guide. Refer to the column labeled "Premium Conversion Election Change That May Be Permitted." You must also satisfy the time limits shown in the column labeled "Time Limits in Which Change May Be Permitted."

If you submit a waiver, your premiums will continue to be paid with after-tax money in future years, unless you later submit another PS Form 8201 to restore pre-tax payment of FEHB premiums.

If you previously submitted a waiver in order to pay with after-tax money, and you want to begin paying your premiums with pre-tax money, you may submit a PS Form 8201 to restore pre-tax payment of your premium contributions. You may change the method of payment from pre-tax to after-tax, or the reverse only during the annual FEHB Open Season or following a qualifying life event and within the time limits described earlier in this section.

Your Right to More Information

This section of the FEHB Guide serves as your summary plan description of the USPS Plan for the Pre-tax Payment of Health Insurance Premiums. There is also a legal plan document containing the full legal plan provisions, which you may arrange to view by writing to:

PRETAX PAYMENT OF HEALTH INSURANCE PREMIUMS
PLAN ADMINISTRATOR
475 L'ENFANT PLAZA SW ROOM 9670
WASHINGTON DC 20260-4101

Federal Employees Dental and Vision Insurance Program (FEDVIP)

What does this Program offer?

The Federal Employees Dental and Vision Insurance Program provides comprehensive dental and vision insurance at competitive group rates. There are seven dental plans and three vision plans from which to choose. FEDVIP features nationwide, international, and regional plans.

A dental or vision insurance plan is much like a health insurance plan; you may be required to meet a deductible and provide a copay or coinsurance payments for your dental or vision services. With any plan choice, you should look at all the information and find a plan that will best fit your needs. You should also review your FEHB plan brochure to determine what dental and/or vision coverage the FEHB plan provides.

If you are currently enrolled in FEDVIP and you take no action during Open Season, your current coverage will continue in 2012, provided you remain eligible for the program. Enrollment continues year to year, automatically. **Please Note**: your premiums and benefits may change for 2012.

Key FEDVIP facts

- FEDVIP is separate and different from the FEHB Program.
- The health care law does not change the age or unmarried requirement for dependents in FEDVIP.
- FEDVIP coverage continues each year. You do not need to re-enroll each year. If you do not want to change plans or enrollment type, do nothing.
- You can only cancel FEDVIP coverage during Open Season, upon deployment to active military duty or upon transfer to another agency where you enroll in their dental and/or vision plan and the agency pays at least 50% of the premium. You cannot cancel just because you retire or because you can no longer afford the premiums.
- If you are enrolled in an FEHB Plan, it is a requirement under the FEDVIP law that your FEHB plan function as the first payer. The FEDVIP plan is always the secondary payer to the FEHB plan.
- You can use your Flexible Spending Account (FSA) with FEDVIP. You can submit your FEDVIP copayments and deductibles as eligible expenses against your FSA account.
- All nationwide FEDVIP plans provide international coverage.
- There are separate and/or different provider networks for each plan.
- Utilizing an in-network provider will reduce your out-of-pocket costs.
- There are no pre-existing condition limitations for enrollment.
- There is no opportunity to convert to a private plan when your FEDVIP coverage ends. There is no 31-day extension of coverage, Temporary Continuation of Coverage (TCC), Spouse Equity coverage, or right to convert to an individual policy (conversion policy).

What enrollment types are available?

- Self Only, which covers only the enrolled employee or retiree;
- Self Plus One, which covers the enrolled employee or retiree plus one eligible family member specified by the enrollee; and
- Self and Family, which covers the enrolled employee or retiree and all eligible family members.

The FEDVIP Guide lists the available dental and vision insurance plans along with basic benefit information. The FEDVIP Guide will be mailed to your address on record.

Federal Employees Dental and Vision Insurance Program (FEDVIP)

Am I eligible to enroll?

In general, Postal Service employees eligible for FEHB coverage (whether or not actually enrolled) and retirees (regardless of FEHB status) are eligible to enroll in a dental and/or vision plan. Former spouses and deferred annuitants are NOT eligible to enroll. Anyone receiving an insurable interest annuity who is not also an eligible family member is NOT eligible to enroll.

Which family members are eligible?

Eligible family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

FEDVIP rules and FEHB rules for family member eligibility are **NOT** the same.

Changes in dependent eligibility under healthcare reform (Affordable Care Act) do not affect eligibility for children under FEDVIP.

How much does it cost?

You pay the entire premium. There is no Postal Service contribution to the premium. If you are an active employee, your premiums are taken from your salary on a pre-tax basis if your salary is sufficient to make the premium withholding. When you retire, premiums will be withheld from your monthly annuity check on a post-tax basis if your annuity is sufficient.

Premiums for the nationwide dental plans and one regional dental plan are based on where you live. This is called your rating region. Your home ZIP code is used to find your rating region. Rating regions vary by carrier. The vision plans do not have rating regions. Enrolling in a FEDVIP plan will not reduce your FEHB premium.

See the FEDVIP Guide to find 1) the rating region assigned to the area where you live by the different dental plans and 2) the related premium you will pay. You may also go to OPM's website at www.opm.gov/insure/dental and www.opm.gov/insure/vision for premium and rating region information.

Federal Employees Dental and Vision Insurance Program (FEDVIP)

When can I enroll?

If you are a new employee eligible for FEDVIP, or an employee who has become newly eligible to enroll, you may enroll within 60 days of first becoming eligible. This is a one-time opportunity outside of Open Season to enroll. There is a separate 60-day enrollment period for dental and vision. For example: you may enroll in a dental plan on day 30 and a vision plan on day 59. Once you enroll, your 60-day opportunity for that type of plan ends.

An eligible employee or retiree may also enroll during the annual FEDVIP Open Season, which runs from the Monday of the second full work week in November through 11:59 p.m. Eastern Time the Monday of the second full work week in December. An eligible employee or retiree may enroll, cancel, or change enrollment type or options during Open Season. You may enroll or make changes outside of Open Season if you experience a qualifying life event (QLE) such as a change in family or other insurance coverage status. Please see the FEDVIP Guide for more information about QLEs that permit employees and retirees to enroll or make changes in FEDVIP.

If you enroll during Open Season, premiums are deducted beginning the first full pay period on or after January 1. For new or newly eligible employees who elect to enroll, coverage is effective the first day of the pay period following the one in which BENEFEDS receives your enrollment. An Open Season enrollment or change is effective January 1.

How do I enroll?

You may enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM. For those without access to a computer, please call 1-877-888-FEDS (1-877-888-3337) (TTY number, 1-877-889-5680).

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through *PostalEASE*.

What should I consider in making my decision to participate in this Program?

There are questions you should ask yourself when deciding to enroll in FEDVIP or selecting a FEDVIP plan. By considering these questions thoroughly, you will be able to determine if FEDVIP is a good option for you.

1. Does my FEHB plan provide dental or vision coverage?

2. Does the FEDVIP plan coordinate benefits with the FEHB plan and how is the coordination of benefits calculated?

3. How affordable is the plan?
   - How much will it cost me on a bi-weekly or monthly basis? Can I afford that for the entire year?
   - Must I pay a deductible?
   - If I use a FEDVIP provider outside of the network, how much will I pay to get care?
   - How frequently can I visit the dentist and how much do I have to pay at each visit?
   - Will the plan provide benefits if I am also covered by another dental or vision plan?

4. Do I have access to any provider?
   - Does the plan give me the freedom to choose my own dentist or am I restricted to a panel of dentists selected by the plan?
   - Are there enough of the kinds of dentists I want to see?
   - Where will I go for care? Are these places near where I work or live?
   - Do I need to get permission before I see a dental specialist?
   - Will the plan allow referrals to specialists? Will my dentist and I be able to choose the specialist?

5. Does the plan provide coverage for specialty services?
   - Are dentures, orthodontics, implants or replacement of missing teeth covered?
   - What are the plan's limitations or exclusions?
   - Are there annual limits on the types of services included?

6. Should I enroll in FEDVIP or cover out-of-pocket expenses through a Postal Service Health Care Flexible Spending Account (FSA)?

Note: Both FEDVIP premiums and FSA contributions are pre-tax. If you enroll in FEDVIP, you can still cover any out-of-pocket dental and vision expenses that FEDVIP does not cover through a Health Care FSA.

How do I find my premium rate?

A brochure, FEDVIP BK-1, *Guide to Federal Employees Dental and Vision Insurance Program* (November 2011), will be mailed to all employees.

How do I get more information about this program?

Visit FEDVIP online at www.opm.gov/insure/dental and www.opm.gov/insure/vision for information including:
- How to enroll
- FEDVIP plan website, brochures, and provider searches
- Dental premium rates
- Vision premium rates

USPS Flexible Spending Accounts Program (FSA)

Flexible Spending Accounts (FSA) Open Season

- Enrollment for 2012 FSAs begins: November 7, 2011
- Enrollment ends: December 25, 2011 (5:00 P.M. Central Time)
- Enrollments are effective: January 1, 2012

Who Can Enroll

Only career employees are eligible to enroll in FSAs for 2012.

Which Family Members are Eligible?

For purposes of the Health Care FSA, qualified dependents include:

- Your spouse.
- Your natural born or adopted child who you (or if you are divorced, you or your ex-spouse) may claim as a dependent on your federal tax return.
- Any other person who you may claim as a dependent on your federal tax return.
- Children who are not your dependents-but only until December 31 of the year before the year in which they turn age 27. "Children" include your natural children, stepchildren, adopted children, eligible foster children, or children who are placed with you for legal adoption. **NOTE:** Because qualified dependent status for non-dependent children ends under this rule on December 31 of the year before the year of a child's 27th birthday, you may only claim eligible expenses for services or items received by or for your child on or before December 31 of the year before the year of your child's 27th birthday. This means that if you end that year with an available balance in your FSA, you may not claim expenses for that child that are incurred during the normal January 1 through March 15 grace period in the following year.

What Are FSAs for and How Do They Work?

There are two types of FSAs available to you — the Health Care FSA for health care expenses and the Dependent Care FSA for dependent care (day care) expenses.

If you're like most people, you have health care expenses you pay yourself — insurance doesn't cover them. Expenses for you and your family, like prescriptions, doctor and dentist visits and vision care. Expenses like health plan deductibles or copayments. If you enroll in FEDVIP and have dental or vision insurance, amounts for non-cosmetic procedures or items that your plan doesn't cover. But your expenses aren't high enough for you to claim a deduction on your taxes.

You can get a tax break, though, by signing up for Flexible Spending Accounts (FSAs). You decide how much to contribute for 2012. Then, you contribute money every payday to an FSA, which is an account that allows you to cover your eligible health care expenses throughout the year with tax-free money. Meanwhile, whatever you contribute isn't subject to Federal income tax, or Social Security tax, or Medicare tax. Since, you get a tax break each payday, it's cheaper to pay for your health care expenses through an FSA. (Without an FSA, you pay for health care expenses using your checkbook or a credit card, and there's no tax break at all.)

You can use FSAs for dependent care (day care) expenses too, and you'll save on taxes the same way.

The full amount that you sign up for is available to you beginning January 1, 2012, to cover your eligible expenses, even though FSA contributions are taken from your pay over the entire year. So, for example, if you have Lasik surgery in February and it costs you $3,000, you can withdraw the entire amount from your Health Care FSA even though you won't have had that much withheld from your pay at that time. It works the same way for the Dependent Care FSA too.

Be sure to the read the FSA brochure that's mailed to you as it explains the limitations on using your FSA—for example, there are specific time limits for expenses to be eligible. You can't cover certain expenses, such as cosmetic items or procedures. And there's a deadline for filing your claims. The brochure explains the details.

What Are the Contribution Limits?

You can contribute up to $5,000 to the Health Care FSA. You can contribute up to $5,000 to the Dependent Care FSA.

How to Enroll

To use the Employee Web — the easiest way to use *PostalEASE* — access the system in any of these ways:

- On the Internet at https://liteblue.usps.gov. Under "Employee Self Service," select *PostalEASE*.
- At an employee self-service kiosk.
- On the Intranet at http://blue.usps.gov. Under "Employee Resources," select *Employee Self Service* and then *PostalEASE*.

To use the telephone, call the Employee Service Line at 1-877-477-3273, option 1.

If you have a medical condition that interferes or for another reason cannot successfully complete your transaction using *PostalEASE*, contact the Human Resources Shared Service Center (HRSSC) for assistance at 1-877-477-3273, option 5.

Details Are in the Mail

A leaflet and a brochure, FSA BK1, *Flexible Spending Accounts* (November 2011), with a *PostalEASE* FSA worksheet included, are being mailed to all career employees. If you do not receive yours by November 28, 2011, contact the HRSSC.

What if I Enroll in a High-Deductible Health Plan with a Health Savings Account?

It is *very important* for you to read the FSA brochure that is mailed to you this FSA open season so that you understand the rules before you sign up for a Health Care FSA. Look for the section that explains the Limited FSA.

Qualifying life events (QLEs) that may permit a change in your Flexible Spending Account participation

1. You marry (including a valid common law marriage, in accordance with applicable state law), divorce, legally separate, or your marriage is annulled.

2. You add a qualified dependent (for example, by birth, or you adopt a child, or your dependent now satisfies eligibility requirements).

3. You lose a qualified dependent (for example, by death, or your child is placed for adoption, or your dependent now ceases to satisfy eligibility requirements).

4. You, your spouse, or your dependent has a change in work site making that person eligible or ineligible for a benefit plan, or a change in residence making that person ineligible for a benefit plan.

5. Your spouse or your dependent starts or ends employment, or an unpaid leave of absence, or a strike or lockout; or has a change in employment status making that person eligible or ineligible for a benefit plan.

6. A court order, judgment or decree (resulting from a change in marital status or legal custody) requires you to begin providing coverage for your child or requires another person to do so.

7. You, your spouse or your dependent becomes or ceases to be eligible for Medicare, Medicaid, or TRICARE.

8. For the Dependent Care FSA ***only***, you change dependent care providers, or your cost for dependent care changes ***and*** the provider is not your relative.

Note: If you begin or end a period of military leave, #4 and #7 above may apply.

USPS Flexible Spending Accounts Program (FSA)

Making a Change

- You have 60 days after a qualifying life event to request a change to your contribution level. To make a change, contact the Human Resources Shared Service Center (HRSSC). Then, complete and submit the FSA *PostalEASE*. Worksheet, which includes a name, Employee ID, date and signature block ONLY for use when you have a qualifying life event and/or as instructed by the HRSSC, along with any supporting documentation that may be required by the HRSSC, within the 60-day limit to: **HR Shared Service Center, Attn: FSA/QLE, PO Box 970400, Greensboro NC 27497-0400**. If you are making a change, the contribution level amount you write on the enrollment form should be the new total amount you want to contribute for the entire plan year (not just the amount for the rest of the plan year).

- Contribution level changes you request must be in keeping with your qualifying life event. For instance, if you have a new baby, you would generally ask for a higher contribution level, not a lower one. The HRSSC will review your request and may ask for proof of your qualifying life event.

- Your FSA contribution level change takes effect the first day of the pay period following the pay period your election to make a change is approved by the HRSSC.

- If you want to increase your Health Care FSA contribution level, make sure you read and understand the special note about this in the FSA brochure.

Questions

Hotline for FSA questions: 800-842-2026.

Employees who are deaf or hard of hearing may call this number via 711, the Telecommunications Relay Service (TRS).

Federal Employees' Group Life Insurance (FEGLI) Program

What does this Program offer?

The FEGLI Program offers group term life insurance.

Key FEGLI facts

- There is no annual Open Season for FEGLI.
- Employees in eligible positions are automatically covered under Basic life insurance, unless they choose to waive that coverage.
- Employees must have Basic insurance in order to have or elect Optional insurance.
- Employees must take action, within strict time limits, to elect Optional insurance. Coverage is not automatic.
- The Postal Service pays the full cost of Basic insurance. Enrollees pay 100% of the cost of Optional insurance.
- FEGLI does not have any cash or paid-up value. You cannot get a loan by borrowing from this insurance.
- Retirees may be able to continue their FEGLI coverage into retirement, but they cannot newly elect FEGLI coverage as a retiree.
- Living benefits are life insurance benefits paid to you while you are still living, rather than paid to a beneficiary or survivor when you die. You are eligible to elect a living benefit if you are an employee, retiree, or compensationer covered under the FEGLI Program who has been diagnosed as terminally ill with a life expectancy of nine months or less, and you have not assigned your insurance.

What coverage is available?

Basic insurance – your annual salary, rounded up to the next even $1,000, plus $2,000. Basic insurance includes accidental death and dismemberment coverage for employees (not for retirees).

Optional insurance

- **Option A - Standard** – $10,000 of insurance. Option A includes accidental death and dismemberment coverage for employees (not for retirees).
- **Option B - Additional** – 1, 2, 3, 4 or 5 times your annual rate of basic pay after rounding it up to the next even $1,000.
- **Option C - Family** – coverage for your spouse and all of your eligible dependent children. You can elect 1, 2, 3, 4 or 5 multiples. Each multiple is equal to $5,000 for your spouse and $2,500 for each eligible child.

How much does it cost?

The Postal Service pays the full cost of your Basic life insurance premium.

You pay 100% of the premium for Optional insurance. The cost depends on your age, based on 5-year age groups.

Federal Employees' Group Life Insurance (FEGLI) Program

Am I eligible to enroll?

Most Postal Service employees are eligible to enroll in FEGLI unless they are excluded by law or regulation. Retirees are eligible to carry their FEGLI into retirement if they meet the following requirements: eligible to retire on an immediate annuity (including FERS MRA+10 retirement), have not converted the coverage to a private plan, and have been insured under FEGLI for the five years immediately preceding retirement or for all periods of service during which FEGLI was available to them if they have been covered for less than 5 years. **There is no waiver of this five-year rule.**

Which family members are eligible?

Eligible FEGLI family members include a spouse and eligible dependent children. Eligible dependent children must be unmarried and under age 22, or if age 22 or over, incapable of self-support because of a mental or physical disability that existed before the child reached age 22. Eligible dependent children include your natural children, adopted children, stepchildren (if they live with you in a regular parent-child relationship), recognized natural children and foster children (if they live with you in a regular parent-child relationship). Stillborn children are not covered.

When can I enroll?

There is no annual Open Season for FEGLI.

If you are a new employee who is eligible for FEGLI, or an employee who has become newly eligible to enroll, you will be automatically enrolled in Basic. If you do not want Basic, you must file a waiver.

As a new or newly eligible employee, you may enroll in Optional insurance within 60 days of becoming eligible. If you take no action, you will have Basic and will not have any Optional insurance.

If you are not a new employee or newly eligible, you may enroll in Basic life insurance and, if you wish, Option A and/or Option B coverage by providing satisfactory medical information at your own expense using the *Request for Life Insurance* (Standard Form 2822). You cannot enroll in Option C this way.

You may elect Basic, Option A, Option B and Option C within 60 days of a FEGLI qualifying life event. In addition, you may increase the number of multiples of Option B and/or Option C. You may elect any number of multiples for Option B and Option C as long as the total number of multiples for each option does not exceed 5.

You may also enroll during a FEGLI Open Season, which is held infrequently. You will receive plenty of notice when there is a FEGLI Open Season. The most recent FEGLI Open Seasons were held in 2004 and in 1999.

Federal Employees' Group Life Insurance (FEGLI) Program

How do I enroll?

Contact the Human Resources Shared Service Center (HRSSC) on 1-877-477-3273, option 5 for details on how you can enroll.

Who gets the benefits paid after my death?

When you die, the Office of Federal Employees' Group Life Insurance (OFEGLI), an administrative unit of Metropolitan Life Insurance Company (MetLife), will pay life insurance benefits in a particular order set by law, unless you have a valid standard form (SF) 2823, *Designation of Beneficiary FEGLI* in your official personnel file. The FE 76-20 *FEGLI Program Booklet for USPS Employees*, available from the HRSSC and at www.opm.gov/insure/life, contains more details.

How does my beneficiary file a claim?

He or she must use form FE-6, *Claim for Death Benefits* to claim FEGLI benefits, available from the HRSSC, or retirement system or at www.opm.gov/insure/life.

How do I get more information about this Program?

Contact the HRSSC on 1-877-477-3273, option 5. If you are retired, contact OPM's Retirement Operations Center at retire@opm.gov or by calling 1-888-767-6738. Neither OFEGLI nor OPM's Insurance Operations offices maintain records for active Postal Service employees or retirees.

Federal Long Term Care Insurance Program (FLTCIP)

What does this Program offer?

The FLTCIP offers insurance that helps cover the costs of certain long term care services. Long term care is the assistance you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment, such as Alzheimer's disease. Long term care can be provided in a facility, like a nursing home, but is most often provided at home.

Key FLTCIP facts

- There is no annual Open Season for FLTCIP.
- You must apply and answer questions about your health to find out if you are approved to enroll.
- You can apply for coverage at any time using the full underwriting application; you do not have to wait for an Open Season.
- New/newly eligible employees and their spouses and newly married spouses of employees can apply with abbreviated underwriting (fewer questions about their health) within 60 days of becoming eligible.
- Qualified family members, including same-sex domestic partners can also apply, with full underwriting.
- Once enrolled, you can keep your coverage even if you are no longer in an eligible group (for example, you leave your job with the Postal Service).

How much does it cost?

If you are approved for coverage, your premium is based on your age on the date your application is received and on the benefit options you select. You may pay your premiums through deductions from pay or annuity, by automatic bank withdrawal, or by direct bill.

Please Note: Your premiums do not change because you get older or your health changes after your coverage becomes effective. However, premiums are not guaranteed. We may only increase premiums if you are among a group of enrollees whose premium is determined to be inadequate.

Am I eligible to apply?

Most Postal Service employees are eligible to apply for coverage. If you are eligible for the FEHB Program you are eligible to apply for coverage under the FLTCIP, even if you are not enrolled in the FEHB Program. Retirees are eligible to apply.

Which family members are eligible?

Enrollment in the FLTCIP is on an individual basis. If you are eligible as a Postal Service employee or annuitant, your spouse, same-sex domestic partner, and your adult children at least 18 years old are eligible to apply for coverage. If you are a Postal Service employee, your parents, parents-in-law, and step parents are also eligible to apply.

For more information on eligibility, visit www.ltcfeds.com/eligibility.

Federal Long Term Care Insurance Program (FLTCIP)

How do I apply?

You apply by completing an application found at www.ltcfeds.com/usps or by calling 1-800-LTC-FEDS. You must pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.

If you are a new or newly eligible employee, you (and your spouse, if applicable) have 60 days to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have 60 days to apply using abbreviated underwriting. You and your qualified relatives, including same-sex domestic partners may apply anytime using the full underwriting application.

What should I consider in making my decision to participate in this Program?

Remember that FEHB plans do not cover the cost of long term care. While Medicare covers some care in nursing homes and at home, it does so only for a limited time, subject to restrictions. The need for long term care can strike anyone at any age and the cost of care can be substantial.

Be sure to visit www.ltcfeds.com/usps for the most up-to-date information about the FLTCIP before deciding whether to apply.

How do I get more information about this Program?

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com/usps.

Appendix A
FEHB Program Features

No waiting periods. You can use your benefits as soon as your coverage becomes effective. There are no pre-existing condition limitations even if you change plans.

A choice of coverage. You can choose Self Only coverage just for you, or Self and Family coverage for you, your spouse, and children under age 26. Under certain circumstances, your FEHB enrollment may cover your disabled child 26 years old or older who is incapable of self-support.

A choice of plans and options. The FEHB Program offers Fee-for-Service plans, plans offering a Point-of-Service product, Health Maintenance Organizations, High Deductible Health Plans and Consumer-Driven Health Plans.

A Government contribution. The Postal Service pays the lesser of 91% of the average premium of all plans weighted by the number of enrollees in each plan but not more than 94.75% of the total premium for any individual plan.

Salary deduction. You pay your share of the premium through a payroll deduction and have the choice of doing so using pre-tax dollars.

Annual enrollment opportunities. Each year you can enroll or change your health plan enrollment during Open Season. Open Season runs from the Monday of the second full work week in November through the Monday of the second full work week in December. Other events allow for certain types of changes throughout the year; see the Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After Tax Premium Payment for details.

Continued group coverage. The FEHB Program offers continued FEHB coverage:

* for you and your family when you retire from the Postal Service (normally you need to be covered under the FEHB Program for the five years of service immediately before you retire),
* for your former spouse if you divorce and he or she has a qualifying court order (contact the Human Resources Shared Service Center (HRSSC) for more information),
* for your family if you die, or
* for you and your family when you move, transfer, go on leave without pay, or enter military service (certain rules about coverage and premium amounts apply; contact the HRSSC).

Coverage after FEHB ends. The FEHB Program offers temporary continuation of coverage (TCC) and conversion to non-group (private) coverage:

* for you and your family if you leave the Postal Service (including when you are not eligible to carry FEHB into retirement),
* for your covered child if he or she turns age 26, or
* for your former spouse if you divorce and he or she does not have a qualifying court order (contact the HRSSC at 1-877-477-3273, option 5).

If you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB plan to cover you. If not, the plan must give you one on request. This certificate may be important to qualify for benefits if you join a non-FEHB plan.

Appendix B
Choosing an FEHB Plan

What type of health plan is best for you?

You have some basic questions to answer about how you pay for and access medical care. Here are the different types of plans from which to choose.

	Choice of doctors, hospitals, pharmacies, and other providers	Specialty care	Out-of-pocket costs	Paperwork
Fee-for-Service w/Preferred Provider Organization (PPO)	You **must** use the plan's network to reduce your out-of-pocket costs. For BCBS Basic Option, you **must** use Preferred providers for your care to be eligible for benefits.	Referral not required to get benefits.	You pay fewer costs if you use a PPO provider than if you don't.	Some, if you don't use network providers.
Health Maintenance Organization	You generally must use the plan's network to reduce your out-of-pocket costs.	Referral generally required from primary care doctor to get benefits.	Your out-of-pocket costs are generally limited to copayments.	Little, if any.
Point-of-Service	You must use the plan's network to reduce your out-of-pocket costs. You may go outside the network but you will pay more.	Referral generally required to get maximum benefits.	You pay less if you use a network provider than if you don't.	Little, if you use the network. You have to file your own claims if you don't use the network.
Consumer-Driven Plans	You may use network and non-network providers. You will pay more by not using the network.	Referral not required to get maximum benefits from PPOs.	You will pay an annual deductible and cost-sharing. You pay less if you use the network.	Some, if you don't use network providers.
High Deductible Health Plans w/Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA)	Some plans are network only, others pay something even if you do not use a network provider.	Referral not required to get maximum benefits from PPOs.	You will pay an annual deductible and cost-sharing. You pay less if you use the network.	If you have an HSA or HRA account, you may have to file a claim to obtain reimbursement.

Appendix B
Choosing an FEHB Plan

What should you consider when choosing a plan?
Having a variety of plans to choose from is a good thing, but it can make the process confusing. There is a tool on the Office of Personel Management's (OPM) website that will help you narrow your plan choice based on the benefits that are important to you; go to www.opm.gov/insure/health/search/plansearch.aspx. You can also find help in selecting a plan using tools provided by PlanSmartChoice and Consumer's Checkbook at www.opm.gov/insure/health/planinfo/index.asp.

Ask yourself these questions:

1. **How much does the plan cost?** This includes the premium you pay.

2. **What benefits does the plan cover?** Make sure the plan covers the services or supplies that are important to you, and know its limitations and exclusions.

3. **What are my out of pocket costs?** Does the plan charge a deductible (the amount you must first pay before the plan begins to pay benefits)? What is the copayment or coinsurance (the amount you share in the cost of the service or supply)?

4. **Who are the doctors, hospitals, and other care providers I can use?** Your costs are lower when you use providers who are part of the plan; these are "in-network" providers.

5. **How well does my plan provide quality care?** Quality care varies from plan to plan, and here are three sources for reviewing quality.

    * Member survey results – evaluations by current plan members are posted within the health plan benefit charts in this Guide.

    * Effectiveness of care – how a plan performs in preventing or treating common conditions is measured by the Healthcare Effectiveness Data and Information Set and is found at www.opm.gov/insure/health/planinfo/quality/hedis.aspx.

    * Accreditation – evaluations of health plans by independent accrediting organizations. Check the cover of your health plan's brochure for its accreditation level or go to http://reportcard.ncqa.org/plan/external/plansearch.aspx.

Appendix B
Choosing an FEHB Plan

Definitions

Brand name drug - A prescription drug that is protected by a patent, supplied by a single company, and marketed under the manufacturer's brand name.

Coinsurance - The amount you pay as your share for the medical services you receive, such as a doctor's visit. Coinsurance is a percentage of the plan's allowance for the service (you pay 20%, for example).

Copayment - The amount you pay as your share for the medical services you receive, such as a doctor's visit. A copayment is a fixed dollar amount (you pay $15, for example).

Deductible - The dollar amount of covered expenses an individual or family must pay before the plan begins to pay benefits. There may be separate deductibles for different types of services. For example, a plan can have a prescription drug benefit deductible separate from its calendar year deductible.

Formulary or Prescription Drug List - A list of both generic and brand name drugs, often made up of different cost-sharing levels or tiers, that are preferred by your health plan. Health plans choose drugs that are medically safe and cost effective. A team including pharmacists and physicians determines the drugs to include in the formulary.

Generic Drug - A generic medication is an equivalent of a brand name drug. A generic drug provides the same effectiveness and safety as a brand name drug and usually costs less. A generic drug may have a different color or shape than the brand name, but it must have the same active ingredients, strength, and dosage form (pill, liquid, or injection).

In-Network - You receive treatment from the doctors, clinics, health centers, hospitals, medical practices, and other providers with whom your plan has an agreement to care for its members.

Out-of-Network - You receive treatment from doctors, clinics, health centers, hospitals, and medical practices other than those with whom the plan has an agreement at additional cost. Members who receive services outside the network may pay all charges.

Premium Conversion - A program to allow Federal employees to use pre-tax dollars to pay health insurance premiums to the Federal Employees Health Benefits (FEHB) Program. Based on Federal tax rules, employees can deduct their share of health insurance premiums from their taxable income, which reduces their taxes.

Provider - A doctor, hospital, health care practitioner, pharmacy, or health care facility.

Qualifying Life Events - An event that may allow participants in the FEHB Program to change their health benefits enrollment outside of an Open Season. These events also apply to employees under premium conversion and include such events as change in family status, loss of FEHB coverage due to termination or cancellation, and change in employment status.

Additional definitions are located at the beginning of the sections introducing the different types of health plans.

Appendix C
FEHB Member Survey Results

Each year Federal Employees Health Benefits plans with 500 or more subscribers mail the Consumers Assessment of Healthcare Providers and Systems (CAHPS)[1] to a random sample of plan members. For Health Maintenance Organizations (HMO)/Point-of-Service (POS) and High Deductible Health Plans (HDHP) and Consumer-Driven Health Plans (CDHP), the sample includes all commercial plan members, including non-Federal members. For Fee-for-Service (FFS)/Preferred Provider Organization (PPO) plans, the sample includes Federal members only. The CAHPS survey asks questions to evaluate members' satisfaction with their health plans. Independent vendors certified by the National Committee for Quality Assurance administer the surveys.

OPM reports each plan's scores on the various survey measures by showing the percentage of satisfied members on a scale of 0 to 100. Also, we list the national average for each measure. Since we offer HMO plans, FFS/PPO plans, HDHP, and CDHP plans, we compute a separate national average for each plan type.

Survey findings and member ratings are provided for the following key measures of member satisfaction:

- Overall Plan Satisfaction – This measure is based on the question, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?" We report the percentage of respondents who rated their plan 8 or higher.
- Getting Needed Care – How often was it easy to get an appointment, the care, tests, or treatment you thought you needed through your health plan?
- Getting Care Quickly – When you needed care right away, how often did you get care as soon as you thought you needed? Not counting the times you needed care right away, how often did you get an appointment at a doctor's office or clinic as soon as you thought you needed?
- How Well Doctors Communicate – How often did your personal doctor explain things in a way that was easy to understand? How often did your personal doctor listen carefully to you, show respect for what you had to say, and spend enough time with you?
- Customer Service – How often did the written materials or the Internet provide the information you needed about how your health plan works? How often did your health plan's customer service give you the information or help you needed? How often were the forms from your health plan easy to fill out?
- Claims Processing – How often did your health plan handle your claims quickly and correctly?
- Plan Information on Costs – How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment, or for specific prescription drug medicines?

In evaluating plan scores, you can compare individual plan scores against other plans and against the national averages. Generally, new plans and those with fewer than 500 FEHB subscribers do not conduct CAHPS. Therefore, some of the plans listed in the Guide will not have survey data.

[1] *CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).*

Appendix D
How to Use *PostalEASE* to Manage Your FEHB Enrollment

The *PostalEASE* telephone system and web sites provide a convenient, confidential, and secure way for you to newly enroll, change your current enrollment, or cancel your enrollment in the Federal Employees Health Benefits (FEHB) Program. If you have access to *PostalEASE* on the Internet (https://liteblue.usps.gov), at an Employee Self-Service Kiosk (available in some facilities), or on the Postal Service Intranet (from the Blue page), using either of these may be easier than using the telephone.

Through *PostalEASE* you may:

- Make a change to your current enrollment during FEHB Open Season (November 14, 2011 – December 13, 2011, 5 p.m. Central Time)
- Make an election as a new employee within 60 days of your date of hire.
- Update your dependents' information — **although if you are not making a change in your enrollment at the same time, you must also contact your health plan carrier directly** with this information. *PostalEASE* will **not** transmit dependent change information to the insurance carrier if an enrollment transaction has not occurred.

Qualifying Life Event (QLE):

You cannot use *PostalEASE* to newly enroll or change your enrollment due to the occurrence of a permitting event, nor to cancel or reduce your coverage due to a qualifying life event (QLE). You must contact the Human Resources Shared Service Center (HRSSC) to assist you with these actions.

If you are not making any changes to your current FEHB enrollment, then you do not need to do anything.

Preparing for PostalEASE FEHB Enrollment

1. **Read the Privacy Act Statement on page 5.**
2. **Read and understand the appropriate *Guide to Benefits* – RI 70-2** for Non-APWU career USPS employees, **RI 70-2A** for APWU career USPS employees, **RI 70-2IN** for career U.S. Postal Inspectors and Office of the Inspector General employees, **RI 70-2EX** for PCES employees, **RI 70-8PS** for certain temporary (noncareer) USPS employees- mailed to you for FEHB Open Season.
3. **Have the following information** ready before using *PostalEASE*.
   a. Your USPS personal identification number (**PIN**). If you don't know your PIN, just call the Employee Service Line at 1-877-477-3273. When prompted to enter your PIN, pause and you will be given the option of having it mailed to your address of record. Usually it will be mailed by the next business day. Or, request your USPS PIN from *PostalEASE* on the Internet (https://liteblue.usps.gov), at an Employee Self-Service Kiosk (available in some facilities), or on the Intranet (from the Blue Page).
   b. Your Employee ID, which is printed at the top of your earnings statement. Enter all 8 digits, even if the first one is a zero.
   c. Your daytime **phone number**.
   d. The name of the **health benefits plan** in which you are enrolling.
   e. The **enrollment code** of the health benefits plan in which you are **enrolling**. For the name and enrollment code, refer to your *Guide to Benefits*, or to the health plan brochure.
   f. The names, Social Security Numbers, addresses, and dates of birth for all **eligible family members** that will be covered under your health benefits enrollment. For more information on family member eligibility, see your *Guide to Benefits*.
   g. The name and policy number of any **other group insurance** you or any of your eligible family members may have (including TRICARE, Medicare, etc.).
   h. If you are changing plans or canceling coverage, the **enrollment code** of the health benefits plan in which you are **currently enrolled** — that is, the plan that you will not have after your choice takes effect. The enrollment code for your current plan is found on your biweekly earnings statement. It is the three-character code that follows the letters "HP" or "HB." For example, the Blue Cross Self and Family Standard plan will be shown as HP105 or HB105, and you will enter the code 105 in *PostalEASE*. You may also refer to your *Guide to Benefits*.
4. **Complete the worksheet** on the following pages, using the information you prepared above.

Appendix D
How to Use *PostalEASE* to Manage Your FEHB Enrollment

Now You Are Ready To Enroll

- If you have access to the *PostalEASE* Employee Web on the Internet (https://liteblue.usps.gov), at an Employee Self-Service Kiosk (available in some facilities), or on the Postal Service Intranet (from the Blue page), using these may be simpler than using the telephone. Just follow the instructions.
- Otherwise, call the Employee Service Line to reach *PostalEASE* toll-free at 1-877-4PS-EASE (1-877-477-3273, option 1) or 1-866-260-7507 for TTY.
- When prompted, select Federal Employees Health Benefits.
- Follow the script and prompts to enter your Employee ID, your USPS PIN, and information from your completed *PostalEASE* FEHB Worksheet.

After Completing Your Entries You Should Note the Following Information

- Record the confirmation number you receive from *PostalEASE*: _____
- Your enrollment will be processed on this date: _____
- Your enrollment will be reflected in your paycheck that is dated: _____

It is recommended that you keep this information and your *PostalEASE FEHB* Worksheet.

You may contact the Human Resources Shared Service Center (HRSSC) for assistance if:

- you are deaf or hard of hearing, or
- you cannot use the telephone, Internet, Employee Self Service kiosk or Intranet for a medical reason, or
- you receive a message in *PostalEASE* directing you to contact the HRSSC when attempting to make a change

Just call the Employee Service Line at 1-877-477-3273. When prompted, select 5 for the HRSSC. Then select Benefits to speak with a representative who will assist you.

To reach the HRSSC using TTY, call 1-866-260-7507. Leave your name and email address or phone number where you can be reached along with a message indicating your call is regarding a *PostalEASE* related issue.

If you currently have an FEHB enrollment and you do not want to make any changes . . . ***do nothing***.

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

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PostalEASE FEHB Worksheet

Changes due to a qualifying life event (QLE) cannot be made via PostalEASE

This worksheet will help you prepare to call *PostalEASE*, or use *PostalEASE* on the Internet (https://liteblue.usps.gov), on an Employee Self-Service Kiosk (now available in some facilities) or on the Postal Service Intranet (from the Blue page). You may contact the Human Resources Shared Service Center (HRSSC) by calling 1-877-477-3273, Opt 5 or TTY, 1-866-260-7507 for assistance if:

- you are deaf or hard of hearing or
- you cannot use the telephone, Internet, Employee Self Service kiosk or Intranet for a medical reason or
- you receive a message in *PostalEASE* directing you to contact the HRSSC when attempting to make a change.

Please Note:

- If you wish to make any change that is not listed under "Type of Action You Are Requesting" below, you must submit your paperwork to the HRSSC. You will need to **provide documentation** showing that your election is due to a QLE and that you are contacting the HRSSC within the required time frame.

For more information on QLEs, please refer to the appropriate Guide to Benefits mailed to you for FEHB Open Season:

- RI 70-2 for Non-APWU career USPS employees, RI 70-2A for APWU career employees, RI 70-2EX for PCES employees,
- RI 70-2IN for career U.S. Postal Inspectors and Office of the Inspector General employees,
- RI 70-8PS for certain temporary (noncareer) USPS employees.

Except for open season and the adding of new family members, most enrollments and changes of enrollment are effective on the first day of the pay period after receipt of this form at the HRSSC. The HRSSC can give you the specific date on which your enrollment or enrollment change will take effect.

Part 1 – Employee Information

Your Name (Last, First, Middle Initial)	Employee ID

Part 2 – Type Of Action You Are Requesting

1) Open Season: ❑ New Enrollment ❑ Change Current Enrollment ❑ Cancel Enrollment

2) New Hire: ❑ New Enrollment ❑ Waive Enrollment

3) Special Enrollment

❑ Change Current Enrollment
(if you are notified that your current plan is being discontinued or your service area is reduced)

❑ Cancel Enrollment
(if you are notified that your current plan is being discontinued or your service area is reduced)

Part 3 – QLE Actions

(Supporting Documentaton Needed)

Marriage: _____ (Date)
Divorce: _____ (Date)
Birth of Child: _____ (Date)
Dependent Death: _____ (Date)
Other: _____ (Date)

Part 4 – Enrollment Name And Code

Update Dependent List ❑ Yes ❑ No

1) New Plan Name: **2) New Enrollment Code:**

3) Old Plan Enrollment Code *(if you are changing plans or canceling your current plan)*

Part 5 – Your Other Group Insurance *(Not used for waiving enrollment as a new employee).*

1) Do you have any group health insurance coverage other than under the FEHB plan in which you are now enrolling or already enrolled?

❑ Yes ❑ No

2) Identify Type of Other Insurance Coverage

❑ Medicare Part A ❑ Medicare Part B

❑ TRICARE or CHAMPUS Policy No. (if known)_____

Other Group Insurance Name _____

Policy No. (if known) _____

Part 6 – Personal Information

Your Gender:	**Married:**	**Daytime Telephone Number** (including area code)
❑ Male ❑ Female	❑ Yes ❑ No	

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PostalEASE FEHB Worksheet

Employee Name: _____ **EIN:** _____

Part 7 – Dependent Information *(for Self and Family coverage only)*

A complete mailing address (if different from the USPS employee's) and other insurance information, if any, must be provided for each covered dependent. If you are adding or updating information for a dependent who does not reside with you, you will need to use the *PostalEASE* Employee Web on the Internet (https://liteblue.usps.gov), an Employee Self-Service Kiosk (available in some facilities) or on the Postal Service Intranet (Blue page) or contact the HRSSC to process your FEHB enrollment or change.

1) ❑ **Please check here if all dependents reside with you.**

2) Complete the following information for each dependent

Family Member Names (Last, First, Middle Initial)	**Address (Street, City, State, ZIP)** (If different from yours)	**Gender**	**Date of Birth**	**Relationship Code***	**SSN**	**Other Group Insurance Co.** Name & Policy No.

*** Relationship Codes:**
01 = Spouse
02 = Spouse From a Common Law Marriage (Requires Certification to be Filed With the HRSSC)
19 = Child Under Age 26
09 = Adopted Child Under Age 26
10 = Foster Child Under Age 26 (Requires Certification to be Filed With the HRSSC)
17 = Stepchild Under Age 26
99 = Unmarried Child Over Age 26 Incapable of Self-Support (Requires Certification to be Filed With the HRSSC)

Part 8

Employee Signature _____ **Date** _____

For HRSSC Use Only

REMARKS: *Specific information on type of qualifying life event, reason for correction, type of certification, supporting documentation, reason for verification, etc., should be provided here.*

Processing NOTES:

Employing Office:	**HRSSC COMP & BENEFITS**	LATE / UNPROCESSED ACTION?	❑ Yes ❑ No
Address:	**PO BOX 970400**	DATE RECEIVED at HRSSC:	
City/State/Zip:	**GREENSBORO NC 27497-0400**	QLE DATE:	
PROCESSED BY:	PPS @ HRSSC	EFFECTIVE DATE:	
Date Scanned To Eagan:		**File copy in OPF for any FEHB transaction processed by HRSSC and ASC**	

Privacy Act Statement: Your information will be used to process your enrollment in the Federal Employees Health Benefits system and to manage your claim under that plan. Collection is authorized by 39 U.S.C. 401, 409, 410, 1001, 1003, 1004,1005, and 1206 and 1206; and 29 U.S, 2601 et seq.

Providing the information is voluntary, but if not provided, we may not process your request. We may disclose your information as follows: in relevant legal proceedings; to law enforcement when the U.S. Postal Service (USPS) or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits: to labor organizations as required by law; to federal, state, local or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; to the Merit Systems Protection Board or Office of Special Counsel; the Selective Service System, records pertaining to supervisors and postmasters may be disclosed to supervisory and other managerial organizations recognized by USPS; and to financial entities regarding financial transaction issues.

OPM Privacy Act and Paperwork Reduction Act Notice: The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. May also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency. While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment. We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB Program. Executive Order 9397 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies. Agencies other than the OPM may have further routine uses for disclosure of information from the records system in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement: We think this form takes an average of 30 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, OPM Forms Officer, (3206-0160), Washington, D.C. 20415-7900. The OMS number 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Appendix E
USPS Employees Enrolled in Pre-Tax Premium Payment

Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

All USPS career employees are automatically enrolled for pre-tax payment of health insurance premiums, unless they waive it; noncareer employees must elect to participate. Pre-tax payment of premium contributions allow employees who are eligible for FEHB the opportunity to pay for their share of FEHB premiums with pre-tax dollars. The pre-tax payment of premiums (known also as premium conversion) is governed by Section 125 of the Internal Revenue Code, and IRS rules govern when a participant may change his or her election outside of the annual Open Season. When an employee experiences a qualifying life event (QLE) as described in the *Table of Permissible Changes in FEHB Enrollment and Pre-tax/After Tax Premium Payment* chart, changes to the employee's FEHB coverage (including change to Self Only and cancellation) and pre-tax payment of premium contributors election may be permitted so long as they are because of and consistent with the QLEs. For more information please visit www.opm.gov/insure/health.

Be aware that time limits apply for requesting changes. A complete listing of QLE's, which includes Table of Permissible Changes in FEHB Enrollment for Individuals who are not participating in Premium Conversion (pre-tax payment) can be found at www.opm.gov/forms/pdf_fill/sf2809.pdf.

If you have questions, contact the Human Resources Shared Service Center on 1-877-477-3273, option 5.

All employees must meet the time limits stated in the far right column. Employees who are paying premiums on a pre-tax basis may only make changes that are in keeping with, or on account of, the changes described in the table. For example, if you have a new baby, you would usually not cancel coverage. This restriction does not appy to Open Season changes, or to the initial opportunity to enroll. Employees who are paying premiums on an after-tax basis may cancel coverage or reduce coverage from Self and Family to Self Only at any time--they do not need to have an event.

USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1A	Initial Opportunity to Enroll, for example: • New employee • Change from excluded position • Temporary (Non-career) employee who completes 1 year of service and is eligible to enroll under 5 USC 8906a	Yes	N/A	N/A	N/A	Automatic unless waived *(except for temporary employees)*	Yes *(Automatic for temporary employees)*	Within 60 days after becoming eligible
1B	Open Season	Yes	Yes	Yes	Yes	Yes	Yes	As announced by OPM
1C	Change in family status that results in increase or decrease in number of eligible family members, for example: • Marriage, divorce, annulment, legal separation • Birth, adoption, acquiring foster child or stepchild, issuance of court order requiring employee to provide coverage for child • Last child loses coverage, for example child reaches age 26, disabled child becomes capable of self-support, child acquires other coverage by court order • Death of spouse or dependent	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after change in family status
		Employees may enroll or change beginning 31 days before the event						
1D	Any change in employee's employment status that could result to entitlement to coverage, for example: • Reemployment after a break in service of more than 3 days • Return to pay status from nonpay status, or return to receiving pay sufficient to cover premium withholdings, if coverage terminated *(If coverage did not terminate, see 1G)*	Yes	N/A	N/A	N/A	Automatic unless waived	Yes	Within 60 days after employment status change
1E	Any change in employee's employment status that could affect the cost of insurance, including: • Change from temporary appointment with eligibility for coverage under 5 USC 8906a to appointment that permits receipt of government contribution • Change from full time to part time career or the reverse	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after employment status change

USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only [1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1F	Employee restored to civilian position after serving in uniformed service [2]	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after return to civilian position
1G	Employee, spouse or dependent: • begins nonpay status or insufficient pay [3] or • ends nonpay status or insufficient pay if coverage continued • *(If employee's coverage terminated, see 1D)* • *(If spouse's or dependent's coverage terminated, see 1M)*	No	No	No	Yes	Yes	Yes	Within 60 days after employment status change
1H	Salary of temporary employee insufficient to make withholdings for plan in which enrolled	N/A	No	Yes	Yes	Yes	Yes	Within 60 days after receiving notice from employing office
1I	Employee (or covered family member) enrolled in FEHB health maintenance organization (HMO) moves or becomes employed outside the geographic area from which the FEHB carrier accepts enrollments or, if already outside the area, moves further from this area. [4]	N/A	Yes	Yes	N/A *(see 1M)*	No *(see 1M)*	No *(see 1M)*	Upon notifying employing office of move
1J	Transfer from post of duty within a state of the United States or the District of Columbia to post of duty outside a State of the United States or District of Columbia, or reverse	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after arriving at new post
1K	Separation from Federal Employment when the employee or employee's spouse is pregnant	Yes	Yes	Yes	N/A	N/A	N/A	During empoyee's final pay period
1L	Employee becomes entitled to Medicare and wants to change to another plan or option. [5]	No	No	Yes *(Change may be made only once)*	N/A *(see 1M)*	No *(see 1M)*	No *(see 1M)*	Any time beginning on the 30th day before becoming eligible for Medicare

Employees may enroll or change beginning 31 days before leaving the old post of duty

[1] Employees may change to Self Only outside of Open Season only if **the QLE caused** the enrollee to be the last eligible family member under the FEHB enrollment. Employees may cancel enrollment outside of Open Season only if **the QLE caused** the enrollee and all the eligible family members to acquire other health insurance coverage. Employees paying premiums post-tax may cancel enrollment or change from Self and Family to Self Only at any time.

[2] Employees who enter active military service are given the opportunity to terminate coverage. Termination for this reason does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement. Additional information on the FEHB coverage of employees who return from active military service is available from the HRSSC.

USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1M	Employees or eligible family member **loses** coverage under FEHB or another group insurance plan including the following: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to self-only of the covering enrollment • Loss of coverage due to termination of membership in employee organization sponsoring the FEHB plan [6] • Loss of coverage under another federally-sponsored health benefits program, including: TRICARE, Medicare, Indian Health Service • Loss of coverage under Medicaid or similar State-sponsored program of medical assistance for the needy • Loss of coverage under a non-Federal health plan, including foreign, state or local government, private sector • Loss of coverage due to change in worksite or residence *(Employees in an FEHB HMO, also see 1I)*	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after loss of coverage
		Employees may enroll or change beginning 31 days before the event						
1N	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-Federally employed spouse terminates employment to accompany the employee	Yes	Yes	Yes	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area to 180 days after arriving in the new commuting area

[3] Employees who begin nonpay status or insufficient pay **must** be given an opportunity to elect to continue or terminate coverage. A termination differs from a cancellation as it allows conversion to nongroup coverage and does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement.

[4] This code reflects the FEHB regulation that gives employees enrolled in an FEHB HMO who **change from Self Only to Self and Family or from one plan or option to another** a different timeframe than that allowed under 1M. For change to Self Only, cancellation, or change in premium conversion status see 1M.

[5] This code reflects the FEHB regulation that gives employees enrolled in FEHB a one-time opportunity to change plans or options under a different timeframe than that allowed by 1P. For change to Self Only, cancellation, or change in premium conversion status, see 1P.

[6] If employees membership terminates, (e.g., for failure to pay membership dues), the employee organization will notify the agency to **terminate** the enrollment.

USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1O	Employee or eligible family member loses coverage due to discontinuation in whole or part of FEHB plan [7]	Yes	Yes	Yes	Yes	Yes	Yes	During open season, unless OPM sets a different time
1P	Employee or eligible family member **gains** coverage under FEHB or another group insurance plan, including the following: • Medicare *(Employees who become eligible for Medicare and want to change plans or options, see 1I)* • TRICARE for Life, due to enrollment in Medicare • TRICARE due to change in employment status, including: (1) entry into active military service, (2) retirement from reserve military service under chapter 67, title 10 • Medicaid or similar state sponsored program of medical assistance for the needy • Health insurance acquired due to change of worksite or residence that affects eligibility for coverage • Health insurance acquired due to spouse's or dependent's change in employment status (including state, local or foreign government or private sector employment) [8]	No	No	No	Yes	Yes	Yes	Within 60 days after QLE
1Q	Change in spouse's or dependent's coverage options under a non-Federal health plan, for example: • Employer starts or stops offering a different type of coverage *(If no other coverage is available, also see 1M)* • Change in cost of coverage • HMO adds a geographic service area that now makes spouse eligible to enroll in that HMO • HMO removes a geographic area that makes spouse ineligible for coverage under that HMO, but other plans or options are available *(If no other coverage is available, see 1M)*	No	No	No	Yes	Yes	Yes	Within 60 days after QLE

[7] Employee's failure to select another FEHB plan is deemed a cancellation for purposes of meeting the requirements for continuing coverage after retirement.

[8] Under IRS rules, this includes start/stop of employment or nonpay status, strike or lockout, and change in worksite.

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Appendix F
FEHB Plan Comparison Charts

Nationwide Fee-for-Service Plans
(Pages 52 through 55)

Fee-for-Service (FFS) plans with a Preferred Provider Organization (PPO) – A Fee-for-Service plan provides flexibility in using medical providers of your choice. You may choose medical providers who have contracted with the health plan to offer discounted charges. You may also choose medical providers who do not contract with the plan, but you will pay more of the cost.

Medical providers who have contracts with the health plan (Preferred Provider Organization or PPO) have agreed to accept the health plan's reimbursement. You usually pay a copayment or a coinsurance amount and do not file claims or other paperwork. Going to a PPO hospital does not guarantee PPO benefits for all services received in the hospital, however. Lab work, radiology and other services from independent practitioners within the hospital are frequently not covered by the hospital's PPO agreement. If you receive treatment from medical providers who are not contracted with the health plan, you either pay them directly and submit a claim for reimbursement to the health plan or the health plan pays the provider directly according to plan coverage, and you pay a deductible, coinsurance or the balance of the billed charge. In any case, you pay a greater amount in out-of-pocket costs.

PPO-only – A PPO-only plan provides medical services only through medical providers that have contracts with the plan. With few exceptions, there is no medical coverage if you or your family members receive care from providers not contracted with the plan.

Fee-for-Service plans open only to specific groups – Several Fee-for-Service plans that are sponsored or underwritten by an employee organization strictly limit enrollment to persons who are members of that organization. If you are not certain if you are eligible, check with the Human Resources Shared Service Center (HRSSC), 1-877-477-3273, option 5 first.

The Health Maintenance Organization (HMO) and Point-of-Service (POS) section begins on page 57.

The High Deductible Health Plan (HDHP) and Consumer-Driven Health Plan (CDHP) section begins on page 92.

Nationwide Fee-for-Service Plans

How to read this chart:

The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* The chart does not show all of your possible out-of-pocket costs.

The **Deductibles** shown are the amount of covered expenses that you pay before your health plan begins to pay.

Calendar Year deductibles for families are two or more times the per person amount shown.

In some plans your combined **Prescription Drug** purchases from Mail Order and local pharmacies count toward the deductible. In other plans, only purchases from local pharmacies count. Some plans require each family member to meet a per person deductible.

The **Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

Doctors shows what you pay for inpatient surgical services and for office visits.

Your share of **Hospital Inpatient Room and Board** covered charges is shown.

Plan Name: Open to All	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
APWU Health Plan (APWU) -high	800-222-2798	471	472	12.37	27.97
Blue Cross and Blue Shield Service Benefit Plan (BCBS) -std	Local phone #	104	105	36.57	89.13
Blue Cross and Blue Shield Service Benefit Plan (BCBS) -basic	Local phone #	111	112	11.81	27.66
GEHA Benefit Plan (GEHA) -high	800-821-6136	311	312	36.39	92.98
GEHA Benefit Plan (GEHA) -std	800-821-6136	314	315	8.99	20.44
MHBP -std	800-410-7778	454	455	47.33	121.88
MHBP - Value Plan	800-410-7778	414	415	8.31	19.82
NALC -high	888-636-6252	321	322	25.66	41.85
SAMBA -high	800-638-6589	441	442	70.63	195.49
SAMBA -std	800-638-6589	444	445	12.77	31.65
Plan Name: Open Only to Specific Groups					
Compass Rose Health Plan (CRHP) -high	800-769-6953	421	422	12.86	39.61
Foreign Service Benefit Plan (FSBP) -high	202-833-4910	401	402	11.97	32.50
Panama Canal Area Benefit Plan (PCABP) -high*	800-424-8196	431	432	10.21	21.32
Rural Carrier Benefit Plan (Rural) -high	800-638-8432	381	382	35.54	28.99

Prescription Drug Payment Levels Plans use a variety of terms to define what you pay for prescription drugs such as *generic, brand name, Tier I, Tier II, Level I, etc*. The 2 to 3 payment levels that plans use follow: **Level I** includes most generic drugs, but may include some preferred brands. **Level II** may include generics and preferred brands not included in Level I. **Level III** includes all other covered drugs, with some exceptions for specialty drugs. Many plans are basing how much you pay for prescription drugs on what they are charged.

Mail Order Discounts If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

The prescription drug copayments or coinsurances described in this chart do not represent the complete range of cost-sharing under these plans. Many plans have variations in their prescription drug benefits (e.g., you pay the greater of a dollar amount or a percentage, or you pay one amount for your first prescription and then a different amount for refills). **You must read the plan brochure for a complete description of prescription drug and all other benefits.**

Plan	Benefit Type	Medical-Surgical – You Pay								
		Deductible			Copay ($)/Coinsurance (%)					
		Per Person		Hospital Inpatient	Doctors		Hospital Inpatient R&B	Prescription Drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services		Level I	Level II / Level III	Mail Order Discounts
		FFS National Average								
APWU -high	PPO Non-PPO	$275 $500	None None	None $300	$18 30%+diff.	10% 30%+diff.	10% 30%	$8 50%	25%/25% 50%/50%	Yes Yes
BCBS -std	PPO Non-PPO	$350 $350	None None	$250 $350	$20 35%	15% 35%	Nothing 35%	20% 45% +	30%/30% 45%+/45%+	Yes Yes
BCBS -basic	PPO	None	None	$150/day x 5	$25	$150	Nothing	$10	$40/$50 or 50%	N/A
GEHA -high	PPO Non-PPO	$350 $350	None None	$100 $300	$20 25%	10% 25%	Nothing Nothing	$5 $5	25% Max $150/N/A 25% Max $150 +/N/A	Yes Yes
GEHA -std	PPO Non-PPO	$350 $350	None None	None None	$10 35%	15% 35%	15% 35%	$5 $5	50% Max $200/N/A 50% Max $200 +/N/A	Yes Yes
MHBP -std	PPO Non-PPO	$400 $600	None None	$200 $500	$20 30%	10% 30%	Nothing 30%	$10 50%	30%($200 max)/50%($200 max) 50%/50%	Yes Yes
MHBP -Value	PPO Non-PPO	$600 $900	None Not Covered	None None	$30 40%	20% 40%	20% 40%	$10 Not Covered	45%/75% Not Covered	Yes Yes
NALC -high	PPO Non-PPO	$300 $300	None None	$200 $350	$20 30%	15% 30%	Nothing 30%	20% 45% 45%+	30%/30% 45%+/45%+	Yes Yes
SAMBA -high	PPO Non-PPO	$300 $300	None None	$200 $300	$20 30%	10% 30%	Nothing 30%	$10 $10	15%($55 max)/30%($90 max) 15%($55 max)/30%($90 max)	Yes Yes
SAMBA -std	PPO Non-PPO	$350 $350	None None	$150 up to $450 $200 up to $600	$20 35%	15% 35%	Nothing 35%	$10 $10	25%($70 max)/35%($100 max) 25%($70 max)/35%($100 max)	Yes Yes
CRHP	PPO Non-PPO	$300 $300	None None	$150 $350	$10 30%	10% 30%	Nothing 30%	$5 $5	$30/30% or $45 $30/30% or $45	Yes Yes
FSBP	PPO Non-PPO	$300 $300	None None	Nothing $200	10% 30%	10% 30%	Nothing 20%	$10 $10	25%/$50 min/NA 25%/$50 min/NA	Yes Yes
PCABP	POS FFS	None None	None None	$25 $100	$5 50%	Nothing 50%	Nothing 50%	20% 20%	20%/20% 20%/20%	No No
Rural	PPO Non-PPO	$350 $400	$200 $200	$100 $300	$20 25%	10% 25%	Nothing 20%	30% 30%	30%/30% 30%/30%	Yes Yes

*The Panama Canal Area Plan provides a Point-of-Service product within the Republic of Panama.

Nationwide Fee-for-Service Plans

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. See Appendix C for a fuller explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• How often was it easy to get an appointment, the care, tests, or treatment you thought you needed through your health plan?
Getting Care Quickly	• When you needed care right away, how often did you get care as soon as you thought you needed? • Not counting the times you needed care right away, how often did you get an appointment at a doctor's office or clinic as soon as you thought you needed?
How Well Doctors Communicate	• How often did your personal doctor explain things in a way that was easy to understand? • How often did your personal doctor listen carefully to you, show respect for what you had to say, and spend enough time with you?
Customer Service	• How often did written materials or the Internet provide the information you needed about how your health plan works? • How often did your health plan's customer service give you the information or help you needed? • How often were the forms from your health plan easy to fill out?
Claims Processing	• How often did your health plan handle your claims quickly and correctly?
Plan Information on Costs	• How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment, or for specific prescription drug medicines?

Plan Name: Open to All	Plan Code	Member Survey Results: Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
FFS National Average		**77.4**	**91.6**	**91**	**94.8**	**89.7**	**92.9**	**72.5**
APWU Health Plan -high	47 47	78	89.8	92.1	93.8	83.7	89.8	73.7
Blue Cross and Blue Shield Service Benefit Plan -std	10 10	78.8	92.4	88.4	94.4	88.8	94.5	71.9
Blue Cross and Blue Shield Service Benefit Plan -basic	11	71.7	90.7	87.6	93.9	88.5	93.2	72.5
GEHA Benefit Plan -high	31 31	85.5	92.8	91.1	94.3	92.8	96.6	74
GEHA Benefit Plan -std	31 31	77.3	89.4	88	93.4	90.1	93.9	73
MHBP -std	45 45	70.6	91.6	91.7	94.3	89.8	92.7	71.3
MHBP - Value Plan	41 41	56.4	87.9	87.7	95.5	85.7	84.9	63.8
NALC -high	32 32	81.1	93.4	91.4	95.1	92.3	95.1	76.6
SAMBA -high	44 44	89.3	94.6	93.7	96.8	90.1	97.3	79.1
SAMBA -std	44 44	74.5	92.3	93.3	95.2	90.3	92.5	74

Plan Name: Open Only to Specific Groups

FFS National Average		**77.4**	**91.6**	**91**	**94.8**	**89.7**	**92.9**	**72.5**
Compass Rose Health Plan	42 42							
Foreign Service Benefit Plan	40 40	78.8	90	92.8	95.1	90.2	88.3	69.8
Panama Canal Area Benefit Plan	43 43							
Rural Carrier Benefit Plan	38 38	84.5	94.5	94.4	96	93.4	96.4	77

Fee-for-Service Plans – Blue Cross and Blue Shield Service Benefit Plan – Member Survey Results for Select States

Again this year we are providing more detailed information regarding the quality of services provided by our health plans. We are including the results of the Member Satisfaction survey at the *state level* for eight local Blue Cross Blue Shield (BCBS) Plans.

			Member Survey Results						
Plan Name	**Location**	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
	FFS National Average		**77.4**	**91.6**	**91**	**94.8**	**89.7**	**92.9**	**72.5**
Blue Cross and Blue Shield Service - Standard Benefit Plan	Arizona	10	81.9	93	89.8	94.7	91.4	96.2	74.3
- Basic		11	75.2	89.5	89.5	92.9	88.3	93.9	64.2
Blue Cross and Blue Shield Service - Standard Benefit Plan	California	10	77.1	93	94	94.7	89.9	95.5	67.3
- Basic		11	65.6	88.5	81.8	92.7	87.1	89.4	65.9
Blue Cross and Blue Shield Service - Standard Benefit Plan	District of Columbia	10	79.4	91.4	89.7	93.1	88.3	91.2	70.8
- Basic		11	64.6	84.3	83.8	90.2	86.2	93.3	62.6
Blue Cross and Blue Shield Service - Standard Benefit Plan	Florida	10	86.4	93.6	94.3	93.4	88.8	95.7	76.3
- Basic		11	76.4	92.2	89.5	92	88.3	93.5	67.1
Blue Cross and Blue Shield Service - Standard Benefit Plan	Illinois	10	82.9	92.8	90.4	94.5	92.8	96.3	70
- Basic		11	75.9	91.3	89	94	82.3	93.3	67.2
Blue Cross and Blue Shield Service - Standard Benefit Plan	Maryland	10	83.2	94.1	91.4	94.1	86.4	93.7	74.3
- Basic		11	71.3	88.3	91.1	92.8	87.8	92.4	66.7
Blue Cross and Blue Shield Service - Standard Benefit Plan	Texas	10	83.5	93.3	90.8	94	89	95.9	72.6
- Basic		11	80.3	92.1	87.2	92.4	91	96.9	68.6
Blue Cross and Blue Shield Service - Standard Benefit Plan	Virginia	10	86.3	94.3	92.8	95.6	90.6	96.5	74.5
- Basic		11	75.8	90.3	91.9	93.5	87.7	95.5	67.9

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Appendix F
FEHB Plan Comparison Charts

Health Maintenance Organization Plans and Plans Offering a Point-of-Service Product (Pages 58 through 81)

Health Maintenance Organization (HMO) – A Health Maintenance Organization provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service you receive and free you from completing paperwork or being billed for covered services. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work.

- The HMO provides a comprehensive set of services – as long as you use the doctors and hospitals affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and sometimes a copayment for in-hospital care.
- Most HMOs ask you to choose a doctor or medical group as your primary care physician (PCP). Your PCP provides your general medical care. In many HMOs, you must get authorization or a "referral" from your PCP to see other providers. The referral is a recommendation by your physician for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures that you see the right provider for the care appropriate to your condition.
- Medical care from a provider not in the plan's network is not covered unless it's emergency care or your plan has an arrangement with another plan.

Plans Offering a Point-of-Service (POS) Product – A Point-of-Service plan is like having two plans in one – an HMO and an FFS plan. A POS allows you and your family members to choose between using, (1) a network of providers in a designated service area (like an HMO), or (2) Out-of-Network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non-HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

The tables on the following pages highlight what you are expected to pay for selected features under each plan. *Always consult plan brochures before making your final decision.*

Primary care/Specialist office visit copay – Shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per stay deductible – Shows the amount you pay when you are admitted into a hospital.

Prescription drug – Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand, Level I, Level II, Tier I, Tier II, etc. In capturing these differences we use the following: **Level I** includes most generic drugs, but may include some preferred brands. **Level II** may include generics and preferred brands not included in Level I. **Level III** includes all other covered drugs with some exceptions for specialty drugs. The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

Mail Order Discount – If your plan has a mail order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through mail order), your plan's response is "yes." If the plan does not have a mail order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results – See Appendix C for a description.

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Arizona					
Aetna Open Access -high- Phoenix and Tucson Areas	877-459-6604	WQ1	WQ2	58.24	184.81
Health Net of Arizona, Inc. -high- Maricopa/Pima/Other AZ counties	800-289-2818	A71	A72	20.77	123.18
Health Net of Arizona, Inc. -std- Maricopa/Pima/Other AZ counties	800-289-2818	A74	A75	11.99	54.42
Arkansas					
QualChoice - high - All of Arkansas	800-235-7111	DH1	DH2	28.79	93.48
QualChoice - std - All of Arkansas	800-235-7111	DH4	DH5	10.79	25.27
California					
Aetna Open Access -high- Los Angeles and San Diego Areas	877-459-6604	2X1	2X2	11.93	35.97
Blue Shield of CA Access+HMO -high- Southern Region	800-880-8086	SI1	SI2	13.00	35.98
Health Net of California -high- Northern Region	800-522-0088	LB1	LB2	194.29	468.30
Health Net of California -std- Northern Region	800-522-0088	LB4	LB5	174.59	422.75
Health Net of California -high- Southern Region	800-522-0088	LP1	LP2	39.96	111.47
Health Net of California -std- Southern Region	800-522-0088	LP4	LP5	23.27	72.90
Kaiser Foundation Health Plan of California -high- Northern California	800-464-4000	591	592	70.73	205.51
Kaiser Foundation Health Plan of California -std- Northern California	800-464-4000	594	595	21.12	75.05
Kaiser Foundation Health Plan of California -high- Southern California	800-464-4000	621	622	12.22	28.24
Kaiser Foundation Health Plan of California -std- Southern California	800-464-4000	624	625	7.83	18.09
United Healthcare of California -high- Most of California - formerly Pacificare of CA	866-546-0510	CY1	CY2	12.42	28.38
Colorado					
Kaiser Foundation Health Plan of Colorado -high- Denver/Boulder/Southern Colorado areas	800-632-9700	651	652	31.29	77.60
Kaiser Foundation Health Plan of Colorado -std- Denver/Boulder/Southern Colorado areas	800-632-9700	654	655	7.93	17.93
Delaware					
Aetna Open Access -high- Kent/New Castle/Sussex areas	877-459-6604	P31	P32	238.93	619.24
Aetna Open Access -basic- Kent/New Castle/Sussex areas	877-459-6604	P34	P35	107.89	267.52

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
			HMO/POS National Average			65.9	85.5	85.5	93.5	83.9	87.6	66.4
Arizona												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	58.3	84.2	86.4	88.3	85.8	88.4	63.6
Health Net of Arizona, Inc.-High	$15/$30	$200/day x 3	$10	$30/$50	Yes	70.2	87.8	86.8	92.1	86.3	94.6	67.5
Health Net of Arizona, Inc.-Std	$15/$40	$250/day x 3	$10	$40/$70	Yes	70.2	87.8	86.8	92.1	86.3	94.6	67.5
Arkansas												
QualChoice- In-Network	$20/$30	$100max$500	$0	$40/$60	Yes	61	84.5	87.3	93.5	87.7	88.7	65.2
QualChoice- Out-Network	40%/40%	40%	N/A	N/A / N/A	N/A	61	84.5	87.3	93.5	87.7	88.7	65.2
QualChoice- In-Network	$20/$40	$200max$1,000	$5	$40/$60	Yes	61	84.5	87.3	93.5	87.7	88.7	65.2
California												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	61.2	80.8	82.2	92.2	81.3	88.2	60.8
Blue Shield of CA Access+HMO-High	$20/$30	$150/ day x 3	$10	$35/$50	Yes	70.9	87.4	87.6	93.8	82.4	87.8	66.5
Health Net of California-High	$15/$30	$100/day x 5	$10	$35/$60	Yes	66.2	83.3	81.9	90	79.4	88.5	59.1
Health Net of California-Std	$30/$50	$500	$15	$35/$60	Yes	66.2	83.3	81.9	90	79.4	88.5	59.1
Health Net of California-High	$15/$30	$100/day x 5	$10	$35/$60	Yes	66.2	83.3	81.9	90	79.4	88.5	59.1
Health Net of California-Std	$30/$50	$500	$15	$35/$60	Yes	66.2	83.3	81.9	90	79.4	88.5	59.1
Kaiser Foundation HP of California -High	$15/$25	$250	$10	$30/$30	Yes	76.4	84.6	83	91	82.6	75.4	59.7
Kaiser Foundation HP of California -Std	$30/$40	$500	$15	$35/$35	Yes	76.4	84.6	83	91	82.6	75.4	59.7
Kaiser Foundation HP of California -High	$10/$20	$250	$10	$30/$30	Yes	81.8	84.5	80.7	93.4	85.3	76.3	68.1
Kaiser Foundation HP of California -Std	$20/$40	$500	$15	$35/$35	Yes	81.8	84.5	80.7	93.4	85.3	76.3	68.1
United Healthcare of California -High	$20/$35	$150/day x 4	$10	$35/$60	Yes	69.2	78.7	82.4	93.5	76.1	88	58.8
Colorado												
Kaiser Foundation HP of Colorado -High	$20/$40	$250	$10	$35/$60	Yes	71.6	83.3	86.2	91.8	77	87.6	68.4
Kaiser Foundation HP of Colorado -Std	$25/$45	$250/day x 3	$15	$40/$80	Yes	71.6	83.3	86.2	91.8	77	87.6	68.4
Delaware												
Aetna Open Access-High	$20/$35	$150/day x 5	$10	$35/$65	Yes	61.6	88.4	88	94.3	85.7	93.2	63.1
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	61.6	88.4	88	94.3	85.7	93.2	63.1

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
District of Columbia					
Aetna Open Access -high- Washington, DC Area	877-459-6604	JN1	JN2	106.97	241.75
Aetna Open Access -basic- Washington, DC Area	877-459-6604	JN4	JN5	12.06	28.23
CareFirst BlueChoice -high- Washington, D.C. Metro Area	888-789-9065	2G1	2G2	15.60	39.52
CareFirst BlueChoice Healthy Blue Option -std- Washington, D.C. Metro Area	888-789-9065	2G4	2G5	12.49	28.09
Kaiser Foundation Health Plan Mid-Atlantic States -high- Washington, DC area	877-574-3337	E31	E32	19.30	60.66
Kaiser Foundation Health Plan Mid-Atlantic States -std- Washington, DC area	877-574-3337	E34	E35	8.69	19.99
M.D. IPA -high- Washington, DC area	877-835-9861	JP1	JP2	27.51	81.08
Florida					
AvMed Health Plan -high- Broward, Dade and Palm Beach	800-882-8633	ML1	ML2	35.33	124.56
AvMed Health Plan -std- Broward, Dade and Palm Beach	800-882-8633	ML4	ML5	11.89	28.53
Capital Health Plan -high- Tallahassee area	850-383-3311	EA1	EA2	9.91	26.27
Coventry Health Care of Florida -high- Southern Florida	800-441-5501	5E1	5E2	11.81	57.85
Coventry Health Care of Florida -std- Southern Florida	800-441-5501	5E4	5E5	10.69	27.62
Humana Medical Plan, Inc. -high- South Florida	888-393-6765	EE1	EE2	27.10	65.49
Humana Medical Plan, Inc. -std- South Florida	888-393-6765	EE4	EE5	11.71	26.35
Humana Medical Plan, Inc. -high- Tampa	888-393-6765	LL1	LL2	108.04	247.61
Humana Medical Plan, Inc. -std- Tampa	888-393-6765	LL4	LL5	13.10	34.00
Georgia					
Aetna Open Access -high- Atlanta and Athens Areas	877-459-6604	2U1	2U2	81.29	201.49
Humana Employers Health of Georgia, Inc. -high- Columbus	888-393-6765	CB1	CB2	13.11	34.01
Humana Employers Health of Georgia, Inc. -std- Columbus	888-393-6765	CB4	CB5	12.36	27.82
Humana Employers Health of Georgia, Inc. -high- Atlanta	888-393-6765	DG1	DG2	12.52	28.16
Humana Employers Health of Georgia, Inc. -std- Atlanta	888-393-6765	DG4	DG5	12.04	27.08
Humana Employers Health of Georgia, Inc. -high- Macon	888-393-6765	DN1	DN2	13.11	34.01
Humana Employers Health of Georgia, Inc. -std- Macon	888-393-6765	DN4	DN5	12.36	27.82
Kaiser Foundation Health Plan of Georgia -high- Atlanta, Athens, Columbus, Macon, Savannah	888-865-5813	F81	F82	25.01	69.89
Kaiser Foundation Health Plan of Georgia -high- Atlanta, Athens, Columbus, Macon, Savannah	888-865-5813	F84	F85	9.45	21.58

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		65.9	85.5	85.5	93.5	83.9	87.6	66.4
District of Columbia												
Aetna Open Access-High	$15/$30	$150/day x 3	$5	$35/$65	Yes	65.9	87.1	87	91.8	90.1	87.4	66.7
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$65	Yes	65.9	87.1	87	91.8	90.1	87.4	66.7
CareFirst BlueChoice-High	$25/$35	$200	Nothing	$30/$50	Yes	61.8	86.2	84.6	91.7	72.2	84.6	53.2
CareFirst BlueChoice In-Network	Nothing/$35	$200	Nothing	$30/$50	Yes							
CareFirst BlueChoice Out-Network	$70/$70	$500	Nothing	$30/$50	Yes							
Kaiser Foundation HP Mid-Atlantic States -High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	76.7	84.7	87.4	92.2	81.6	87.3	71.6
Kaiser Foundation HP Mid-Atlantic States -Std	$20/$30	$250/day x 3	$12/$22Net	$35/$55/$50/$70	Yes	76.7	84.7	87.4	92.2	81.6	87.3	71.6
M.D. IPA-High	$25/$40	$150/day x 3	$7	$30/$150/$250	Yes	63.2	83.8	87.1	92.5	84.1	90	65
Florida												
AvMed Health Plan-High	$15/$40	$150/day x 5	$5	$30/$50/30%	No	72.4	86.9	85.5	91.3	89.4	85.3	64.8
AvMed Health Plan-Std	$25/$45	$175/day x 5	$10	$40/$60/30%	No	72.4	86.9	85.5	91.3	89.4	85.3	64.8
Capital Health Plan-High	$15/$25	$250	$15	$30/$50	No	86.2	86.2	89.6	94.2	90.9	97.8	77.8
Coventry Health Plan of Florida-High	$15/$30	Ded+$150x3	$3/$20	$40/$60/20%	No	50.2	81.2	82.2	89.9	78.7	87.3	64.7
Coventry Health Plan of Florida-Standard	$20/$50	Ded+$100x5	$10	$50/$70/20%	No	50.2	81.2	82.2	89.9	78.7	87.3	64.7
Humana Medical Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	52.4	82.8	86.6	92.6	82.8	84.9	62.8
Humana Medical Plan, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes	52.4	82.8	86.6	92.6	82.8	84.9	62.8
Humana Medical Plan, Inc. -High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Medical Plan, Inc. -Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Georgia												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	56.9	88.8	83.5	92.7	88.2	87.3	58.9
Humana Employers Health of Georgia, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	50.4	82.4	83	95.6	80.6	81.2	64.2
Humana Employers Health of Georgia, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	50.4	82.4	83	95.6	80.6	81.2	64.2
Humana Employers Health of Georgia, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Kaiser Foundation HP of Georgia -High	$10/$25	$350	$10/$20 Comm	$30/$40 Comm/ $30/$40 Comm	Yes	76.8	84.5	84	92.2	81.8	82.2	61.4
Kaiser Foundation HP of Georgia -Std	$20/$30	$250/day x 3	$15/$25 Comm	$30/$40 Comm/ $30/$40 Comm	Yes	76.8	84.5	84	92.2	81.8	82.2	61.4

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Guam					
TakeCare -high- Guam/N.Mariana Islands/Belau(Palau)	671-647-3526	JK1	JK2	12.06	80.16
TakeCare -std- Guam/N.Mariana Islands/Belau(Palau)	671-647-3526	JK4	JK5	10.70	28.26
Hawaii					
HMSA -high- All of Hawaii	808-948-6499	871	872	11.48	25.56
Kaiser Foundation Health Plan of Hawaii -high- Hawaii/Kauai/Lanai/Maui/Molokai/Oahu	808-432-5955	631	632	14.15	28.09
Kaiser Foundation Health Plan of Hawaii -std- Hawaii/Kauai/Lanai/Maui/Molokai/Oahu	808-432-5955	634	635	5.97	12.84
Idaho					
Altius Health Plans -high- Southern Region	800-377-4161	9K1	9K2	42.31	85.89
Altius Health Plans -std- Southern Region	800-377-4161	DK4	DK5	10.32	22.71
Group Health Cooperative -high- Kootenai and Latah	888-901-4636	541	542	41.91	71.16
Group Health Cooperative -std- Kootenai and Latah	888-901-4636	544	545	9.26	20.91
Illinois					
Aetna Open Access -high- Chicago Area	877-459-6604	IK1	IK2	108.99	304.02
Blue Preferred Plus POS -high- Madison and St. Clair counties	888-811-2092	9G1	9G2	71.95	140.35
Health Alliance HMO -high- Central/E.Central/N. Cent/South/West Illinois	800-851-3379	FX1	FX2	51.82	144.34
Humana Benefit Plan of Illinois, Inc. -high- Central and Northwestern	888-393-6765	9F1	9F2	133.68	305.29
Humana Benefit Plan of Illinois, Inc. -std- Central and Northwestern	888-393-6765	AB4	AB5	13.11	34.01
Humana Health Plan Inc. -high- Chicago Area	888-393-6765	751	752	89.32	205.49
Humana Health Plan Inc. -std- Chicago Area	888-393-6765	754	755	13.10	34.00
Union Health Service -high- Chicago area	312-829-4224	761	762	12.43	28.88
United Healthcare of the Midwest -high- Southwest Ilinois	877-835-9861	B91	B92	40.31	90.84
United Healthcare Plan of the River Valley Inc. -high- West Central Illinois	800-747-1446	YH1	YH2	12.87	61.81

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
HMO/POS National Average						**65.9**	**85.5**	**85.5**	**93.5**	**83.9**	**87.6**	**66.4**
Guam												
TakeCare-High	$20/$40	$100/day for 5 days	$10	$15/$25/$50	No	64.2	72.6	62.6	89.5	69.4	66.4	56.3
TakeCare-Std	$25/$40	$150/day for 5 days	$15	$20/$40/$80	No	64.2	72.6	62.6	89.5	69.4	66.4	56.3
Hawaii												
HMSA- In-Network	$15/$15	$100	$7	$30/$65	Yes	83.3	92.4	91	95.9	83.7	94.1	66.6
HMSA- Out-Network	30%/30%	30%	$7 + 20%	$30+20%/ $65+20%	No	83.3	92.4	91	95.9	83.7	94.1	66.6
Kaiser Foundation HP of Hawaii -High	$20/$20	$100	$15	$15/$15	Yes	75.1	82.1	79.7	93.5	79.2	85.3	70.7
Kaiser Foundation HP of Hawaii -Std	$30/$30	10%	$20	$20/$20	Yes	75.1	82.1	79.7	93.5	79.2	85.3	70.7
Idaho												
Altius Health Plans-High	$20/$30	$200	$7	$25/$50	Yes	55.6	86	88	94.8	81.7	85.3	62.5
Altius Health Plans-Std	$20/$35	None	$7	$35/$60	Yes	55.6	86	88	94.8	81.7	85.3	62.5
Group Health Cooperative-High	$25/$25	$350/day x 3	$20	$40/$60	Yes	69.1	83.9	84.4	92.6	86.7	89.6	71.1
Group Health Cooperative-Std	$25+20%/$25+20%	$500/day x 3	$20	$40/$60	Yes	69.1	83.9	84.4	92.6	86.7	89.6	71.1
Illinois												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	61.5	82.6	82	90.9	86.6	82.3	64.2
Blue Preferred Plus POS In-Network	$25/$35	$500	$10	$30/$50/25%/ $50/25%	Yes	71.8	89.7	85	91.5	85.7	91.3	65.9
Blue Preferred Plus POS Out-Network	30% after ded.	30% after ded.	N/A	N/A	N/A	71.8	89.7	85	91.5	85.7	91.3	65.9
Health Alliance HMO-High	$20/$30	$200/5 days	$15	$30/$50	Yes	84.9	89.7	88.4	96	92.7	90.2	72.6
Humana BP of Illinois Inc.-High	$20/$35	$250 x 3	$10	$40/$60	Yes	60.6	87.9	86.1	95.4	77.4	73.5	71.9
Humana BP of Illinois Inc.-Std	$25/$40	$400 x 3	$10	$40/$60	Yes	60.6	87.9	86.1	95.4	77.4	73.5	71.9
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	65.1	85.3	87.1	92.6	80.6	84.3	70.2
Humana Health Plan, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	65.1	85.3	87.1	92.6	80.6	84.3	70.2
Union Health Service-High	$15/$15	None	$15	$30/$35	No							
UHC of the Midwest, Inc.-High	$25/$40	$450	$7	$30/$60	Yes	56.9	86.3	86.6	94.9	81.5	89.4	61.7
UHC Plan of the River Valley, Inc.-High	$20/$45	Nothing	$10	$35/$50	Yes	52.4	87.3	85.3	95.6	79.8	88.6	62.2

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Indiana					
Aetna Open Access -high- Northern Indiana Area	877-459-6604	IK1	IK2	108.99	304.02
Health Alliance HMO -high- Western Indiana	800-851-3379	FX1	FX2	51.82	144.34
Humana Health Plan Inc. -high- Lake/Porter/LaPorte Counties	888-393-6765	751	752	89.32	205.49
Humana Health Plan Inc. -std- Lake/Porter/LaPorte Counties	888-393-6765	754	755	13.10	34.00
Humana Health Plan Inc. -high- Southern Indiana	888-393-6765	MH1	MH2	31.57	75.55
Humana Health Plan Inc. -std- Southern Indiana	888-393-6765	MH4	MH5	13.11	34.01
Physicians Health Plan of Northern Indiana -high- Northeast Indiana	260-432-6690	DQ1	DQ2	39.16	86.00
Iowa					
Coventry Health Care of Iowa -high- Central/Eastern/Western Iowa	800-257-4692	SV1	SV2	11.50	38.22
Coventry Health Care of Iowa -std- Central/Eastern/Western Iowa	800-257-4692	SY4	SY5	8.96	21.05
Health Alliance HMO -high- Central Iowa	800-851-3379	FX1	FX2	51.82	144.34
HealthPartners -high-	952-883-5000	V31	V32	102.77	252.62
HealthPartners -std-	952-883-5000	V34	V35	8.71	20.04
Sanford Health Plan -high- Northwestern Iowa	800-752-5863	AU1	AU2	68.32	173.62
Sanford Health Plan -std- Northwestern Iowa	800-752-5863	AU4	AU5	56.71	146.70
UnitedHealthcare Plan of the River Valley Inc. -high- Eastern and Central Iowa	800-747-1446	YH1	YH2	12.87	61.81
Kansas					
Aetna Open Access -high- Kansas City Area	877-459-6604	HY1	HY2	11.45	58.07
Coventry Health Care of Kansas -high- Kansas City Metro Area (KS and MO)	800-969-3343	HA1	HA2	11.82	41.68
Coventry Health Care of Kansas -std- Kansas City Metro Area (KS and MO)	800-969-3343	HA4	HA5	9.79	22.99
Humana Health Plan, Inc. -high- Kansas City	888-393-6765	MS1	MS2	161.98	368.97
Humana Health Plan, Inc. -std- Kansas City	888-393-6765	MS4	MS5	13.10	34.00

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		65.9	85.5	85.5	93.5	83.9	87.6	66.4
Indiana												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	61.5	82.6	82	90.9	86.6	82.3	64.2
Health Alliance HMO-High	$20/$30	$200/5 days	$15	$30/$50	Yes	84.9	89.7	88.4	96	92.7	90.2	72.6
Humana Health Plan Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	65.1	85.3	87.1	92.6	80.6	84.3	70.2
Humana Health Plan Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	65.1	85.3	87.1	92.6	80.6	84.3	70.2
Humana Health Plan Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	47.5	86	86.4	92.3	87.1	90.1	69.4
Humana Health Plan Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	47.5	86	86.4	92.3	87.1	90.1	69.4
Physicians Health Plan of Northern Indiana-High	$15/$15	20%	$10	$25/$50	Yes	58.3	87.9	88	95.2	90.5	94.4	60.3
Iowa												
Coventry Health Care of Iowa-High	$20/$45	15%	$3/$10	$40/$65	Yes	56.7	85.7	86.7	96.6	82.4	90.7	67.5
Coventry Health Care of Iowa-Std	$20/$45	20%	$3/$10	30%/5,000Max/ 30%/5,000Max	No	56.7	85.7	86.7	96.6	82.4	90.7	67.5
Health Alliance HMO-High	$20/$30	$200/5 days	$15	$30/$50	Yes	84.9	89.7	88.4	96	92.7	90.2	72.6
HealthPartners-High	$25/$45	Nothing	$12	$45/$90	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
HealthPartners-Std	$0 for 3, then 20%/ $0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
Sanford Health Plan- In-Network	$20/$30	$100/day x 5	$15	$30/$50	N/A	53	83.1	86.1	96.3	90.5	90.7	70.3
Sanford Health Plan- Out-Network	40%/40%	40%	N/A	N/A / N/A	N/A	53	83.1	86.1	96.3	90.5	90.7	70.3
Sanford Health Plan- In-Network	$25/$25	$100/day x 5	$15	$30/$50	No	53	83.1	86.1	96.3	90.5	90.7	70.3
Sanford Health Plan- Out-Network	40%/40%	40%	N/A	N/A / N/A	No	53	83.1	86.1	96.3	90.5	90.7	70.3
UHC Plan of the River Valley, Inc.-High	$25/$45	Nothing	$10	$35/$50	Yes	52.4	87.3	85.3	95.6	79.8	88.6	62.2
Kansas												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes							
Coventry Health Care of Kansas-High	$20/$60	None	$3/$12	$40/$65	Yes	50.1	87.1	88	95	85.3	86.8	62.4
Coventry Health Care of Kansas-Std	$30/$60	None	$3/$12	$50/$75	Yes	50.1	87.1	88	95	85.3	86.8	62.4
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	64.6	87.2	86.8	92.8	87.4	92.7	72.5
Humana Health Plan, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	64.6	87.2	86.8	92.8	87.4	92.7	72.5

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Kentucky					
Humana Health Plan, Inc. -high- Louisville	888-393-6765	MH1	MH2	31.57	75.55
Humana Health Plan, Inc. -std- Louisville	888-393-6765	MH4	MH5	13.11	34.01
Humana Health Plan, Inc. -high- Lexington	888-393-6765	MI1	MI2	12.99	32.86
Humana Health Plan, Inc. -std- Lexington	888-393-6765	MI4	MI5	11.06	24.89
Louisiana					
Coventry Health Care of Louisiana -high- New Orleans area	800-341-6613	BJ1	BJ2	38.76	111.52
Coventry Health Care of Louisiana -std- New Orleans area	800-341-6613	BJ4	BJ5	12.63	35.15
Maryland					
Aetna Open Access -high- Northern/Central/Southern Maryland Areas	877-459-6604	JN1	JN2	106.97	241.75
Aetna Open Access -basic- Northern/Central/Southern Maryland Areas	877-459-6604	JN4	JN5	12.06	28.23
CareFirst BlueChoice -high- All of Maryland	866-296-7363	2G1	2G2	15.60	39.52
CareFirst BlueChoice Healthy Blue Option -std- All of Maryland	866-296-7363	2G4	2G5	12.49	28.09
Coventry Health Care -high- All of Maryland	800-833-7423	IG1	IG2	10.47	26.28
Coventry Health Care -std- All of Maryland	800-833-7423	IG4	IG5	9.74	24.35
Kaiser Foundation Health Plan Mid-Atlantic States -high- Baltimore/Washington, DC areas	877-574-3337	E31	E32	19.30	60.66
Kaiser Foundation Health Plan Mid-Atlantic States -std- Baltimore/Washington, DC areas	877-574-3337	E34	E35	8.69	19.99
M.D. IPA -high- All of Maryland	877-835-9861	JP1	JP2	27.51	81.08
Massachusetts					
Fallon Community Health Plan -basic- Central/Eastern Massachusetts	800-868-5200	JG1	JG2	48.71	165.22

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		65.9	85.5	85.5	93.5	83.9	87.6	66.4
Kentucky												
Humana Health Plan, Inc. -High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc. -Std	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc. -High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc. -Std	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Louisiana												
Coventry Health Care of Louisiana-High	$25/$45	$100	$5	$40/$75	Yes	57.9	86.6	85.3	96.4	79.3	84.3	67.7
Coventry Health Care of Louisiana-Std	$30/$55	30%	$5	$40/$75	Yes	57.9	86.6	85.3	96.4	79.3	84.3	67.7
Maryland												
Aetna Open Access-High	$15/$30	$150/day x3	$5	$35/$65	Yes	65.9	87.1	87	91.8	90.1	87.4	66.7
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$65	Yes	65.9	87.1	87	91.8	90.1	87.4	66.7
CareFirst BlueChoice-High	$25/$35	$200	Nothing	$30/$50	Yes	61.8	86.2	84.6	91.7	72.2	84.6	53.2
CareFirst BlueChoice In-Network	Nothing/$35	$200	Nothing	$30/$50	Yes							
CareFirst BlueChoice Out-Network	$70/$70	$500	Nothing	$30/$50	Yes							
Coventry Health Care-High	$20/$40	$200/day x 3	$3/$15	$30/$60	Yes	47.7	81	81.1	93.5	70.8	81.8	55.3
Coventry Health Care-Std	$20/$40	$200/day x 3	$3/$15	$30/$60	Yes	47.7	81	81.1	93.5	70.8	81.8	55.3
Kaiser Foundation HP Mid-Atlantic States -High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	76.7	84.7	87.4	92.2	81.6	87.3	71.6
Kaiser Foundation HP Mid-Atlantic States -Std	$20/$30	$250/day x 3	$12/$22Net	$35/$55/$50/$70	Yes	76.7	84.7	87.4	92.2	81.6	87.3	71.6
M.D. IPA-High	$25/$40	$150/day x 3	$7	$30/$150/$250	Yes	63.2	83.8	87.1	92.5	84.1	90	65
Massachusetts												
Fallon Community Health Plan-Basic	$25/$35	$150 to $750max	$10	$30/$60	Yes	61	86.2	88.3	95	82.8	79.9	62.7

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Michigan					
Bluecare Network of MI -high- Traverse City	800-662-6667	H61	H62	31.55	168.49
Bluecare Network of MI -high- Grand Rapids	800-662-6667	J31	J32	47.33	209.52
Bluecare Network of MI -high- East Region	800-662-6667	K51	K52	23.74	65.79
Bluecare Network of MI -high- Southeast Region	800-662-6667	LX1	LX2	12.53	96.72
Grand Valley Health Plan -high- Grand Rapids area	616-949-2410	RL1	RL2	38.71	187.30
Grand Valley Health Plan -std- Grand Rapids area	616-949-2410	RL4	RL5	12.57	99.01
Health Alliance Plan -high- Southeastern Michigan/Flint area	800-556-9765	521	522	22.58	93.92
Health Alliance Plan -std- Southeastern Michigan/Flint area	800-556-9765	GY4	GY5	12.43	44.44
HealthPlus MI -high- East Central Michigan	800-332-9161	X51	X52	11.63	52.00
Physicians Health Plan -std- Mid-Michigan	866-539-3342	9U4	9U5	43.95	148.00
Minnesota					
HealthPartners -high-	952-883-5000	V31	V32	102.77	252.62
HealthPartners -std-	952-883-5000	V34	V35	8.71	20.04
Missouri					
Aetna Open Access -high- Kansas City Area	877-459-6604	HY1	HY2	11.45	58.07
Blue Preferred Plus POS -high- St. Louis/Central/SW areas	888-811-2092	9G1	9G2	71.95	140.35
Coventry Health Care of Kansas -high- Kansas City Metro Area (KS and MO)	800-969-3343	HA1	HA2	11.82	41.68
Coventry Health Care of Kansas -std- Kansas City Metro Area (KS and MO)	800-969-3343	HA4	HA5	9.79	22.99
Humana Health Plan, Inc. -high- Kansas City area	888-393-6765	MS1	MS2	161.98	368.97
Humana Health Plan, Inc. -std- Kansas City area	888-393-6765	MS4	MS5	13.10	34.00
United Healthcare of the Midwest -high- St. Louis Area	877-835-9861	B91	B92	40.31	90.84

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		65.9	85.5	85.5	93.5	83.9	87.6	66.4
Michigan												
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes							
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes							
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes	61	84.4	87	91.1	85.2	88.7	61.3
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes	61	84.4	87	91.1	85.2	88.7	61.3
Grand Valley Health Plan-High	$10/$10	Nothing	$5	$15/$15	No	79.6	86.9	91.9	93.9	89	86.4	77.8
Grand Valley Health Plan-Std	$20/$20	$500 x 3	$10	$40/$40	No	79.6	86.9	91.9	93.9	89	86.4	77.8
Health Alliance Plan-High	$10/$20	Nothing	$5	$25/$25	Yes	74.8	87.6	84.2	95.7	84.9	86.9	65.3
Health Alliance Plan-Std	$15/$30	Nothing	$10	$40/$40	Yes							
HealthPlus MI-High	$10/$20	None	$8	$40/$60	Yes	76.3	90.2	90.4	95.3	87.3	90	72.4
Physicians Health Plan of Mid-Michigan-Std	$20/Nothing	20%	$15	$25/$50	Yes	77.4	90.6	88.6	96.4	89.3	88.7	69
Minnesota												
HealthPartners-High	$25/$45	Nothing	$12	$45/$90	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
HealthPartners-Std	$0 for 3, then 20%/ $0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
Missouri												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes							
Blue Preferred Plus POS In-Network	$25/$25	$500	$10	$30/$50/25%/ $50/25%	Yes	71.8	89.7	85	91.5	85.7	91.3	65.9
Blue Preferred Plus POS Out-Network	30% after ded/ 30% after ded	30% after ded.	N/A	N/A / N/A	N/A	71.8	89.7	85	91.5	85.7	91.3	65.9
Coventry Health Care of Kansas-High	$20/$60	20%	$3/ $12	$40/$65	Yes	50.1	87.1	88	95	85.3	86.8	62.4
Coventry Health Care of Kansas-Std	$30/$60	20%	$3/ $12	$50/$75	Yes	50.1	87.1	88	95	85.3	86.8	62.4
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	64.6	87.2	86.8	92.8	87.4	92.7	72.5
Humana Health Plan, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	64.6	87.2	86.8	92.8	87.4	92.7	72.5
United Healthcare of the Midwest, Inc.-High	$25/$40	$450	$7	$30/$60	Yes	56.9	86.3	86.6	94.9	81.5	89.4	61.7

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Nevada					
Aetna Open Access -high- Clark County and Las Vegas area	877-459-6604	HF1	HF2	10.26	45.94
Health Plan of Nevada -high- Las Vegas area	800-777-1840	NM1	NM2	10.13	23.88
New Jersey					
Aetna Open Access -high- Northern New Jersey	877-459-6604	JR1	JR2	143.12	345.55
Aetna Open Access -basic- Northern New Jersey	877-459-6604	JR4	JR5	63.68	165.21
Aetna Open Access -high- Southern NJ	877-459-6604	P31	P32	238.93	619.24
Aetna Open Access -basic- Southern NJ	877-459-6604	P34	P35	107.89	267.52
GHI Health Plan -high- Northern New Jersey	212-501-4444	801	802	68.41	234.29
GHI Health Plan -std- Northern New Jersey	212-501-4444	804	805	11.32	26.43
New Mexico					
Lovelace Health Plan -high- All of New Mexico	800-808-7363	Q11	Q12	56.56	160.93
Presbyterian Health Plan -high- All counties in New Mexico	800-356-2219	P21	P22	31.16	80.23

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		65.9	85.5	85.5	93.5	83.9	87.6	66.4
Nevada												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes							
Health Plan of Nevada-High	$10/$20	$150	$5	$35/$55	Yes	56.7	70.9	70.6	89.8	78	84.5	56.1
New Jersey												
Aetna Open Access-High	$20/$35	$150/day x 5	$10	$35/$65	Yes	61.7	85.5	88.6	93.7	85.2	86.1	60.5
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	61.7	85.5	88.6	93.7	85.2	86.1	60.5
Aetna Open Access-High	$20/$35	$150/day x 5	$10	$35/$65	Yes	72.9	89	91	94.8	90.2	90.2	74.1
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	72.9	89	91	94.8	90.2	90.2	74.1
GHI Health Plan- In-Network	$15/$15	$100	$15	$25/$50	Yes	60.4	85.6	86.1	92.6	76.3	77.2	57.2
GHI Health Plan- Out-Network	+50% of sch.	+50% of sch.	N/A	N/A / N/A	No	60.4	85.6	86.1	92.6	76.3	77.2	57.2
GHI Health Plan-Std	$25/$25	$250/day x 3	$5	$25/$50	Yes	60.4	85.6	86.1	92.6	76.3	77.2	57.2
New Mexico												
Lovelace Health Plan-High	$20/$35	$250 after ded	$5	$35/$60/50%	Yes	62.3	80.7	78.6	89.6	80.7	86.2	74.6
Presbyterian Health Plan-High	$25/$35	$100 x 5 days	$10	$40/$75/25%	Yes	65.3	83.1	81.4	91.8	82.3	87.6	67.3

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
New York					
Aetna Open Access -high- NYC Area/Upstate NY	877-459-6604	JC1	JC2	99.84	299.92
Aetna Open Access -basic- NYC Area/Upstate NY	877-459-6604	JC4	JC5	36.47	135.37
Blue Choice -high- Rochester area	800-462-0108	MK1	MK2	52.76	142.83
Blue Choice -std- Rochester area	800-462-0108	MK4	MK5	12.92	92.08
CDPHP Universal Benefits -high- Upstate, Hudson Valley, Central New York	877-269-2134	SG1	SG2	30.70	148.62
CDPHP Universal Benefits -std- Upstate, Hudson Valley, Central New York	877-269-2134	SG4	SG5	10.43	26.91
GHI HMO -high- Brnx/Brklyn/Manhat/Queen/Richmon/Westche	877-244-4466	6V1	6V2	125.61	394.19
GHI HMO -high- Capital/Hudson Valley Regions	877-244-4466	X41	X42	76.29	264.28
GHI Health Plan -high- All of New York	212-501-4444	801	802	68.41	234.29
GHI Health Plan -std- Most of New York	212-501-4444	804	805	11.32	26.43
HIP of Greater New York -high- New York City area	800-HIP-TALK	511	512	45.21	218.22
HIP of Greater New York -std- New York City area	800-HIP-TALK	514	515	14.33	136.39
Independent Health Assoc -high- Western New York	800-501-3439	QA1	QA2	19.89	112.97
MVP Health Care -high- Eastern Region	888-687-6277	GA1	GA2	12.95	93.55
MVP Health Care -std- Eastern Region	888-687-6277	GA4	GA5	11.56	28.93
MVP Health Care -high- Western Region	888-687-6277	GV1	GV2	12.69	81.28
MVP Health Care -std- Western Region	888-687-6277	GV4	GV5	11.07	27.70
MVP Health Care -high- Central Region	888-687-6277	M91	M92	25.06	126.40
MVP Health Care -std- Central Region	888-687-6277	M94	M95	12.14	54.94
MVP Health Care -high- Northern Region	888-687-6277	MF1	MF2	61.48	217.55
MVP Health Care -std- Northern Region	888-687-6277	MF4	MF5	28.07	133.88
MVP Health Care -high- Mid-Hudson Region	888-687-6277	MX1	MX2	29.00	136.07
MVP Health Care -std- Mid-Hudson Region	888-687-6277	MX4	MX5	12.25	59.43

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
			HMO/POS National Average			65.9	85.5	85.5	93.5	83.9	87.6	66.4
New York												
Aetna Open Access-High	$20/$35	$150/day x 5	$10	$35/$65	Yes	65.1	82.8	85.3	92.7	87.3	87.5	60
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	65.1	82.8	85.3	92.7	87.3	87.5	60
Blue Choice-High	$20/$20	$240	$10	$30/$100	No	72.4	92.1	92.4	94.7	86	93.1	71
Blue Choice-Std	$25/$40	$500	$7	$50/$100	No	72.4	92.1	92.4	94.7	86	93.1	71
CDPHP Universal Benefits, Inc.-High	$20/$30	$100 x 5	25%	25%/25%	No	71	91.1	88.2	95.7	90.9	90.3	73.9
CDPHP Universal Benefits, Inc.-Std	$25/$40	$500+10%	30%	30%/30%	No	71	91.1	88.2	95.7	90.9	90.3	73.9
GHI HMO Select-High	$25/$40	$500	$10	$30/$50	Yes	51.3	80.6	85.9	94.5	81.4	81.7	65
GHI HMO Select-High	$25/$40	$500	$10	$30/$50	Yes	51.3	80.6	85.9	94.5	81.4	81.7	65
GHI Health Plan- In-Network	$15/$15	$100	$15	$25/$50	Yes	60.4	85.6	86.1	92.6	76.3	77.2	57.2
GHI Health Plan- Out-Network	+50% of sch	+50% of sch.	N/A	N/A / N/A	No	60.4	85.6	86.1	92.6	76.3	77.2	57.2
GHI Health Plan-Std	$25/$25	$250/day x 3	$5	$25/$50	Yes	60.4	85.6	86.1	92.6	76.3	77.2	57.2
HIP of Greater New York-High	$10/$20	None	$15	$30/$50	Yes	70.1	84.3	81.3	89.8	79	84.4	56.1
HIP of Greater New York-Std	$20/$40	$500	$15	$30/$50	Yes	70.1	84.3	81.3	89.8	79	84.4	56.1
Independent Health Assoc.- In-Network	$20/$20	$250	$10	$20/$35	No	74.1	90.5	91.5	95.3	89.2	93.5	78.4
Independent Health Assoc.- Out-Network	25%/25%	25%	N/A	N/A / N/A	No	74.1	90.5	91.5	95.3	89.2	93.5	78.4
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	69	90.5	88.9	95.9	86.2	94	78.6
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	69	90.5	88.9	95.9	86.2	94	78.6
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	69	90.5	88.9	95.9	86.2	94	78.6
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	69	90.5	88.9	95.9	86.2	94	78.6
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	69	90.5	88.9	95.9	86.2	94	78.6
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	69	90.5	88.9	95.9	86.2	94	78.6
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	69	90.5	88.9	95.9	86.2	94	78.6
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	69	90.5	88.9	95.9	86.2	94	78.6
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	69	90.5	88.9	95.9	86.2	94	78.6
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	69	90.5	88.9	95.9	86.2	94	78.6

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
North Dakota					
HealthPartners -High-	952-883-5000	V31	V32	102.77	252.62
HealthPartners -Std-	952-883-5000	V34	V35	8.71	20.04
Heart of America Health Plan -high- Northcentral North Dakota	800-525-5661	RU1	RU2	10.89	27.99
Ohio					
AultCare HMO -high- Stark/Carroll/Holmes/Tuscarawas/Wayne Co.	330-363-6360	3A1	3A2	32.81	133.22
HMO Health Ohio -high- Northeast Ohio	800-522-2066	L41	L42	118.18	305.71
Kaiser Foundation Health Plan of Ohio -high- Cleveland/Akron areas	800-686-7100	641	642	66.48	169.16
Kaiser Foundation Health Plan of Ohio -std- Cleveland/Akron areas	800-686-7100	644	645	10.47	24.08
The Health Plan of the Upper Ohio Valley -high-Eastern Ohio	800-624-6961	U41	U42	21.12	54.63
Oklahoma					
Globalhealth, Inc. -high- Oklahoma	877-280-2990	IM1	IM2	9.48	22.84
Oregon					
Kaiser Foundation Health Plan of Northwest -high- Portland/Salem areas	800-813-2000	571	572	47.55	113.94
Kaiser Foundation Health Plan of Northwest -std- Portland/Salem areas	800-813-2000	574	575	11.32	26.00

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		65.9	85.5	85.5	93.5	83.9	87.6	66.4
North Dakota												
HealthPartners -High	$25/$45	Nothing	$12	$45/$90	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
HealthPartners -Std	$0 for 3, then 20%/ $0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
Heart of America Health Plan-High In-Network	$15/$25	None	50%	50%/50%	None							
Heart of America Health Plan-High Out-Network	20%/20%	20%	N/A	N/A	N/A							
Ohio												
AultCare HMO-High	$15/$20	$150	$15	$30/$45	No	86.5	93.5	92.6	94.6	94.6	95.8	86.3
HMO Health Ohio-High	$20/$20	$250	$20	$30/$40	Yes	67.9	87.1	87.5	96.1	84	91.2	70.1
Kaiser Foundation HP of Ohio-High	$20/$20	$250	$10	$30/$30	Yes	73.6	85.7	85	90.7	83.5	85.8	72.4
Kaiser Foundation HP of Ohio-Std	$30/$40	$500	$15	$40/$40	Yes	73.6	85.7	85	90.7	83.5	85.8	72.4
The Health Plan of the Upper Ohio Valley-High	$10/$20	$250	$15	$30/$50	Yes	73.9	90.5	89	96.3	92.7	95.7	75.8
Oklahoma												
Globalhealth, Inc.-High	$15/$35	$150/day x 3	$10	$30/$40	Yes	56	73.1	81.2	94.1	71.5	88.3	62.6
Oregon												
Kaiser Foundation HP of Northwest-High	$15/$25	$200	$15	$40/$40	Yes	67.7	76.9	77.8	89.3	86.4	84.8	67.9
Kaiser Foundation HP of Northwest-Std	$25/$35	$500	$20	$40/$40	Yes	67.7	76.9	77.8	89.3	86.4	84.8	67.9

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Pennsylvania					
Aetna Open Access -high- Philadelphia	800-392-9137	P31	P32	238.93	619.24
Aetna Open Access -basic- Philadelphia	800-392-9137	P34	P35	107.89	267.52
Aetna Open Access -high- Pittsburgh and Western PA Areas	877-459-6604	YE1	YE2	11.84	65.34
Geisinger Health Plan -std- Northeastern/Central/South Central areas	800-447-4000	GG4	GG5	62.77	160.64
HealthAmerica Pennsylvania -high- Greater Pittsburgh area	866-351-5946	261	262	29.25	96.74
HealthAmerica Pennsylvania -std- Central Pennsylvania	866-351-5946	SW4	SW5	23.20	56.70
UPMC Health Plan -high- Western Pennsylvania	888-876-2756	8W1	8W2	40.69	109.85
UPMC Health Plan -std- Western Pennsylvania	888-876-2756	UW4	UW5	21.38	65.44
Puerto Rico					
Humana Health Plans of Puerto Rico, Inc. -high- Puerto Rico	800-314-3121	ZJ1	ZJ2	7.93	17.83
Triple-S Salud, Inc. -high- All of Puerto Rico	787-774-6060	891	892	8.13	18.29
South Dakota					
HealthPartners - High-	952-883-5000	V31	V32	102.77	252.62
HealthPartners - Std-	952-883-5000	V34	V35	8.71	20.04
Sanford Health Plan -high- Eastern/Central/Rapid City Areas	800-752-5863	AU1	AU2	68.32	173.62
Sanford Health Plan -std- Eastern/Central/Rapid City Areas	800-752-5863	AU4	AU5	56.71	146.70
Tennessee					
Aetna Open Access -high- Memphis Area	877-459-6604	UB1	UB2	24.12	136.39
Humana Health Plan, Inc. -high- Knoxville	888-393-6765	GJ1	GJ2	13.11	34.01
Humana Health Plan, Inc. -std- Knoxville	888-393-6765	GJ4	GJ5	11.13	25.03

Plan Name – Location		Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
				Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
					HMO/POS National Average		65.9	85.5	85.5	93.5	83.9	87.6	66.4
Pennsylvania													
Aetna Open Access-High		$20/$35	$150/day x 5	$10	$35/$65	Yes	56.7	87.3	88.5	94.6	75.2	88.6	68.2
Aetna Open Access-Basic		$15/$35	20% Plan Allow	$5	$35/$65	Yes	56.7	87.3	88.5	94.6	75.2	88.6	68.2
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$65	Yes	56.7	87.3	88.5	94.6	75.2	88.6	68.2
Geisinger Health Plan-Std		$20/$35	20%aftrDeduct	30% $5/$15	40% $40/$120/ 50% $60/$180	Yes	70.4	88.9	89.9	95.9	84.1	89.6	71.3
HealthAmerica Pennsylvania-High		$25/$50	15%	$5	$35/$60	Yes	69.5	86.4	88.8	94.6	83.6	91.9	70.9
HealthAmerica Pennsylvania-Std		$25/$50	15%	$5	$35/$60	Yes	69.5	86.4	88.8	94.6	83.6	91.9	70.9
UPMC Health Plan-High		$20/$35	None	$5	$35/$70	Yes	76.4	90.3	87.1	95.9	87	88.5	71.6
UPMC Health Plan-Std		$20/$35	None	$5	$35/$70	Yes	76.4	90.3	87.1	95.9	87	88.5	71.6
Puerto Rico													
Humana HP of Puerto Rico, Inc. -	In-Network	$5/$5	None	$2.50	$10/$15	Yes	75.3	80.7	81.5	93.6	83.4	81.1	59.1
Humana HP of Puerto Rico, Inc.-	Out-Network	$10/$10	$50	N/A	N/A / N/A	No	75.3	80.7	81.5	93.6	83.4	81.1	59.1
Triple-S Salud, Inc.-	In-Network	$7.50/$10	None	$5 or $12	Greater of $15 or 20%/ 25% up to $100/$175 max	Yes	71.6	85.7	79.6	96.8	68.3	69.5	51.4
Triple-S Salud, Inc.-	Out-Network	$7.50+10%/$10+10%	10% +	N/A	N/A / N/A	No	71.6	85.7	79.6	96.8	68.3	69.5	51.4
South Dakota													
HealthPartners-High		$25/$45	Nothing	$12	$45/$90	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
HealthPartners-Std		$0 for 3, then 20%/ $0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
Sanford Health Plan-	In-Network	$20/$30	$100/day x 5	$15	$30/$50	N/A	53	83.1	86.1	96.3	90.5	90.7	70.3
Sanford Health Plan-	Out-Network	40%/40%	40%	N/A	N/A / N/A	N/A	53	83.1	86.1	96.3	90.5	90.7	70.3
Sanford Health Plan-	In-Network	$25/$25	$100/day x 5	$15	$30/$50	No	53	83.1	86.1	96.3	90.5	90.7	70.3
Sanford Health Plan-	Out-Network	40%/40%	40%	N/A	N/A / N/A	No	53	83.1	86.1	96.3	90.5	90.7	70.3
Tennessee													
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$65	Yes	63.9	87.7	84.2	93.6	85	91.9	70.8
Humana Health Plan, Inc.-High		$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-Std		$25/$40	$500/day x 3	$10	$40/$60	Yes							

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Texas					
Aetna Open Access -high- Austin and San Antonio Areas	877-459-6604	P11	P12	111.56	348.75
Firstcare -high- West Texas	800-884-4901	CK1	CK2	11.89	155.92
Humana Health Plan of Texas -high- Corpus Christi	888-393-6765	UC1	UC2	35.66	84.75
Humana Health Plan of Texas -std- Corpus Christi	888-393-6765	UC4	UC5	13.11	34.00
Humana Health Plan of Texas -high- San Antonio	888-393-6765	UR1	UR2	157.28	358.40
Humana Health Plan of Texas -std- San Antonio	888-393-6765	UR4	UR5	13.10	34.00
Humana Health Plan of Texas -high- Austin	888-393-6765	UU1	UU2	41.26	97.34
Humana Health Plan of Texas -std- Austin	888-393-6765	UU4	UU5	13.11	34.01
UnitedHealthcare Benefits of Texas, Inc. -high- San Antonio - formerly Pacificare of TX	866-546-0510	GF1	GF2	40.87	110.52
Utah					
Altius Health Plans -high- Wasatch Front	800-377-4161	9K1	9K2	42.31	85.89
Altius Health Plans -std- Wasatch Front	800-377-4161	DK4	DK5	10.32	22.71
SelectHealth -high- Urban and Suburban Utah	800-538-5038	SF1	SF2	52.37	108.17
Virgin Islands					
Triple-S Salud, Inc. -high- US Virgin Islands	800-981-3241	851	852	9.99	22.68
Virginia					
Aetna Open Access -high- Northern/Central/Richmond Virginia Areas	877-459-6604	JN1	JN2	106.97	241.75
Aetna Open Access -basic- Northern/Central/Richmond Virginia Areas	877-459-6604	JN4	JN5	12.06	28.23
CareFirst BlueChoice -high- Northern Virginia	866-296-7363	2G1	2G2	15.60	39.52
CareFirst BlueChoice Healthy Blue Option -std- Northern Virginia	866-296-7363	2G4	2G5	12.49	28.09
Kaiser Foundation Health Plan Mid-Atlantic States -high- Northern Virginia/Fredericksburg area	877-574-3337	E31	E32	19.30	60.66
Kaiser Foundation Health Plan Mid-Atlantic States -std- Northern Virginia/Fredericksburg area	877-574-3337	E34	E35	8.69	19.99
M.D. IPA -high- N.VA/Cntrl VA/Richmond	877-835-9861	JP1	JP2	27.51	81.08
Optima Health Plan -high- Hampton Roads and Richmond areas	800-206-1060	9R1	9R2	27.98	97.97
Optima Health Plan -std- Hampton Roads and Richmond areas	800-206-1060	9R4	9R5	9.05	21.40
Piedmont Community Healthcare -high- Lynchburg area	888-674-3368	2C1	2C2	12.38	28.34

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		65.9	85.5	85.5	93.5	83.9	87.6	66.4
Texas												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	69.8	83.3	79.3	89.6	82.9	88.6	65.2
Firstcare-High	$20/$55	$200/day x 5	$15	$35/$65	No	59.7	84.6	87.5	94.6	78.1	86.5	63.7
Humana Health Plan of Texas-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan of Texas-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Health Plan of Texas-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	58.7	86	79.5	91	80.5	87	62.1
Humana Health Plan of Texas-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	58.7	86	79.5	91	80.5	87	62.1
Humana Health Plan of Texas-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	62.7	85.9	86.6	94	82.1	92.2	65.3
Humana Health Plan of Texas-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	62.7	85.9	86.6	94	82.1	92.2	65.3
UnitedHealthcare Benefits of Texas-High	$20/$40	$250/day x 5	$10	$35/$60	Yes	65.4	86.4	84.2	93.6	79.7	90.5	64.6
Utah												
Altius Health Plans-High	$20/$30	$200	$7	$25/$50	Yes	55.6	86	88	94.8	81.7	85.3	62.5
Altius Health Plans-Std	$20/$35	None	$7	$35/$60	Yes	55.6	86	88	94.8	81.7	85.3	62.5
SelectHealth-High	$15/$25	$100	$5	$25/50%	N/A	55.3	83.4	82.3	93	93.5	92	71.2
Virgin Islands												
Triple-S Salud, Inc.- In-Network	$7.50/$10	None	$5 or $12	Greater of $15 or 20%/ 25% up to $100/$175 max	Yes							
Triple-S Salud, Inc.- Out-Network	$7.50 & 10%+/ $10 & 10%+	10%+	N/A	N/A/N/A	No							
Virginia												
Aetna Open Access-High	$15/$30	$150/day x3	$5	$35/$65	Yes	65.9	87.1	87	91.8	90.1	87.4	66.7
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$65	Yes	65.9	87.1	87	91.8	90.1	87.4	66.7
CareFirst BlueChoice-High	$25/$35	$200	Nothing	$30/$50	Yes	61.8	86.2	84.6	91.7	72.2	84.6	53.2
CareFirst BlueChoice-High In-Network	Nothing/$35	$200	Nothing	$30/$50	Yes							
CareFirst BlueChoice-High Out-Network	$70/$70	$500	Nothing	$30/$50	Yes							
Kaiser Foundation HP-High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	76.7	84.7	87.4	92.2	81.6	87.3	71.6
Kaiser Foundation HP-Std	$20/$30	$250/day x 3	$12/$22Net	$35/$55/$50/$70	Yes	76.7	84.7	87.4	92.2	81.6	87.3	71.6
M.D. IPA-High	$25/$35	$150/day x 3	$7	$25/$150/$250	Yes	63.2	83.8	87.1	92.5	84.1	90	65
Optima Health Plan-High	$15/$0 child<13/$30	$200	$10	$25/$50/$75	Yes	68.9	90	84.9	93.4	91.7	93.3	71.9
Optima Health Plan-Std	$20/$30	None	$5	$25/50% up to $3,000	No	68.9	90	84.9	93.4	91.7	93.3	71.9
Piedmont Community HC-High	$35/$35	20%	$15	$40/$55	Yes							

Health Maintenance Organization (HMO) and Point-of-Service (POS) Plans

See page 57 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Washington					
Group Health Cooperative -high-Western WA/Central WA/Spokane/Pullman	888-901-4636	541	542	41.91	71.16
Group Health Cooperative -std- Western WA/Central WA/Spokane/Pullman	888-901-4636	544	545	9.26	20.91
KPS Health Plans -std- All of Washington	800-552-7114	L11	L12	10.32	22.28
KPS Health Plans -high- All of Washington	800-552-7114	VT1	VT2	72.55	147.81
Kaiser Foundation Health Plan of Northwest -high- Vancouver/Longview	800-813-2000	571	572	47.55	113.94
Kaiser Foundation Health Plan of Northwest -std- Vancouver/Longview	800-813-2000	574	575	11.32	26.00
West Virginia					
The Health Plan of the Upper Ohio Valley -high- Northern/Central West Virginia	800-624-6961	U41	U42	21.12	54.63
Wisconsin					
Dean Health Plan -high- South Central Wisconsin	800-279-1301	WD1	WD2	20.35	114.08
Group Health Cooperative -high- South Central Wisconsin	608-828-4827	WJ1	WJ2	12.12	53.59
HealthPartners -high-	952-883-5000	V31	V32	102.77	252.62
HealthPartners -std-	952-883-5000	V34	V35	8.71	20.04
MercyCare HMO -high- South Central Wisconsin	800-895-2421	EY1	EY2	12.37	65.46
Physicians Plus -high- Dane County	800-545-5015	LW1	LW2	12.15	66.69
Wyoming					
Altius Health Plans -high- Uinta County	800-377-4161	9K1	9K2	42.31	85.89
Altius Health Plans -std- Uinta County	800-377-4161	DK4	DK5	10.32	22.71

Plan Name – Location		Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
				Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
HMO/POS National Average							**65.9**	**85.5**	**85.5**	**93.5**	**83.9**	**87.6**	**66.4**
Washington													
Group Health Cooperative-High		$25/$25	$350/day x 3	$20	$40/$60	Yes	69.1	83.9	84.4	92.6	86.7	89.6	71.1
Group Health Cooperative-Std		$25+20%/ $25+20%	$500/day x 3	$20	$40/$60	Yes	69.1	83.9	84.4	92.6	86.7	89.6	71.1
KPS Health Plans-Std	In-Network	$15/3 or 20%/20%	Nothing	$10	$35/50%/ $40 max $100	Yes	77.5	93.4	92.9	94.8	91	93.7	71.8
KPS Health Plans-	Out-Network	$15/3 +40%+diff/ 40%+diff	Nothing	Not Covered	Not Covered	No	77.5	93.4	92.9	94.8	91	93.7	71.8
KPS Health Plans-High	In-Network	$30/$30	None	$5	$25/50% or $100	Yes	77.5	93.4	92.9	94.8	91	93.7	71.8
KPS Health Plans-	Out-Network	$30+40%+diff/ $30+40%+diff	None	Not covered	N/A / N/A	No	77.5	93.4	92.9	94.8	91	93.7	71.8
Kaiser Foundation HP of Northwest-High		$15/$25	$200	$15	$40/$40	Yes	67.7	76.9	77.8	89.3	86.4	84.8	67.9
Kaiser Foundation HP of Northwest-Std		$25/$35	$500	$20	$40/$40	Yes	67.7	76.9	77.8	89.3	86.4	84.8	67.9
West Virginia													
The HP of the Upper Ohio Valley-High		$10/$20	$250	$15	$30/$50	Yes	73.9	90.5	89	96.3	92.7	95.7	75.8
Wisconsin													
Dean Health Plan-High		$10/$10	None	$10	30%/$75max/30%	No	77	87.1	88.3	96.2	85.4	92.1	68.9
Group Health Cooperative-High		$10/$10	None	$5	$20/$20	Yes	79.6	78.8	84.7	96.1	89.3	91.6	75.6
HealthPartners-High		$25/$45	Nothing	$12	$45/$90	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
HealthPartners-Std		$0 for 3, then 20%/ $0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	64.1	87.3	89.7	95.1	88.8	91.2	66
MercyCare HMO-High		$10/$10	Nothing	$10	$20/$50	Yes							
Physicians Plus-High		$10/$10	Nothing	$10	30%/50%	No	76.6	86	88.9	95	90.1	91.2	72.3
Wyoming													
Altius Health Plans-High		$20/$30	$200	$7	$25/$50	Yes	55.6	86	88	94.8	81.7	85.3	62.5
Altius Health Plans-Std		$20/$35	None	$7	$35/$60	Yes	55.6	86	88	94.8	81.7	85.3	62.5

Appendix F
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement (Pages 88 through 99)

A High Deductible Health Plan (HDHP) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The HDHP gives you greater flexibility and discretion over how you use your health care benefits.

When you enroll, your health plan establishes for you either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The plan automatically deposits the monthly "premium pass through" into your HSA. The plan credits an amount into the HRA. (This is the "Premium Contribution to HSA/HRA" column in the following charts.)

Preventive care is often covered in full, usually with no or only a small deductible or copayment. Preventive care expenses may also be payable up to an annual maximum dollar amount (up to $300 for instance). As you receive other non-preventive medical care, you must meet the plan deductible before the health plan pays benefits. You can choose to pay your deductible with funds from your HSA or you can choose instead to pay for your deductible out-of-pocket, allowing your savings to continue to grow.

The HDHP features higher annual deductibles (a minimum of $1,200 for Self and $2,400 for Family coverage) and annual out-of-pocket limits (not to exceed $6,050 for Self and $12,100 for Family coverage) than other insurance plans. Depending on the HDHP you choose, you may have the choice of using In-Network and Out-of-Network providers. There may be higher deductibles and out-of-pocket limits when you use Out-of-Network providers. Using In-Network providers will save you money.

Health Savings Account (HSA)

A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pre-tax basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax free, and that amount is available on a tax free basis to pay medical costs. You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return. If you are enrolled in a High Deductible Health Plan with an HSA you may not participate in a Health Care Flexible Spending Account, but you are permitted to participate in a Limited Expense FSA. HSA's are subject to a number of rules and limitations established by the Department of the Treasury.

Visit www.ustreas.gov/offices/public-affairs/hsa for more information. The 2012 maximum contribution limits are $3,100 for Self Only coverage and $6,250 for Self and Family coverage. If you are over 55, you can make an additional "catch up" contribution. You can use funds in your account to help pay your health plan deductible.

Appendix F
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

Federal employees who are enrolled in HDHPs are eligible to have Health Savings Accounts (HSAs).

Features of an HSA include:

- Tax-deductible deposits you make to the HSA. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). See IRS Publication 969.
- Tax-deferred interest earned on the account.
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused funds and interest from year to year.
- Portability; the account is owned by you and is yours to keep – even when you retire, leave government service, or change plans.

Health Reimbursement Arrangement (HRA)

Health Reimbursement Arrangements are a common feature of Consumer-Driven Health Plans. They may be referred to by the health plan under a different name, such as personal care account. They are also available to enrollees in High Deductible Health Plans who are not eligible for an HSA. HRAs are similar to HSAs except:

- An enrollee cannot make deposits into an HRA;
- A health plan may impose a ceiling on the value of an HRA;
- Interest is not earned on an HRA; and
- The amount in an HRA is not transferable if the enrollee leaves the health plan.

If you are enrolled in a High Deductible Health Plan with an HRA you may participate in a Health Care Flexible Spending Account.

The plan will credit the HRA different amounts depending on whether you have a Self Only or a Self and Family enrollment. You can use funds in your account to help pay your health plan deductible.

Features of an HRA include:

- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused credits from year to year.
- Credits in an HRA do not earn interest.
- Credits in the HRA are forfeited if you leave federal employment or switch health insurance plans.

Appendix F
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

	Health Savings Account (HSA)	**Health Reimbursement Arrangement (HRA)**
ELIGIBILITY	You must enroll in a High Deductible Health Plan (HDHP). No other general medical insurance coverage is permitted. You cannot be enrolled in Medicare Part A or Part B. You cannot be claimed as a dependent on someone else's tax returns.	You must enroll in a High Deductible Health Plan (HDHP).
FUNDING	The plan deposits a monthly "premium pass through" into your account.	The plan deposits the credit amount directly into your account.
CONTRIBUTIONS	The maximum allowed is a combination of the health plan "premium pass through" and the member contribution up to the maximum contribution amount set by the IRS each year.	Only that portion of the premium specified by the health plan will be contributed. You cannot add your own money to an HRA.
DISTRIBUTIONS	May be used to pay the out-of-pocket medical expenses for yourself, your spouse, or your dependents (even if they are not covered by the HDHP), or to pay the plan's deductible. See IRS Publication 502 for a complete list of eligible expenses.	May be used to pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP, or to pay the plan's deductible. See IRS Publication 502 for a complete list of eligible expenses.
PORTABLE	Yes, you can take this account with you when you change plans, separate from service, or retire.	If you retire and remain in your HDHP you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under that HDHP will be eligible for reimbursement, subject to timely filing requirements. Unused credits are forfeited.
ANNUAL ROLLOVER	Yes, funds accumulate without a maximum cap.	Yes, credits accumulate without a maximum cap.

IMPORTANT REMINDER: This is only a summary of the features of the HDHP/HSA or HRA. Refer to the specific Plan brochure for the complete details covering Plan design, operation, and administration as each Plan will have differences.

Appendix F
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

A Consumer-Driven plan provides you with freedom in spending health care dollars the way you want. The typical plan has features such as: member responsibility for certain up-front medical costs, an employer-funded account that you may use to pay these up-front costs, and catastrophic coverage with a high deductible. You and your family receive full coverage for In-Network preventive care.

How to Use *PostalEASE* for Health Savings Account (HSA) Contributions For Employees Enrolled in High Deductible Health Plans

***PostalEASE* is a self-service enrollment system** that provides a convenient, confidential, and secure way for you to make payroll contributions to your Health Savings Account (HSA). You must be enrolled in a High Deductible Health Plan and have a personal, non-commercial, savings or checking account already established at your financial institution. If you have access to *PostalEASE* on the Internet (https://liteblue.usps.gov), at an Employee Self-Service Kiosk (available in some facilities), or on the Postal Service Intranet (from the Blue page), using these may be easier than using the telephone. You can use *PostalEASE* to:

a. Begin contributing to an HSA. b. Change your contributions. c. Cancel your contributions.

To use *PostalEASE*:

1. Read the Privacy Act Statement printed on page 2.
2. Complete the Worksheet below and continue to the next section.

ATTENTION: You alone are responsible for the tax consequences of electing to make Health Savings Account (HSA) contributions. The Postal Service cannot determine your eligibility to begin or continue HSA contributions. If you make HSA contributions and you are not eligible under the Internal Revenue Code, there may be tax consequences that will cost you money. If you have questions about whether to contribute to an HSA, contact the Internal Revenue Service, a qualified financial counselor, or your health plan for assistance. The Postal Service cannot advise you on whether to contribute to an HSA or what the tax consequences might be.

If you elect to contribute to an HSA (this applies to both regular and catch-up HSA contributions) and you do not terminate your HSA contribution during the year, and your contribution does not end because you have reached the annual IRS contribution limit, then your HSA contribution will always automatically end after the last pay period of the calendar year (Pay Period 26, or Pay Period 27 in years with 27 pay periods). If you want to begin contributing in the new calendar year, you will need to make a new election to begin contributing to your HSA for Pay Period 1 or later of the new calendar year.

Internal Revenue Code Requirements

To contribute to an HSA, under the Internal Revenue Code you must participate in a High Deductible Health Plan, have no other insurance coverage except for those specifically allowed under the Internal Revenue Code (for example, disability, dental, vision, long-term care, and limited flexible spending accounts), and not be claimed as a dependent on someone else's tax return. High Deductible Health Plans in the Federal Employees Health Benefits (FEHB) program are listed in a separate section of the Guide to Benefits that applies to you, which is available at www.opm.gov/insure or from the HR Shared Service Center by calling 1-877-477-3273, Option 5. Under the Internal Revenue Code, you must not contribute to an HSA if you participate in a health care flexible spending account (FSA), a spouse's health care FSA, a spouse's family enrollment in other non-high deductible health insurance coverage, TRICARE, Medicare, or have received VA benefits within the previous 3 months.

There are annual Internal Revenue Code HSA contribution limits that may be adjusted each calendar year. It is your responsibility to know the calendar year limits. The 2012 annual contribution limit, including the HDHP premium pass through, is $3,100 for Self Only and $6,250 for Family enrollment. Employees who are age 55 and older may contribute an additional pre-tax catch-up amount of $1,000. Visit www.irs.gov for more details.

In electing your contribution amount, please note that if you have insufficient funds available for your entire elected contribution, a partial deduction will not be taken.

PostalEASE Health Savings Account (HSA) Contributions Worksheet

- Check the action you're taking: ❑ Begin or add contributions ❑ Cancel contributions ❑ Change contributions
- Enter your 9-digit HSA financial institution routing number (obtain from your HSA financial institution):
  ___ ___ ___ ___ - ___ ___ ___ ___ ___
- Enter the account number to be credited: _____
- Enter the amount of the new or changed contributions in whole dollars: $_____.oo

Now that you have completed the worksheet, you are ready to use *PostalEASE*

1. Have the following information ready when you use *PostalEASE.*
   - Your employee identification number (EIN). This can be found at the top of your pay stub.
   - Your USPS personal identification number (PIN). Don't know your USPS PIN? Go to https://liteblue.usps.gov and click "Forget Your PIN?" Enter your EIN (printed at the top of your earnings statement). Choose a new PIN immediately with Self-Service PIN Reset—just follow the instructions. Or, request your PIN from the USPS intranet Blue or a self-service kiosk—click on Employee Self-Service, then *PostalEASE* . Or, dial 1-877-477-3273 and press 1. Enter your employee identification number (EIN). When prompted for your PIN, pause, then press 2. Your USPS PIN will be mailed to your address of record the next business day.
   - Your completed *PostalEASE* Health Savings Account (HSA) Contributions Worksheet, including the routing number for the HSA financial institution and the account number you will be transferring earnings to (the HSA account must already be established).

2. If you have access to the *PostalEASE* Employee Web on the Internet (from http://liteblue.usps.gov), on the Intranet (from the Blue page), or at an employee self-service kiosk (available in some facilities), using any of these may be simpler than using the telephone. Using *PostalEASE* online will also allow you to print a written confirmation of the banking information you provide to *PostalEASE* . Just sign on to *PostalEASE*, under the Benefits Column select the Health Savings Accounts (HSA) option, and follow the instructions.

3. Otherwise, you can reach *PostalEASE* toll-free at 1-877-4PS-EASE (1-877-477-3273), option 1.
   - When prompted, select *PostalEASE*, and then enter your employee identification number (EIN) and USPS PIN.
   - Follow the script and prompts to complete the transaction using the information from your completed *PostalEASE* Health Savings Account (HSA) Contributions Worksheet.

4. After completing your entries, you will hear and should note the following:
   - Confirmation number: _____
   - Your contribution will be processed on this date: _____
   - Your contribution will be reflected in your paycheck that is dated: _____

5. It is recommended that you keep this information and your *PostalEASE* Health Savings Account (HSA) Contributions Worksheet.

You may contact the Human Resources Shared Service Center (HRSSC) for assistance if:
- you are deaf or hard of hearing, or
- you cannot use the telephone, Internet, Employee Self Service kiosk or Intranet for a medical reason, or
- you receive a message in *PostalEASE* directing you to contact the HRSSC when attempting to make a change.

Just call the Employee Service Line at 1-877-477-3273. When prompted, select 5 for the HRSSC. Then select Benefits to speak with a representative who will assist you.

To reach the HRSSC using TTY, call 1-866-260-7507. Leave your name and email address or phone number where you can be reached along with a message indicating your call is regarding a *PostalEASE* related issue.

Privacy Act Statement: Your information will be used to process your Health Savings Account Contributions. Collection is authorized by 39 U.S.C. 401, 409, 410, 1001, 1003, 1004, 1005, 1206; and 29 U.S.C. 2601 et seq.

Providing the information is voluntary, but if not provided, we may not process your transaction. We may disclose your information as follows: in relevant legal proceedings; to law enforcement when the U. S. Postal Service (USPS) or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities or individuals under contract with USPS; to entities authorized to perform audits; to labor organizations as required by law; to federal, state, local or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; to the Merit Systems Protection Board or Office of Special Counsel; the Selective Service System, records pertaining to supervisors and postmasters may be disclosed to supervisory and other managerial organizations recognized by USPS; and to financial entities regarding financial transaction issues.

Appendix F
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

The tables on the following pages highlight what you are expected to pay for selected features under each plan. The charts are not a complete statement of your out-of-pocket obligations in every individual circumstance. Unlike many regular medical plans, the covered out-of-pocket expenses under a High Deductible Health Plan, including office visit copayments and prescription drug copayments, count toward the calendar year deductible and the catastrophic limit. *You must read the plan's brochure for details.*

Premium Contribution (pass through) to HSA/HRA (or personal care account) shows the amount your health plan automatically deposits or credits into your account on a monthly basis for Self Only/Self and Family enrollments. (Consumer-Driven Health Plans credit accounts annually). The amount credited under "Premium Contribution" is shown as a monthly amount for comparison purposes only.

Calendar Year (CY) Deductible Self/Family is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles, coinsurance and copayments, before the plan pays catastrophic benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance and copays, before the plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician after the deductible is met for other than preventive care.

Inpatient Hospital shows what you pay after the deductible is met for hospital services when an inpatient. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days), a coinsurance amount such as

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
APWU Health Plan -CDHP - Nationwide	866-833-3463	474	475	8.65	19.45
GEHA High Deductible Health Plan -HDHP - Nationwide	800-821-6136	341	342	9.69	22.13
MHBP Consumer Option -HDHP- Nationwide	800-694-9901	481	482	11.20	25.38

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FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

20%, or a flat deductible amount (e.g., $200 per admission). This amount does not include charges from physicians or for services that may not be charged by the hospital such as laboratory or radiology.

Outpatient Surgery shows what you pay the doctor for surgery performed on an outpatient basis.

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per person per year).

Prescription Drugs are catagorized using a variety of terms to define what you pay such as generic, brand, Level I, Level II, Tier I, Tier II, etc. In capturing these differences we use the following: **Level I** includes most generic drugs, but may include some preferred brands. **Level II** may include generics and preferred brands not included in Level I. **Level III** includes all other covered drugs with some exceptions for specialty drugs. The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

High Deductible Health Plans and Consumer Driven Health Plans are much different from the other types of plans shown in this Guide. You can use in-network providers to save money. If you use out-of-network providers, however, you not only pay more of the costs but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (For example, you receive a bill from an out-of-network provider for $100 but the plan allows $85 for the service. You pay the higher copayment for out-of-network care plus the $15 difference between $100 – the billed amount – and the plan's allowance of $85.) In addition, the difference you pay between the billed amount and the plan's allowance does not count toward satisfying the catastrophic limit.

Plan Name	Benefit Type	Premium Contribution Self/Family	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
APWU Health Plan-	In-Network	$1200/$2400	$600/$1,200	$3,000/$4,500	15%	None	15%	Nothing	25%/25%/25%
APWU Health Plan-	Out-Network	$1200/$2400	$600/$1,200	$9,000/$9,000	40%+diff.	None	40%+diff.	Nothing up to $1200	Not Covered
GEHA HDHP-	In-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	5%	5%	5%	Nothing	25%/25%/25%
GEHA HDHP-	Out-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	25%	25%	25%	Ded/25%	25%+/25%+/25%+
MHBP Consumer Option-	In-Network	$70/$141	$2,000/$4,000	$5,000/$10,000	$15	$75 day-$750	Nothing	Nothing	$10/$25/$40
MHBP Consumer Option-	Out-Network	$70/$141	$2,000/$4,000	$7,500/$15,000	40%	40%	40%	Not Covered	Not Covered

High Deductible Health Plans and Consumer-Driven Health Plan Member Survey Results

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. See Appendix C for a fuller explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• How often was it easy to get an appointment, the care, tests, or treatment you thought you needed through your health plan?
Getting Care Quickly	• When you needed care right away, how often did you get care as soon as you thought you needed? • Not counting the times you needed care right away, how often did you get an appointment at a doctor's office or clinic as soon as you thought you needed?
How Well Doctors Communicate	• How often did your personal doctor explain things in a way that was easy to understand? • How often did your personal doctor listen carefully to you, show respect for what you had to say, and spend enough time with you?
Customer Service	• How often did written materials or the Internet provide the information you needed about how your health plan works? • How often did your health plan's customer service give you the information or help you needed? • How often were the forms from your health plan easy to fill out?
Claims Processing	• How often did your health plan handle your claims quickly and correctly?
Plan Information on Costs	• How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment, or for specific prescription drug medicines?

Member Survey Results

High Deductible Health Plans Plan Name	Plan Code	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
HDHP National Average		**59.2**	**86.3**	**88.5**	**93.1**	**85**	**88.9**	**57.7**
Aetna Health Fund - Nationwide	22	60	85.6	89.3	93.5	85.9	90	59.2
GEHA High Deductible Health Plan - Nationwide	34	63.7	86.4	88.5	92.3	85.2	87.6	59.3
MHBP Consumer Option - Nationwide	48	54	86.8	87.7	93.6	83.9	89.2	54.7

Consumer-Driven Health Plans Plan Name	Plan Code	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
CDHP National Average		**57.7**	**84.9**	**86.8**	**92.9**	**83.3**	**86.7**	**61.9**
Aetna Health Fund - Nationwide	22	60	85.6	89.3	93.5	85.9	90	59.2
APWU Health Fund - Nationwide	47	64.3	88.4	86.8	92.4	80.3	80.9	65.7
Humana Coverage First -TX	TU, TV	48.9	80.6	84.1	92.9	83.9	89.1	60.9

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High Deductible and Consumer-Driven Health Plans

See page 88-89 for an explanation of the columns on these pages.

The Aetna Healthfund is available in all or part of the following states:

AL, AK, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS,

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Aetna HealthFund -CDHP	877-459-6604	221	222	23.01	61.68
Aetna HealthFund -HDHP	877-459-6604	224	225	9.12	19.88

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Florida					
Coventry Health Care of Flordia -HDHP-Southern Florida	800-441-5501	J41	J42	11.21	27.83
Humana CoverageFirst -CDHP- Tampa Area	888-393-6765	MJ1	MJ2	12.29	27.66
Humana CoverageFirst -CDHP- South Florida Area	888-393-6765	QP1	QP2	10.54	23.71
Georgia					
Humana CoverageFirst -CDHP- Atlanta Area	888-393-6765	AD1	AD2	11.12	25.03
Humana CoverageFirst -CDHP- Macon Area	888-393-6765	LM1	LM2	11.48	25.82
Guam					
TakeCare -HDHP- Guam/N. Mariana Islands/Belau (Palau)	671-647-3526	KX1	KX2	7.89	20.78
Idaho					
Altius Health Plans -HDHP- Southern Region	800-377-4161	9K4	9K5	8.44	17.48

MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, and WY.

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Florida									
Coventry Health Care of Florida		$83.34/$166.67	$2,500/$5,000	$5,000/$10,000	$10	20%	20%	Nothing	$5/$35/$50/20%
Humana CoverageFirst-	In-Network	$83.33	$1,000/$ 000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Georgia									
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Guam									
TakeCare-	In-Network	$86.66/$222.08	$3000/$6000	$5,000/$10,000	20% after Ded	20% after Ded	20% after Ded	Nothing	$20/$40/$150
TakeCare-	Out-Network	$86.66/$222.08	$3000/$6000	$10,000/$20,000	30% after Ded	30% after Ded	30% after Ded	1st $300/ded	30% after Ded
Idaho									
Altius Health Plans		$45.83/$91.66	$1,200/$2,400	$5,000/$10,000	$20	10%	10%	Nothing	$7/$25/$50

High Deductible and Consumer-Driven Health Plans

See page 88-89 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Illinois					
Humana CoverageFirst -CDHP- Central/Northwestern Illinois	888-393-6765	GB1	GB2	12.29	27.66
Humana CoverageFirst -CDHP- Chicago Area	888-393-6765	MW1	MW2	11.71	26.35
Indiana					
Humana CoverageFirst -CDHP- Lake/Porter/LaPorte Counties	888-393-6765	MW1	MW2	11.71	26.35
Iowa					
Coventry Health Care of Iowa -HDHP- Central/Eastern/Western Iowa	800-257-4692	SV4	SV5	8.34	19.91
Kansas					
Coventry Health Care of Kansas (Kansas City)-HDHP- Kansas City Metro Area (KS and MO)	800-969-3343	9H1	9H2	9.42	22.14
Humana CoverageFirst -CDHP- Kansas City Area	888-393-6765	PH1	PH2	10.54	23.71
Kentucky					
Humana CoverageFirst -CDHP- Lexington Area	888-393-6765	6N1	6N2	9.75	21.95
Maryland					
Coventry Health Care -HDHP- All of Maryland	800-833-7423	GZ1	GZ2	9.53	21.82

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Illinois									
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Indiana									
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Iowa									
Coventry Health Care of Iowa		$66.67/$133.34	$2,000/$4,000	$5,000/$10,000	$20	15%	15%	Nothing	$3/$10/$40/$65
Kansas									
Coventry Health Care of Kansas (Kansas City)-HDHP		$66.66/$133.33	$2,500/$5,000	$3,500/$7,000	20%	20%	20%	Nothing	Nothing
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Kentucky									
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Maryland									
Coventry Health Care HDHP	In-Network	$41.67/$83.34	$2,000/$4,000	$4,000/$8,000	$15	Nothing	Nothing	Nothing	$15/$30/$60
Coventry Health Care HDHP	Out-Network	$41.67/$83.34	$2,000/$4,000	$4,000/$8,000	30%	30%	30%	30%	N/A

High Deductible and Consumer-Driven Health Plans

See page 88-89 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Missouri					
Coventry Health Care of Kansas (Kansas City)-HDHP-Kansas City Metro Area (KS and MO)	800-969-3343	9H1	9H2	9.42	22.14
Humana CoverageFirst -CDHP- Kansas City Area	888-393-6765	PH1	PH2	10.54	23.71
New York					
Independent Health Assoc -HDHP- Western New York	800-501-3439	QA4	QA5	9.34	23.96
Ohio					
AultCare HMO -HDHP- Stark/Carroll/Holmes/Tuscarawas/Wayne Co.	330-363-6360	3A4	3A5	7.52	15.07
Pennsylvania					
HealthAmerica Pennsylvania-HDHP- Greater Pittsburgh Area	866-351-5946	Y61	Y62	11.55	26.59
HealthAmerica Pennsylvania-HDHP- Central Pennsylvania	866-351-5946	YW1	YW2	15.82	32.60
UPMC Health Plan -HDHP- Western Pennsylvania	888-876-2756	8W4	8W5	11.52	25.80
Texas					
Humana CoverageFirst -CDHP- Corpus Christi Area	888-393-6765	TP1	TP2	11.48	25.82
Humana CoverageFirst -CDHP- San Antonio Area	888-393-6765	TU1	TU2	11.71	26.35
Humana CoverageFirst -CDHP- Austin Area	888-393-6765	TV1	TV2	11.91	26.79

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Missouri									
Coventry Health Care of Kansas (Kansas City)-HDHP		$66.66/$133.33	$2,500/$5,000	$3,500/$7,000	20%	20%	20%	$20/$35/0%	Nothing
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
New York									
Independent Health Assoc.-	In-Network	$66.41/$166.67	$2000/$4000	$5000/$10000	$15	Nothing	20%	$15	$7/$25/$40
Independent Health Assoc.-	Out-Network	$66.41/$166.67	$2000/$4000	$5000/$10000	40%	40%	40%	Ded/40%	N/A
Ohio									
AultCare HMO-	In-Network	$74.58/$149.58	$2,000/$4,000	$4,000/$8,000	20%	20%	20%	Nothing	20%/20%/20%
AultCare HMO-	Out-Network	$74.58/$149.58	$4,000/$8,000	$8,000/$16,000	40% UCR	40% UCR	40% UCR	50% UCR	40%/40%/40%
Pennsylvania									
HealthAmerica Pennsylvania-HDHP		$52.09/$104.17	$1,500/$3,000	$4,000/$8,000	$15	None	Nothing	$15/$25	$5/$35/$50
HealthAmerica Pennsylvania-HDHP		$52.09/$104.17	$1,500/$3,000	$4,000/$8,000	$15	None	Nothing	Nothing	$5/$35/$50
UPMC Health Plan-	In-Network	$104.17/$208.34	$2,500/$5,000	$4,000/$8,000	Nothing after ded	None	Nothing after ded	Nothing	$5/$35/$70
UPMC Health Plan-	Out-Network	$104.17/$208.34	$2,500/$5,000	$5,500/$11,000	20% after ded	20% after ded	20% after ded	20%	N/A
Texas									
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+

High Deductible and Consumer-Driven Health Plans

See page 88-89 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Utah					
Altius Health Plans -HDHP- Wasatch Front	800-377-4161	9K4	9K5	8.44	17.48
Washington					
KPS Health Plans -HDHP- All of Washington	800-552-7114	L14	L15	9.25	20.22
Wyoming					
Altius Health Plans -HDHP- Uinta County	800-377-4161	9K4	9K5	8.44	17.48

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Utah									
Altius Health Plans		$45.83/$91.66	$1,200/$2,400	$5,000/$10,000	$20	10%	10%	Nothing	$7/$25/$50
Washington									
KPS Health Plans-	In-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	20%	None	20%	Nothing up to $400	$10/$35/50%/ $40 max $100
KPS Health Plans-	Out-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	40%	None	40%	Not Covered	Not Covered
Wyoming									
Altius Health Plans		$45.83/$91.66	$1,200/$2,400	$5,000/$10,000	$20	10%	10%	Nothing	$7/$25/$50

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

- If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.
- If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW or www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.
- Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-800-362-1504

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants/default.aspx
Phone: (Outside of Maricopa County): 1-877-764-5437
Phone: (Maricopa County): 602-417-5437

ARKANSAS – CHIP
Website: http://www.arkidsfirst.com/
Phone: 1-888-474-8275

CALIFORNIA – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-866-298-8443

COLORADO – Medicaid and CHIP
Medicaid Website: http://www.colorado.gov/
Medicaid Phone: 1-800-866-3513
CHIP Website: http:// www.CHPplus.org
CHIP Phone: 303-866-3243

FLORIDA – Medicaid
Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/ (Programs, then Medicaid)
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9948

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.khpa.ks.gov
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://www.la.hipp.dhh.louisiana.gov
Phone: 1-888-342-6207

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html
Phone: 1-800-321-5557

MASSACHUSETTS – Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth
Medicaid & CHIP Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/ (Health Care, then Medical Assistance)
Phone: (Outside of Twin Cities area): 800-657-3739
Phone: (Twin Cities area): 651-431-2670

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm
Phone: 573-751-6944

MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.dhhs.ne.gov/med/medindex.htm
Phone: 1-877-255-3092

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

NEVADA – Medicaid and CHIP
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900
CHIP Website: http://www.nevadacheckup.nv.org/
CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/ombp/index.htm
Phone: 603-271-4238

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW MEXICO – Medicaid and CHIP
Medicaid Website: http://www.hsd.state.nm.us/mad/index.html
Medicaid Phone: 1-888-997-2583
CHIP Website: http://www.hsd.state.nm.us/mad/index.html (Insure New Mexico)
CHIP Phone: 1-888-997-2583

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.nc.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov
Medicaid & CHIP Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm
Phone: 1-800-644-7730

RHODE ISLAND – Medicaid
Website: www.dhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov/
Phone: 1-888-549-0820

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT– Medicaid
Website: http://www.greenmountaincare.org
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://www.wvrecovery.com/hipp.htm
Phone: 304-342-1604

WISCONSIN – Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://www.health.wyo.gov/healthcarefin/index.html
Telephone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

Summary Information

	New Hires Can Enroll	Open Season	How to Enroll	Program Website
FEHB	Within 60 days from new hire date	Annual – November 14 to December 13, 2011 5 p.m. Central Time	*PostalEASE* https://liteblue.usps.gov 1-877-477-3273, option 1	**www.opm.gov/insure/health**
FEDVIP	Within 60 days from new hire date	Annual – November 14 to December 12, 2011 11:59 p.m. Eastern Time	Go to www.BENEFEDS.com or call 1-877-888-3337	**www.opm.gov/insure/dental** **www.opm.gov/insure/vision**
FSA	During 26th or 27th pay period after career appointment	Annual – November 7 to December 25, 2011 5 p.m. Central Time	*PostalEASE*	**https://liteblue.usps.gov**
FEGLI	Within 60 days from new hire date for optional insurance; automatically enrolled in Basic insurance until you take action to cancel	No annual Open Season	Via SF 2817 for new hires Others provide medical information on SF 2822	**www.opm.gov/insure/life**
FLTCIP	Apply (not necessarily enroll) within 60 days from new hire date with abbreviated underwriting	No annual Open Season	Go to www.LTCFEDS.com/usps or call 1-800-582-3337	**www.opm.gov/insure/ltc**

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