The **2013**

Guide To Benefits

For Certain Temporary (Non-Career) United States Postal Service Employees

The information contained in this *Guide to Benefits* is only a summary of the benefits available under each program and health plan. Before you select a plan or option, please read the health plan's federal brochure as it is the official statement of benefits. All benefits are subject to the definitions, limitations, and exclusions set forth in the health plan's federal brochure.

Visit us at: www.opm.gov/insure

Healthcare and Insurance

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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 2013, 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

	Newly Eligible Employees Can Enroll	Open Season	How to Enroll	Program Website
FEHB	Within 60 days of becoming eligible	Annual – November 12 to December 11, 2012 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 of becoming eligible	Annual – November 12 to December 10, 2012 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**
FLTCIP	Apply (not necessarily enroll) within 60 days of becoming eligible 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

The Postal Service offers three benefits programs to eligible noncareer employees. This Guide includes information on the three programs:

- Federal Employees Health Benefits Program
- Federal Employees Dental and Vision 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, this Guide 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.

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

Newly Eligible Employees

As a 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 8 for general information on FEHB (including eligibility) and for guidance on choosing a plan; 2. If you decide to enroll, examine the 2013 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; TTY 1-866-260-7507.
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 2013 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 2013 FEDVIP Guide for USPS Employees for complete information.
FLTCIP	1. See page 24 for general information on FLTCIP (including eligibility) and for guidance on making a decision whether to apply; 2. See page 25 for information on how to apply for coverage.

Open Season Snapshot

Current Employees

During Open Season, you have the opportunity to enroll or 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 2013 premiums and satisfaction survey results in Appendix F; 2. Examine your plan's 2013 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 2013, **do nothing** – your enrollment will continue automatically; 5. If **not** satisfied with your current plan for 2013, see Appendix B for guidance on choosing another plan. 6. See page 6 for information on FEHB and retirement.	1. See page 8 for general information on FEHB (including eligibility) and Appendix B for guidance on choosing a plan; 2. If you decide to enroll, examine the 2013 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 32 – 38 and enroll via *PostalEASE*. 4. Contact the Human Resources Shared Service Center (HRSSC), 1-877-477-3273, option 5; TTY 1-866-260-7507 if you require assistance.
FEDVIP	1. Check your plan's 2013 premiums in the FEDVIP Guide and examine your plan's 2013 brochure for benefit and enrollment/service area changes; 2. If also enrolled in FEHB, check your 2013 FEHB brochure for any changes in dental and/or vision benefits; 3. If satisfied with your plan's rates and benefits for 2013, **do nothing** – your enrollment will continue automatically; 4. If **not** satisfied with your current plan for 2013, 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 2013 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 2013 FEHB brochure for any changes in dental and/or vision benefits. 4. See page 22 and the 2013 FEDVIP Guide 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 your retirement date, 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 or IHS 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 they 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.

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 Retirement and Benefits. 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.

The purpose of this 2013 Guide to Benefits is to provide information about enrollment and premium features that USPS non-career employees must consider when selecting a health insurance plan under the FEHB Program. The Guide is a summary of FEHB plans – the plan brochures give specific benefit information. You can get individual plan brochures directly from the health plans or from the OPM web site **www.opm.gov/insure/health** which also has a copy of this guide and other helpful information. Some plans available to federal and Postal employees are sponsored by unions or associations that charge a membership fee in addition to health insurance premiums. You should read individual plan brochures carefully before making any final coverage decisions.

FEHB eligibility, enrollment requirements premium costs, and the plans available for 2013 are the same for USPS temporary (non-career) employees as for federal (non-postal) temporary employees.

Non-career employees who are eligible for FEHB may elect to have premium costs withheld from pay on a pre-tax basis. See pages 17 through 19 of this Guide for more information regarding pre-tax payment. There are advantages and disadvantages to the pre-tax payment of premium contributions that you need to understand. Certain restrictions may affect your ability to cancel coverage outside of FEHB Open Season.

Federal Employees Health Benefits (FEHB) Program

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, or the full periods of service since your first opportunity to enroll if less than 5 years, 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.

If you are currently enrolled in the FEHB Program and do not want to change plans or enrollment type during open season, you do not need to do anything. Your enrollment will continue automatically.

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). If you do not pay premiums pre-tax, you may change to Self Only or cancel at anytime.
- 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.

What enrollment types are available?

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

How much does it cost?

For Postal Category 1, the Postal Service pays the lesser of 80% of the average premium of all plans weighted by the number of enrollees in each plan but not more than 83.5% of the total premium for any individual plan. For Postal Category 2, the Postal Service pays the lesser of 78% of the average premium of all plans weighted by the number of enrollees in each plan but not more than 81.25% of the total premium for any individual plan.

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; TTY 1-866-260-7507 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 your retirement date, 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.**

Coverage

Newly Eligible – Newly eligible non-career employees may select a health plan within 60 days of becoming eligible.

Currently Enrolled – Non-career employees currently enrolled under the FEHB program have an opportunity to select or change plans:

- During Open Season, or;
- When certain qualifying life events occur (see Table of Permissible Changes on pages 40 through 43 of this Guide). **NOTE: These elections must be made within the time limits as specified in the table.**

Your choice of plans and options includes Self Only coverage just for you, or Self and Family coverage for you, your spouse, and children under age 26 (and in some cases, a disabled child 26 years or older who is incapable of self-support).

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 recognized natural children, legally adopted children, and stepchildren.

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

Contact the HRSSC for additional information 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

Dual enrollment is when you or an eligible family member under your Self and Family enrollment are covered under more than one FEHB enrollment. No enrollee or family member may receive benefits under more than one FEHB enrollment. If you or a family member receives benefits under more than one plan, it is considered fraud and you are subject to disciplinary action.

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
- Insufficient Pay*
- Separation
- Divorce
- Death
- Relocation

* If at any time after your initial enrollment, you do not have sufficient earnings to allow for health insurance premium withholdings, the unpaid premium will be withheld in the following pay period provided there is a sufficient amount of earnings to cover the premium cost after mandatory deductions have been made. When two adjustments for insufficient earnings have occurred, you will receive a statement and an invoice will be sent to your employing office for the total amount due. The total amount of the invoice must be paid within 30 days of the invoice date or your FEHB coverage will be terminated retroactive to the date the initial unpaid health insurance premiums were due.

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 the Human Resources Shared Service Center (HRSSC) 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 40 through 43 of this Guide. If you have questions, contact the HRSSC on 1-877-477-3273, option 5; TTY 1-866-260-7507

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.

When can I enroll?

If you are an employee who has become newly eligible to enroll, you may enroll within 60 days of becoming eligible, or you may be eligible to enroll during the annual Open Season. You may also be eligible to enroll, change your enrollment type, or change plans outside of Open Season if you experience a qualifying life event (QLE) such as a change in family or other insurance coverage status. See the Table of Permissible Changes on pages 40 through 43 for more specific information about qualifying life events that permit employees to enroll or change enrollment in the FEHB Program.

For 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.

Note: Certain pay status requirements may also apply. The HRSSC can advise you of your specific effective date.

FEHB Open Season

Each year eligible employees have the opportunity to enroll or change enrollment during an Open Season. **The 2012 Open Season is from November 12 through December 11 at 5:00 p.m. Central Time.** Eligible 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 12, 2012. **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 12, 2013, and the change in premium rate deductions will be seen on your February 1, 2013, 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 2013. If your plan is not participating in 2013 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 11, 2013.

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 40 through 43 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 individual plans that interest you, and the bulletin board notices on health benefits topics. These topics include family member eligibility, the option to continue or to terminate enrollment during periods of non-pay status or insufficient pay, dual enrollment prohibition, coverage for former spouses, and discontinued health insurance plans. If you choose to have your premium contribution deducted on a pre-tax basis, be sure to read the section in this Guide 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 40 through 43 of this Guide.

You can go to https://liteblue.usps.gov and download all of the Benefits Guides including the Guide for Non-APWU, Non-NRLCA Career USPS Employees, the Guide for APWU and NRLCA Career Employees, the Guide for Postal Career Executive Service Employees, the Guide for United States Postal Service Inspectors and Office of Inspector General Employees, Guide for Information Technology/Accounting Services Employees, and the Guide for Certain Temporary (Non-career) USPS Employees. The Guide for TCC and Former Spouse Enrollees, and 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, policy, enrollment criteria, continued coverage after certain life events, or any other FEHB policies, or if you need assistance making your choice in *PostalEASE*, contact the HRSSC on 1-877-477-3273, option 5; TTY 1-866-260-7507.

Federal Employees Health Benefits (FEHB) Program

How do I enroll or change my enrollment?

- Complete the *PostalEASE* FEHB Worksheet on pages 32 through 38.
- 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

FEHB Program Health Information Technology and Price/Cost Transparency

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 eligible 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 32 - 38 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 2013 plan year, you may do so during the annual FEHB Open Season, which is from November 12 through December 11, 2012, 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 non-career employee, you may need to contact the HRSSC for initial enrollment within 60 days of becoming eligible or during the following Open Season unless you experience a qualifying life event (QLE).

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 meet the requirements on page 6, (Thinking About Retiring?). 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

Premium payment for non-career employees is automatically withheld on an after-tax basis. However, 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

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. If you want to pay your premiums with pre-tax money, you must request Postal Service (PS) Form 8202, *Pre-Tax Health Insurance Premium Election/Waiver Form for Non-Career Employees* from the Human Resources Shared Service Center (HRSSC) on 1-877-477-3273, option 5; TTY 1-866-260-7507. For more information, see the section "How to Elect or Waive 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 40 through 43 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 40 through 43 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.

Pre-Tax Payment of Premium Contributions

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 a *PostalEASE* FEHB Worksheet to the HRSSC within the time limits shown in the column labeled "Time Limits in Which Change May be Permitted" in the table on pages 40 through 43 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 Human Resources Shares Service Center (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 on 1-877-477-3273, option 5; TTY 1-866-260-7507 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 Elect or Waive 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 are eligible and you wish to pay your premiums with pre-tax money, you must contact the HRSSC and ask for Postal Service (PS) Form 8202, *Pre-Tax Health Insurance Premium Election/Waiver Form for Noncareer Employees*. During Open Season, complete the form and return it to the HRSSC by close of business December 11, 2012. If this is your initial opportunity to enroll in FEHB and you qualify for pre-tax payments, 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 Table on pages 40 through 43 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 previously submitted an election to participate in pre-tax payments and you want to begin paying your premiums with after-tax money again, you may submit a new PS Form 8202 to restore after-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 2013, provided you remain eligible for the program. Enrollment continues year to year, automatically. **Please Note**: your premiums and benefits may change for 2013.

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. In order to determine whether your dependent child age 22 or over is incapable of self-support, you may be asked to provide a medical certificate that describes a disability with onset prior to age 22; or acceptable documentation that the medical condition is not compatible with employment, that there is a medical reason to restrict your child from working, or that he/she may suffer injury or harm by working.

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

Note: 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.

When can I enroll or change my enrollment?

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 or change my enrollment?

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 2012), 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

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 even if you do not apply. 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.

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.

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.

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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.

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

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. Also Qualifying Life Events (QLEs) 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 on page 39 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; TTY 1-866-260-7507).

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.

Types of Plans	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 BC/BS 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. You file a claim to obtain reimbursement from your HRA.
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.	Some if you don't use network providers. 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/hedis/2012/index.asp.

   • 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 insurance premiums to the 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 enrollees 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 FEHB 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 12, 2012 – December 11, 2012, 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, Non-NRLCA career USPS employees, **RI 70-2A** for APWU and NRLCA career USPS employees, **RI 70-2IN** for career U.S. Postal Inspectors and Office of the Inspector General employees, **RI 70-2IT** for IT/ASC 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, dates of birth, e-mail addresses and telephone numbers for all **eligible family members** that will be covered under your health benefits enrollment. You will also need telephone numbers, email and mailing addresses for eligible family members who don't live with you. 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 "HT." For example, the Blue Cross Self and Family Standard plan will be shown as HP105FAM or HT105FAM, 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***.

Dual enrollment is when you or an eligible family member under your Self and Family enrollment are covered under more than one FEHB enrollment. No enrollee or family member may receive benefits under more than one FEHB enrollment. If you or a family member receives benefits under more than one plan, it is considered fraud and your are subject to disciplinary action.

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, Option 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, Non-NRLCA career USPS employees • RI 70-2A for APWU and NRLCA 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 70-2IT for IT/ASC career 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) Are you covered by insurance other than Medicare?

❑ Yes ❑ No

If Yes, indicate type of other insurance in item 2.

2) Identify Type of Other Insurance Coverage

❑ Medicare Part A ❑ Medicare Part B ❑ Medicare Part D
❑ TRICARE ❑ OTHER_____

Other Insurance Policy No._____

❑ FEHB An FEHB Self & Family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.

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 residents reside with you.**

2) Complete the following information for each dependent

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship code
Address *(if different from enrollee)* If you are covered by Medicare,		If you are covered by Medicare, check all that apply ☐ A ☐ B ☐ D	Medicare Claim Number	
		Are you covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No		
Indicate the type(s) of other insurance: ☐ TRICARE ☐ Other *Name of other insurance:* ________ *Policy number:* ________ ☐ FEHB *An FEHB Self and Family enrollment covers all eligible family members. No person may be covered by more than one FEHB enrollment.*				
Email address *(if home address is different from enrollee's)*		Preferred telephone number *(if home address is different from enrollee's)*		

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship code
Address *(if different from enrollee)* If you are covered by Medicare,		If you are covered by Medicare, check all that apply ☐ A ☐ B ☐ D	Medicare Claim Number	
		Are you covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No		
Indicate the type(s) of other insurance: ☐ TRICARE ☐ Other *Name of other insurance:* ________ *Policy number:* ________ ☐ FEHB *An FEHB Self and Family enrollment covers all eligible family members. No person may be covered by more than one FEHB enrollment.*				
Email address *(if home address is different from enrollee's)*		Preferred telephone number *(if home address is different from enrollee's)*		

Name of family member *(last, first, middle initial)*	Social Security Number	Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Relationship code
Address *(if different from enrollee)* If you are covered by Medicare,		If you are covered by Medicare, check all that apply ☐ A ☐ B ☐ D	Medicare Claim Number	
		Are you covered by insurance other than Medicare? ☐ Yes, indicate below. ☐ No		
Indicate the type(s) of other insurance: ☐ TRICARE ☐ Other *Name of other insurance:* ________ *Policy number:* ________ ☐ FEHB *An FEHB Self and Family enrollment covers all eligible family members. No person may be covered by more than one FEHB enrollment.*				
Email address *(if home address is different from enrollee's)*		Preferred telephone number *(if home address is different from enrollee's)*		

*** Relationship Codes:**

01 = Spouse
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 = Child Age 26 or Older Incapable of Self-Support (Requires Certification to be Filed With the HRSSC)

PostalEASE FEHB Worksheet

Part 8

Employee Signature _____ **Date** _____

Email Address _____ **Preferred telephone number** _____

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 Tables 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; TTY 1-866-260-7507.

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
Event 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 H.R. .Shared Service Center**
1	Employee electing to receive or receiving pre-tax (premium conversion) benefits							
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 • 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
Event 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 the H.R. Shared Service Center**
1F	Employee restored to civilian position after serving in uniformed services[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
			Employees may enroll or change beginning 31 days before leaving the old post of duty					
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 1P)*	N/A *(see 1P)*	N/A *(see 1P)*	Any time beginning on the 30th day before becoming eligible for Medicare

[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 H.R. Shared Service Center, 1-877-477-3273, option 5; TTY 1-866-260-7507

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
Event 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 the H.R. Shared Service Center**
1M	Employee 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.
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

[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 employee's membership terminates, (e.g., for failure to pay membership dues), the employee organization will notify the agency to **terminate** the enrollment.

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

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
Event 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 the H.R. Shared Service Center**
1P	Enrolled 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 1L) • 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 • 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 (includes state, local or foreign government or private sector employment) [8]	No	No	No	Yes[9]	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[9]	Yes	Yes	Within 60 days after QLE
1R	Employee or eligible family member becomes eligible for assistance under Medicaid or a State Children's Health Insurance Program (CHIP).	Yes	Yes	Yes	Yes[9]	Yes	Yes	Within 60 days after the date employee or family member becomes eligible for assistance.

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

[9] Employees may change to Self Only outside of Open Season only if the QLE caused all eligible family members to acquire other health insurance coverage. Employees may cancel enrollment outside of Open Season only if the QLE caused the enrollee and all eligible family members to acquire other health insurance coverage.

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Appendix F
FEHB Plan Comparison Charts

Nationwide Fee-for-Service Plans
(Pages 46 through 49)

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), first on 1-877-477-3273, option 5; TTY 1-866-260-7507.

The Health Maintenance Organization (HMO) and Point-of-Service (POS) section begins on page 51.

The High Deductible Health Plan (HDHP) and Consumer-Driven Health Plan (CDHP) section begins on page 88.

The tables on the following pages highlight selected features that may help you narrow your choice of health plans. The tables do not show all of your possible out-of-pocket costs. All benefits are subject to the definitions, limitations, and exclusions set forth in each plan's federal brochure which is the official statement of benefits available under the plan's contract with the Office of Personnel Management. Always consult plan brochures before making your final decision.

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	245.02	554.03
Blue Cross and Blue Shield Service Benefit Plan (BCBS) -std	Local phone #	104	105	276.75	625.09
Blue Cross and Blue Shield Service Benefit Plan (BCBS) -basic	Local phone #	111	112	236.30	553.30
GEHA Benefit Plan (GEHA) -high	800-821-6136	311	312	282.00	641.35
GEHA Benefit Plan (GEHA) -std	800-821-6136	314	315	179.74	408.76
MHBP -std	800-410-7778	454	455	287.45	657.84
MHBP -Value Plan	800-410-7778	414	415	172.44	411.12
NALC -high	888-636-6252	321	322	264.99	575.43
SAMBA -high	800-638-6589	441	442	305.39	719.19
SAMBA -std	800-638-6589	444	445	243.16	555.35
Plan Name: Open Only to Specific Groups					
Compass Rose Health Plan (CRHP) -high	877-531-1159	421	422	262.18	602.73
Foreign Service Benefit Plan (FS) -high	202-833-4910	401	402	229.12	564.54
Panama Canal Area Benefit Plan (PCABP) -high	800-424-8196	431	432	206.22	430.45
Rural Carrier Benefit Plan (Rural) -high	800-638-8432	381	382	278.41	568.66

The information in this Guide is not the official statement of benefits. Each plan's Federal brochure is the official statement of benefits.

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 + 35%+	$20 35%+	15% 35%+	Nothing Nothing	20%/15%MedicareB 45% +	30%Tier2/30%Tier4/45%Tier 3 45%+/45%+	Yes Yes
BCBS -basic	PPO	None	None	$150/day x 5	$25	$150	Nothing	$10	$40/$50Tier4/50%($50min)Tier3	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%	$5 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%/45% 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	$350 $400	None None	$200 $400	$15 30%	10% 30%	Nothing 30%	$5 $5	$35/30%or$50 $35/30%or$50	Yes Yes
FS	PPO Non-PPO	$250 $300	None None	Nothing $200	10% 30%	10% 30%	Nothing 20%	$10 $10	25%/$30 min./N/A 25%/$30 min./N/A	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 25%	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?

		Member Survey Results						
Plan Name: Open to All	**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		**80.7**	**92.1**	**91.9**	**94.8**	**90.5**	**93.3**	**72.4**
APWU Health Plan -high	47 47	76.5	92	91.4	95.6	86.4	90.4	69.5
Blue Cross and Blue Shield Service Benefit Plan -std	10 10	79.9	91.5	91	94.3	90.3	96.2	68.9
Blue Cross and Blue Shield Service Benefit Plan -basic	11	72.1	90.2	89.9	92.5	92.5	92.8	66.7
GEHA Benefit Plan -high	31 31	86.3	90.4	91.1	95.5	91.7	93.7	74.3
GEHA Benefit Plan -std	31 31	74.5	89	91.6	94.3	84	91.9	74.1
MHBP -std	45 45	83.9	92.9	93	96.4	92.8	94.2	71.5
MHBP -Value Plan	41 41	64.5	89.6	87.1	94.1	90.4	90.8	61.2
NALC -high	32 32	86.3	95	92.2	95.7	93.7	96.4	77
SAMBA -high	44 44	91.1	94.6	94.6	96.4	92.1	96.8	80.2
SAMBA -std	44 44	78.5	92.5	92.9	94.2	92.9	93.4	74
Plan Name: Open Only to Specific Groups								
FFS National Average		**80.7**	**92.1**	**91.9**	**94.8**	**90.5**	**93.3**	**72.4**
Compass Rose Health Plan	42 42	85.1	93.7	95.8	95.2	90.2	90.3	71.4
Foreign Service Benefit Plan	40 40	78.9	90.8	90.7	93.8	89.7	90.3	72
Panama Canal Area Benefit Plan	43 43							
Rural Carrier Benefit Plan	38 38	87.4	95.4	93.1	95.7	92.3	96.6	79

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			**80.7**	**92.1**	**91.9**	**94.8**	**90.5**	**93.3**	**72.4**
Blue Cross and Blue Shield Service - Standard	Arizona	10	86.3	90.6	89.5	92.9	91.2	95.3	74
Benefit Plan - Basic		11	79	90.5	86.6	92	91.8	96	68.6
Blue Cross and Blue Shield Service - Standard	California	10	84.7	91.9	89.4	93.7	89.7	93.7	66.4
Benefit Plan - Basic		11	72.5	87	87.5	92.3	88.9	92.6	65.1
Blue Cross and Blue Shield Service - Standard	District of Columbia	10	76.8	89.2	88.8	93.2	83.4	89.8	66.2
Benefit Plan - Basic		11	70.3	87.4	88.6	92.1	83.6	92.4	62
Blue Cross and Blue Shield Service - Standard	Florida	10	91.4	93.4	92.5	95.2	93.7	95.8	75.3
Benefit Plan - Basic		11	77.4	90.2	86.5	93.2	88.2	94.5	67.3
Blue Cross and Blue Shield Service - Standard	Illinois	10	84.3	91.3	92.3	94.7	89.5	95.3	71.1
Benefit Plan - Basic		11	78.2	91.9	89.3	94.4	88.8	95.1	66
Blue Cross and Blue Shield Service - Standard	Maryland	10	84.1	93.5	92.3	94.1	85.9	91	72.6
Benefit Plan - Basic		11	74.4	91.6	87.2	94.6	89.1	94.7	65.1
Blue Cross and Blue Shield Service - Standard	Texas	10	90.2	92.6	90.8	95.8	88.7	98	72
Benefit Plan - Basic		11	81.7	91.9	90.5	94.6	81.7	91	68.6
Blue Cross and Blue Shield Service - Standard	Virginia	10	86.8	92.6	91.8	94.9	89.4	95.7	73.6
Benefit Plan - Basic		11	79.8	91.7	92.8	94.3	89.4	96.3	67.8

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Appendix F
FEHB Plan Comparison Charts

Health Maintenance Organization Plans and Plans Offering a Point-of-Service Product (Pages 52 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 drugs – 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 51 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
Alabama					
Aetna Value Plan-Most of Alabama	877-459-6604	F54	F55	229.60	521.41
Arizona					
Aetna Value Plan-All of Arizona	877-459-6604	G54	G55	225.45	511.98
Aetna Open Access-HIgh-Phoenix and Tucson Areas	877-459-6604	WQ1	WQ2	294.67	712.56
Health Net of Arizona, Inc. -high- Maricopa/Pima/Other AZ counties	800-289-2818	A71	A72	289.70	733.40
Health Net of Arizona, Inc. -std- Maricopa/Pima/Other AZ counties	800-289-2818	A74	A75	242.02	612.67
Arkansas					
Aetna Value Plan - Most of Arkansas	877-459-6604	F54	F55	229.60	521.41
QualChoice - high - All of Arkansas	800-235-7017	DH1	DH2	273.95	641.52
QualChoice - std - All of Arkansas	800-235-7017	DH4	DH5	213.66	500.34
California					
Aetna HMO - Los Angeles and San Diego Areas	877-459-6604	2X1	2X2	259.29	604.82
Anthem Blue Cross Select HMO - High - Southern California	800-235-8631	B31	B32	261.07	595.24
Blue Shield of CA Access+HMO -high- Southern Region	800-880-8086	SI1	SI2	255.95	575.91
Health Net of California -high- Northern Region	800-522-0088	LB1	LB2	472.38	1092.17
Health Net of California -std- Northern Region	800-522-0088	LB4	LB5	449.88	1040.16
Health Net of California -high- Southern Region	800-522-0088	LP1	LP2	315.46	729.37
Health Net of California -std- Southern Region	800-522-0088	LP4	LP5	300.44	694.64
Kaiser Foundation Health Plan of California -high- Northern California	800-464-4000	591	592	336.92	804.26
Kaiser Foundation Health Plan of California -std- Northern California	800-464-4000	594	595	283.13	662.53
Kaiser Foundation Health Plan of California -high- Southern California	800-464-4000	621	622	239.17	552.78
Kaiser Foundation Health Plan of California -std- Southern California	800-464-4000	624	625	153.26	354.23
UnitedHealthcare of California -high- Central and Southern California	866-546-0510	CY1	CY2	257.31	588.00
UnitedHealthcare of California -std- Central and Southern California	866-546-0510	CY4	CY5	219.37	501.53

The information contained in this Guide is not the official statement of benefits. Each plan's Federal brochure is the official statement of benefits.

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			67.7	85	85.4	93.5	85.2	87.7	66.4
Alabama												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Arizona												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	60.5	82.6	82.9	90.1	87.2	90.7	62.7
Health Net of Arizona, Inc.-High	$20/$40	$200/day x 5	$10	$30/50%	Yes	73.2	87.6	85.2	92.8	84.6	93.5	70.7
Health Net of Arizona, Inc.-Std	$25/$50	25%	$10	$40/50%	Yes	73.2	87.6	85.2	92.8	84.6	93.5	70.7
Arkansas												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
QualChoice-In-Network QualChoice-Out-Network	$20/$30 40%/40%	$100max$500 40%	$0 N/A	$40/$60 N/A	Yes No							
QualChoice- In-Network	$20/$40	$200max$1,000	$5	$40/$60	Yes							
California												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	59.6	72.6	77.8	88.8	82.4	88.2	58.8
Anthem Blue Cross Blue Shield HMO-High	$25/$35	None	$5,$40,$60	$5,$40, $60/$60	Yes							
Blue Shield of CA Access+HMO-High	$20/$30	$150/ day x 3	$10	$35/$50	Yes	73.6	82.8	86.2	91.9	87	84.8	65.3
Health Net of California-High	$20/$30	$150/day x 5	$10	$35/$60	Yes	66.2	83.2	79.4	90.9	81.5	83.3	65
Health Net of California-Std	$30/$50	$750	$15	$35/$65	Yes	66.2	83.2	79.4	90.9	81.5	83.3	65
Health Net of California-High	$20/$30	$150/day x 5	$10	$35/$60	Yes	66.2	83.2	79.4	90.9	81.5	83.3	65
Health Net of California-Std	$30/$50	$750	$15	$35/$65	Yes	66.2	83.2	79.4	90.9	81.5	83.3	65
Kaiser Foundation HP of California -High	$15/$25	$250	$10	$30/$30	Yes	77.8	86.6	85.7	92.1	84	74.2	62.2
Kaiser Foundation HP of California -Std	$30/$40	$500	$15	$35/$35	Yes	77.8	86.6	85.7	92.1	84	74.2	62.2
Kaiser Foundation HP of California -High	$10/$20	$250	$10	$30/$30	Yes	82.5	82.4	78.2	93.2	83.8	82.4	70.2
Kaiser Foundation HP of California -Std	$20/$40	$500	$15	$35/$35	Yes	82.5	82.4	78.2	93.2	83.8	82.4	70.2
United Healthcare of California -High	$20/$35	$150/day x 4	$10	$35/$60	Yes	65.3	79.7	78.1	89.9	77.6	86.9	59.9
United Healthcare of California -Standard	$25/$40	30%	$10	$25/$50	Yes							

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

See page 51 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
Colorado					
Aetna Value Plan - All of Colorado	877-459-6604	G54	G55	225.45	511.98
Kaiser Foundation Health Plan of Colorado -high- Denver/Boulder/Southern Colorado areas	800-632-9700	651	652	281.31	635.77
Kaiser Foundation Health Plan of Colorado -std- Denver/Boulder/Southern Colorado areas	800-632-9700	654	655	166.80	376.97
Connecticut					
Aetna Value Plan - All of Connecticut	877-459-6604	EP4	EP5	223.19	506.85
Delaware					
Aetna Value Plan - All of Delaware	877-459-6604	EP4	EP5	223.19	506.85
Aetna Open Access -High- Kent/New Castle/Sussex areas	877-459-6604	P31	P32	499.15	1204.37
Aetna Open Access -Basic- Kent/New Castle/Sussex areas	877-459-6604	P34	P35	372.11	859.25
District of Columbia					
Aetna Value Plan - All of Washington, D.C.	877-459-6604	F54	F55	229.60	521.41
Aetna Open Access -high- Washington, DC Area	877-459-6604	JN1	JN2	392.10	878.26
Aetna Open Access -basic- Washington, DC Area	877-459-6604	JN4	JN5	246.99	561.70
CareFirst BlueChoice -high- Washington, D.C. Metro Area	888-789-9065	2G1	2G2	262.88	591.39
CareFirst BlueChoice -std- Washington, D.C. Metro Area	888-789-9065	2G4	2G5	249.74	561.82
Kaiser Foundation Health Plan Mid-Atlantic States -high- Washington, DC area	877-574-3337	E31	E32	261.37	601.15
Kaiser Foundation Health Plan Mid-Atlantic States -std- Washington, DC area	877-574-3337	E34	E35	174.38	401.06
M.D. IPA -high- Washington, DC area	877-835-9861	JP1	JP2	267.90	617.78

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			67.7	85	85.4	93.5	85.2	87.7	66.4
Colorado												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Kaiser Foundation HP of Colorado -High	$20/$40	$250	$10	$35/$60	Yes	70.8	84.3	84.3	93.5	80.1	81.4	67.1
Kaiser Foundation HP of Colorado -Std	$25/$45	10%	$15	$40/$80	Yes	70.8	84.3	84.3	93.5	80.1	81.4	67.1
Connecticut												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Delaware												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	66.3	83.3	85.2	92.9	84.7	89.8	63.8
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	66.3	83.3	85.2	92.9	84.7	89.8	63.8
District of Columbia												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$15/$30	$150/day x 3	$5	$35/$65	Yes	64.9	84.7	85.2	94.3	89.1	85.7	62.1
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$65	Yes	64.9	84.7	85.2	94.3	89.1	85.7	62.1
CareFirst BlueChoice-High	$25/$35	$200	Nothing	$30/$50	Yes	63.1	84.3	87.3	91.5	79.8	85.9	55.8
CareFirst BlueChoice-In-Network	Nothing/$35	$200	Nothing	$30/$50	Yes	63.1	84.3	87.3	91.5	79.8	85.9	55.8
CareFirst BlueChoice-Out-Network	$70/$70	$500	Nothing	$30/$50	Yes	63.1	84.3	87.3	91.5	79.8	85.9	55.8
Kaiser Foundation HP Mid-Atlantic States -High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	77.8	84.7	85.4	93.2	83.5	75.8	69.6
Kaiser Foundation HP Mid-Atlantic States -Std	$20/$30	$250/day x 3	$12/$22Net	$35/$55/$50/$70	Yes	77.8	84.7	85.4	93.2	83.5	75.8	69.6
M.D. IPA-High	$25/$40	$150/day x 3	$7	$30/$60	Yes	57.4	83.5	88.1	92.3	86.1	87.2	67.9

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

See page 51 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
Florida					
Aetna Value Plan - Most of Florida	877-459-6604	F54	F55	229.60	521.41
AvMed Health Plan -high- Broward, Dade and Palm Beach	800-882-8633	ML1	ML2	294.72	707.37
AvMed Health Plan -std- Broward, Dade and Palm Beach	800-882-8633	ML4	ML5	232.80	558.75
Capital Health Plan -high- Tallahassee area	850-383-3311	EA1	EA2	201.02	532.72
Coventry Health Plan of Florida -high- Southern Florida	800-441-5501	5E1	5E2	262.64	630.36
Coventry Health Plan of Florida -std- Southern Florida	800-441-5501	5E4	5E5	240.74	622.01
Humana Medical Plan, Inc. -high- South Florida	888-393-6765	EE1	EE2	276.13	614.38
Humana Medical Plan, Inc. -std- South Florida	888-393-6765	EE4	EE5	227.36	505.89
Humana Medical Plan, Inc. -high- Tampa	888-393-6765	LL1	LL2	375.88	836.33
Humana Medical Plan, Inc. -std- Tampa	888-393-6765	LL4	LL5	252.63	562.09
Georgia					
Aetna Value Plan - All of Georgia	877-459-6604	F54	F55	229.60	521.41
Aetna Open Access -high- Atlanta and Athens Areas	877-459-6604	2U1	2U2	365.85	839.50
Humana Employers Health of Georgia, Inc. -high- Columbus	888-393-6765	CB1	CB2	252.63	562.09
Humana Employers Health of Georgia, Inc. -std- Columbus	888-393-6765	CB4	CB5	238.73	531.17
Humana Employers Health of Georgia, Inc. -high- Atlanta	888-393-6765	DG1	DG2	252.63	562.08
Humana Employers Health of Georgia, Inc. -std- Atlanta	888-393-6765	DG4	DG5	240.55	535.23
Humana Employers Health of Georgia, Inc. -high- Macon	888-393-6765	DN1	DN2	252.63	562.09
Humana Employers Health of Georgia, Inc. -std- Macon	888-393-6765	DN4	DN5	238.73	531.17
Kaiser Foundation Health Plan of Georgia -high- Atlanta, Athens, Columbus, Macon, Savannah	888-865-5813	F81	F82	254.57	581.69
Kaiser Foundation Health Plan of Georgia -std- Atlanta, Athens, Columbus, Macon, Savannah	888-865-5813	F84	F85	178.29	407.39
Guam					
Calvo's Selectcare-High-Guam, Northern Mariana Islands, Palau	671-479-7982	B41	B42	246.06	646.60
TakeCare -high- Guam/N.Mariana Islands/Belau(Palau)	671-647-3526	JK1	JK2	229.80	603.86
TakeCare -std- Guam/N.Mariana Islands/Belau(Palau)	671-647-3526	JK4	JK5	202.27	534.13

The information contained in this Guide is not the official statement of benefits. Each plan's Federal brochure is the official statement of benefits.

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		67.7	85	85.4	93.5	85.2	87.7	66.4
Florida												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
AvMed Health Plans-High	$15/$40	$150/day x 5	$5	$30/$50/30%	No	74.4	82	82.4	93.9	89.5	92.5	68.9
AvMed Health Plans-Std	$25/$45	$175/day x 5	$10	$40/$60/30%	No	74.4	82	82.4	93.9	89.5	92.5	68.9
Capital Health Plan-High	$15/$25	$250	$15 Tier 1	$30Teir2/$50Tier3	No	84.4	92.7	91.7	94.5	88.9	94.4	76.5
Coventry Health Plan of Florida-High	$15/$30	Ded+$150x3	$3/$20	$40/$60/20%	No	46.3	79.3	77.7	86.9	81.6	73.9	59.9
Coventry Health Plan of Florida-Standard	$20/$50	Ded+$150x5	$3/$10	$50/$70/20%	No	46.3	79.3	77.7	86.9	81.6	73.9	59.9
Humana Medical Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	61.3	82.7	83.5	94.6	85	82.8	68.9
Humana Medical Plan, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes	61.3	82.7	83.5	94.6	85	82.8	68.9
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 Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	61.4	86.7	84.3	92	82.9	87	59.9
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	52.8	87.3	86.7	95.4	77.1	86.4	56.6
Humana Employers Health of Georgia, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	52.8	87.3	86.7	95.4	77.1	86.4	56.6
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	$15/$30	$250 day/x 3	$10/$20 Comm	$40/$50 Comm	Yes	78	82.2	84.2	92.9	85.8	87.4	64.7
Kaiser Foundation HP of Georgia -Std	$20/$35	$250/day x 3	$15/$25 Comm	$40/$50 Comm	Yes	78	82.2	84.2	92.9	85.8	87.4	64.7
Guam												
Calvo's Selectcare-In-Network	$15/$40	$200	$10	$25/50%ofAWP	Yes							
Calvo's Selectcare-Out-Network	30%/30%	30%	N/A	N/A	No							
TakeCare-High	$15at FHP/$40	$100/day for 5 days	$10	$10/$25/$50	No	67.9	75.1	73.1	90.7	76.2	71.3	60.3
TakeCare-Std	$15/$40	$150/day for 5 days	$15	$15/$40/$80	No	67.9	75.1	73.1	90.7	76.2	71.3	60.3

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

See page 51 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
Hawaii					
HMSA -high- All of Hawaii	800-776-4622	871	872	212.16	472.26
Kaiser Foundation Health Plan of Hawaii -high- Hawaii/Kauai/Lanai/Maui/Molokai/Oahu	808-432-5955	631	632	250.17	557.91
Kaiser Foundation Health Plan of Hawaii -std- Hawaii/Kauai/Lanai/Maui/Molokai/Oahu	808-432-5955	634	635	128.50	286.56
Idaho					
Aetna Value Plan - Most of Idaho	877-459-6604	H44	H45	230.19	522.77
Altius Health Plans -high- Southern Region	800-377-4161	9K1	9K2	288.15	633.97
Altius Health Plans -std- Southern Region	800-377-4161	DK4	DK5	208.43	458.53
Group Health Cooperative -high- most of Washington State & Northern Idaho	888-901-4636	541	542	302.54	650.48
Group Health Cooperative -std- most of Washington State & Northern Idaho	888-901-4636	544	545	194.54	439.21
SelectHealth-High-Utah, Idaho	801-538-5038	SF1	SF2	285.34	636.52
SelectHealth-Std-Utah, Idaho	801-538-5038	SF4	SF5	255.09	569.04
Illinois					
Aetna Value Plan - Most of Illinois	877-459-6604	H44	H45	230.19	522.77
Blue Cross and Blue Shield of Illinois-High-Illinois	800-892-2803	A21	A22	320.00	726.44
Blue Preferred Plus POS -high- Madison and St. Clair counties	888-811-2092	9G1	9G2	322.05	697.26
Health Alliance HMO -high- Central/E.Central/N. Cent/South/West	800-851-3379	FX1	FX2	320.98	748.21
Humana Benefit Plan of Illinois, Inc. -high- Central and Northwestern	888-393-6765	9F1	9F2	385.96	858.77
Humana Benefit Plan of Illinois, Inc. -std- Central and Northwestern	888-393-6765	AB4	AB5	252.63	562.09
Humana Health Plan Inc. -high- Chicago	888-393-6765	751	752	346.33	770.59
Humana Health Plan Inc. -std- Chicago	888-393-6765	754	755	252.62	562.08
Union Health Service -high- Chicago area	312-423-4200	761	762	238.66	548.88
United Healthcare of the Midwest -high- Southwest Ilinois	877-835-9861	B91	B92	289.62	647.03
United Healthcare Plan of the River Valley Inc. -high- West Central Illinois	800-747-1446	YH1	YH2	256.46	605.84

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						**67.7**	**85**	**85.4**	**93.5**	**85.2**	**87.7**	**66.4**
Hawaii												
HMSA-In-Network	$15/$15	$100	$7	$30/$65	Yes	88.1	91.3	88.9	95.2	85.7	94.4	64.2
HMSA-Out-Network	30%/30%	30%	$7 + 20%	$30+20%/ $65+20%	No	88.1	91.3	88.9	95.2	85.7	94.4	64.2
Kaiser Foundation HP of Hawaii -High	$20/$20	$100	$15	$15/$15	Yes	75.7	80.2	80.7	93.6	79.4	87.1	67.6
Kaiser Foundation HP of Hawaii -Std	$30/$30	10%	$20	$20/$20	Yes	75.7	80.2	80.7	93.6	79.4	87.1	67.6
Idaho												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Altius Health Plans-High	$20/$30	$200	$7	$25/$50	Yes	60.8	86.5	89.6	94.7	82.1	88.3	60.7
Altius Health Plans-Std	$20/$35	None	$7	$35/$60	Yes	60.8	86.5	89.6	94.7	82.1	88.3	60.7
Group Health Cooperative-High	$25/$25	$350/day x 3	$20	$40/$60	Yes	70.9	82.8	86.2	92.1	85.5	91.5	71.3
Group Health Cooperative-Std	~~4/$25-$25+20%~~	$500/day x 3	$20	$40/$60	Yes	70.9	82.8	86.2	92.1	85.5	91.5	71.3
SelectHealth-High	$15/$25	$100	$5	$25/$50	Yes							
SelectHealth-Standard	$20/$30	$100 after ded	$5,$25,$50	$25/$50/$50	Yes							
Illinois												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Blue Cross and Blue Shield of Illinois-High	$20/$35	None	$10 copay	$40/$60	Yes							
Blue Preferred Plus POS-In-Network	$25/$35	$500	$10	$30/$50/25%/ $50/25%	Yes	64.7	89.6	87.5	93.6	82.6	91.1	63.9
Blue Preferred Plus POS-Out-Network	30% after ded.	30% after ded.	N/A	N/A	No	64.7	89.6	87.5	93.6	82.6	91.1	63.9
Health Alliance HMO-High	$25/$50	$200/day up to $5	$7	$35/$70	Yes	82.3	89.6	88.8	97.3	92.2	88.1	70.9
Humana Benefit Plan of Illinois Inc. -High	$20/$35	$250 /day x 3	$10	$40/$60	Yes	56.5	84.1	85.1	91	75.5	73.9	67.8
Humana Benefit Plan of Illinois Inc. -Std	$25/$40	$500/day X 3	$10	$40/$60	Yes	56.5	84.1	85.1	91	75.5	73.9	67.8
Humana Health Plan, Inc. -High	$20/$35	$250/day x 3	$10	$40/$60	Yes	62.1	80.9	77.9	90.9	83	82.3	68.5
Humana Health Plan, Inc. -Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	62.1	80.9	77.9	90.9	83	82.3	68.5
Union Health Service -High	$15/$15	None	$10	$35/$60	No							
UHC of the Midwest, Inc. -High	$25/$40	$450	$7	$30/$60	Yes	71.4	91.1	89.4	96.7	87.9	92	69.5
UHC Plan of the River Valley, Inc. -High	$20/$50	Nothing	$10	$35/$50	Yes	53.5	86.7	85.4	96.2	83	90.4	59.9

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

See page 51 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					
Health Alliance HMO -high- Western Indiana	800-851-3379	FX1	FX2	320.98	748.21
Humana Health Plan of Ohio -high-Portions of Indiana	888-393-6765	A61	A62	239.99	533.98
Humana Health Plan of Ohio -std-Portions of Indiana	888-393-6765	A64	A65	215.99	480.57
Humana Health Plan Inc. -high- Lake/Porter/LaPorte Counties	888-393-6765	751	752	346.33	770.59
Humana Health Plan Inc. -std- Lake/Porter/LaPorte Counties	888-393-6765	754	755	252.62	562.08
Humana Health Plan Inc. -high- Southern Indiana	888-393-6765	MH1	MH2	252.63	562.09
Humana Health Plan Inc. -std- Southern Indiana	888-393-6765	MH4	MH5	239.98	533.96
Physicians Health Plan of Northern Indiana -high- Northeast Indiana	260-432-6690	DQ1	DQ2	308.00	685.56
Iowa					
Aetna Value Plan - All of Iowa	877-459-6604	H44	H45	230.19	522.77
Coventry Health Care of Iowa -high- Central/Eastern/Western Iowa	800-257-4692	SV1	SV2	240.19	584.85
Coventry Health Care of Iowa -std- Central/Eastern/Western Iowa	800-257-4692	SY4	SY5	177.14	416.29
Health Alliance HMO -high- Central Iowa	800-851-3379	FX1	FX2	320.98	748.21
HealthPartners -high-Option-Northern Iwoa	800-883-2177	V31	V32	337.53	776.32
HealthPartners -std-Option-Northern Iowa	800-883-2177	V34	V35	165.92	381.62
Sanford Health Plan -high- Northwestern Iowa	800-752-5863	AU1	AU2	303.08	697.32
Sanford Health Plan -std- Northwestern Iowa	800-752-5863	AU4	AU5	291.47	670.40
UnitedHealthcare Plan of the River Valley Inc. -high- Eastern and Central Iowa	800-747-1446	YH1	YH2	256.46	605.84
Kansas					
Aetna Value Plan - Most of Kansas	877-459-6604	G54	G55	225.45	511.98
Aetna Open Access - High- Kansas City area	877-459-6604	HY1	HY2	229.02	610.84
Coventry Health Care of Kansas -high- Kansas City Metro Area (KS and MO)	800-969-3343	HA1	HA2	239.92	563.84
Coventry Health Care of Kansas -std- Kansas City Metro Area (KS and MO)	800-969-3343	HA4	HA5	202.69	476.31
Humana Health Plan, Inc. -high- Kansas City area	888-393-6765	MS1	MS2	429.74	956.17
Humana Health Plan, Inc. -std- Kansas City area	888-393-6765	MS4	MS5	252.58	562.00

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 6	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		67.7	85	85.4	93.5	85.2	87.7	66.4
Indiana												
Health Alliance HMO-High	$25/$50	Nothing	$7	$35/$70	Yes	82.3	89.6	88.8	97.3	92.2	88.1	70.9
Humana HP of Ohio-High	$20/$35	$250 x 3 days	$10	$40/$60	Yes							
Humana HP of Ohio-Std	$25/$40	$500 x 3 days	$10	$40/$60	Yes							
Humana Health Plan Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	62.1	80.9	77.9	90.9	83	82.3	68.5
Humana Health Plan Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	62.1	80.9	77.9	90.9	83	82.3	68.5
Humana Health Plan Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	47.2	87.2	79.6	92.9	86.6	86	65.7
Humana Health Plan Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	47.2	87.2	79.6	92.9	86.6	86	65.7
Physicians Health Plan of Northern Indiana-High	$15/$15	20%	$10	$25/$50	Yes	54.7	89.2	85.6	94.3	86.3	94.8	58.8
Iowa												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Coventry Health Care of Iowa-High	$20/$45	20%	$3/$10	$45/$70	Yes	49	86	86.6	96	84.7	89.1	66.5
Coventry Health Care of Iowa-Std	$20/$45	20%	$3/$10	30%/5,000Max	No	49	86	86.6	96	84.7	89.1	66.5
Health Alliance HMO-High	$25/$50	$200/day up to 5	$7	$35/$70	Yes	82.3	89.6	88.8	97.3	92.2	88.1	70.9
HealthPartners-High Option	$25/$45	Nothing	$12	$45/$90	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
HealthPartners-Standard Option	$0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
Sanford Health Plan-In-Network-High	$20/$30	$100/day x 5	$15	$30/$50	No	52.3	83.9	86.6	96	83.1	91	65.6
Sanford Health Plan-Out-Network-High	40%/40%	40%	40%+	40%+	No	52.3	83.9	86.6	96	83.1	91	65.6
Sanford Health Plan-In-Network-Std	$25/$25	$100/day x 5	$15	$30/$50	No	52.3	83.9	86.6	96	83.1	91	65.6
Sanford Health Plan-Out-Network-Std	40%/40%	40%	40%+	40%+	No	52.3	83.9	86.6	96	83.1	91	65.6
UHC Plan of the River Valley, Inc.-High	$25/$50	Nothing	$10	$35/$50	Yes	53.5	86.7	85.4	96.2	83	90.4	59.9
Kansas												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes							
Coventry Health Care of Kansas-High	$25/$60	25%	$3/$12	$50/$75	Yes	59.1	87.2	87	95.8	86.7	89.2	62.9
Coventry Health Care of Kansas-Std	$30/$60	30%	$3/$12	$50/20%	Yes	59.1	87.2	87	95.8	86.7	89.2	62.9
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	64.4	86.3	86.9	93.2	87.2	90.9	72.2
Humana Health Plan, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	64.4	86.3	86.9	93.2	87.2	90.9	72.2

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

See page 51 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					
Aetna Value Plan-Most of Kentucky	877-459-6604	H44	H45	230.19	522.77
Humana Health Plan of Ohio-High-Portions of Kentucky	888-393-6765	A61	A62	239.99	533.98
Humana Health Plan of Ohio-Std-Portions of Kentucky	888-393-6765	A64	A65	215.99	480.57
Humana Health Plan, Inc. -high- Louisville	888-393-6765	MH1	MH2	252.63	562.09
Humana Health Plan, Inc. -std- Louisville	888-393-6765	MH4	MH5	239.98	533.96
Humana Health Plan, Inc. -high- Lexington	888-393-6765	MI1	MI2	262.65	584.41
Humana Health Plan, Inc. -std- Lexington	888-393-6765	MI4	MI5	239.98	533.96
Louisiana					
Aetna Value Plan - Most of Louisiana	877-459-6604	F54	F55	229.60	521.41
Coventry Health Care of Louisiana -high- New Orleans area	800-341-6613	BJ1	BJ2	285.33	662.65
Coventry Health Care of Louisiana -std- New Orleans area	800-341-6613	BJ4	BJ5	240.64	558.85
Maine					
Aetna Value Plan-All of Maine	877-459-6604	EP4	EP5	223.19	506.85
Maryland					
Aetna Value Plan-All of Maryland	877-459-6604	F54	F55	229.60	521.41
Aetna Open Access -high- Northern/Central/Southern Maryland Areas	877-459-6604	JN1	JN2	392.10	878.26
Aetna Open Access -basic- Northern/Central/Southern Maryland Areas	877-459-6604	JN4	JN5	246.99	561.70
CareFirst BlueChoice -high- All of Maryland	888-789-9065	2G1	2G2	262.88	591.39
CareFirst BlueChoice -std- All of Maryland	888-789-9065	2G4	2G5	249.74	561.82
Coventry Health Care -high- All of Maryland	800-833-7423	IG1	IG2	252.90	634.70
Coventry Health Care -std- All of Maryland	800-833-7423	IG4	IG5	227.61	569.03
Kaiser Foundation Health Plan Mid-Atlantic States -high- Baltimore/Washington, DC areas	877-574-3337	E31	E32	261.37	601.15
Kaiser Foundation Health Plan Mid-Atlantic States -std- Baltimore/Washington, DC areas	877-574-3337	E34	E35	174.38	401.06
M.D. IPA -high- All of Maryland	877-835-9861	JP1	JP2	267.90	617.78

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	67.7	85	85.4	93.5	85.2	87.7	66.4
Kentucky												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Humana HP of Ohio-High	$20/$35	$250 x 3 days	$10	$40/$60	Yes							
Humana HP of Ohio-Std	$25/$40	$500 x 3 days	$10	$40/$60	Yes							
Humana Health Plan, Inc. -High	$20/$35	$250/day x 3	$10	$40/$60	Yes	47.2	87.2	79.6	92.9	86.6	86	65.7
Humana Health Plan, Inc. -Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	47.2	87.2	79.6	92.9	86.6	86	65.7
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												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Coventry Health Care of Louisiana-High	$25/$45	Ded+$100	$5	$40/$75	Yes	50	77.7	84	97.5	71.5	84.2	66.9
Coventry Health Care of Louisiana-Std	$30/$55	Ded+30%	$5	$40/$75	Yes	50	77.7	84	97.5	71.5	84.2	66.9
Maine												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Maryland												
Aetna Value Plan	$25/$40	20%	$10	30%50%	Yes							
Aetna Open Access-High	$15/$30	$150/day x3	$5	$35/$65	Yes	64.9	84.7	85.2	94.3	89.1	85.7	62.1
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$65	Yes	64.9	84.7	85.2	94.3	89.1	85.7	62.1
CareFirst BlueChoice-High	$25/$35	$200	Nothing	$30/$50	Yes	63.1	84.3	87.3	91.5	79.8	85.9	55.8
CareFirst BlueChoice-In-Network	Nothing/$35	$200	Nothing	$30/$50	Yes	63.1	84.3	87.3	91.5	79.8	85.9	55.8
CareFirst BlueChoice-Out-Network	$70/$70	$500	Nothing	$30/$50	Yes	63.1	84.3	87.3	91.5	79.8	85.9	55.8
Coventry Health Care-High	$20/$40	$200/day x 3	$3/$15	$30/$60	Yes	55.5	81.8	86.1	92.7	84.3	81.7	54.4
Coventry Health Care-Std	$20/$40	$200/day x 3	$3/$15	$30/$60	Yes	55.5	81.8	86.1	92.7	84.3	81.7	54.4
Kaiser Foundation HP Mid-Atlantic States -High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	55.5	81.8	86.1	92.7	84.3	81.7	54.4
Kaiser Foundation HP Mid-Atlantic States -Std	$20/$30	$250/day x 3	$12/$22Net	$35/$55/$50/$70	Yes	77.8	84.7	85.4	93.2	83.5	75.8	69.6
M.D. IPA-High	$25/$40	$150/day x 3	$7	$30/$60	Yes	57.4	83.5	88.1	92.3	86.1	87.2	67.9

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

See page 51 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
Massachusetts					
Aetna Value Plan - Most of Massachusetts	877-459-6604	EP4	EP5	223.19	506.85
Fallon Community Health Plan -basic- Central/Eastern Massachusetts	800-868-5200	JG1	JG2	291.79	709.13
Michigan					
Aetna Value Plan-All of Michigan	877-459-6604	G54	G55	225.45	511.98
Bluecare Network of MI -high- Traverse City	800-662-6667	H61	H62	228.38	593.36
Bluecare Network of MI -high- Grand Rapids	800-662-6667	J31	J32	278.02	722.42
Bluecare Network of MI -high- East Region	800-662-6667	K51	K52	283.83	647.03
Bluecare Network of MI -high- Southeast Region	800-662-6667	LX1	LX2	267.62	642.00
Grand Valley Health Plan -high- Grand Rapids area	616-949-2410	RL1	RL2	301.45	705.39
Grand Valley Health Plan -std- Grand Rapids area	616-949-2410	RL4	RL5	281.70	659.19
Health Alliance Plan -high- Southeastern Michigan/Flint area	800-556-9765	521	522	271.61	651.84
Health Alliance Plan -std- Southeastern Michigan/Flint area	800-556-9765	GY4	GY5	259.24	622.17
HealthPlus MI -high- East Michigan	800-332-9161	X51	X52	245.33	637.45
Physicians Health Plan -std- Mid-Michigan	866-539-3342	9U4	9U5	222.32	520.61
Minnesota					
Aetna Value Plan - Most of Minnesota	877-459-6604	H44	H45	230.19	522.77
HealthPartners -High Option - All of Minnesota	800-883-2177	V31	V32	337.53	776.32
HealthPartners -Standard Option - All of Minnesota	800-883-2177	V34	V35	165.92	381.62
Mississippi					
Aetna Value Plan-Most of Mississippi	877-459-6604	H44	H45	230.19	522.77

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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						**67.7**	**85**	**85.4**	**93.5**	**85.2**	**87.7**	**66.4**
Massachusetts												
Aetna Value Plan	$25/$40	20%	$10	30%50%	Yes							
Fallon Community Health Plan-Basic	$25/$35	$150 to $750max	$10	$30/$60	Yes	64	84.1	87.9	94.1	83.5	84.7	61.1
Michigan												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Bluecare Network of MI-High	$10/$15	$200	$10	$30/N/A	Yes	62.2	85.6	87.9	92	87.4	87	60.7
Bluecare Network of MI-High	$10/$15	$200	$10	$30/N/A	Yes	62.2	85.6	87.9	92	87.4	87	60.7
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes	62.2	85.6	87.9	92	87.4	87	60.7
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes	62.2	85.6	87.9	92	87.4	87	60.7
Grand Valley Health Plan-High	$10/$10	Nothing	$5	$15/$15	No	77	85.4	89.8	92.7	91.1	86.4	78
Grand Valley Health Plan-Std	$20/$20	$500 x 3	$10	$40	No	77	85.4	89.8	92.7	91.1	86.4	78
Health Alliance Plan-High	$10/$20	Nothing	$5	$25/$25	Yes	82.2	86.1	85.8	94	84	91.3	65.3
Health Alliance Plan-Std	$15/$30	Nothing	$10	$40/$40	Yes	82.2	86.1	85.8	94	84	91.3	65.3
HealthPlus MI-High	$10/$20	None	$8	$40/$60	Yes	76.6	85.8	89.7	93.7	90.8	94.2	73.4
Physicians Health Plan-Std	$25/$35	20%	$10	$40/50%	Yes	78	91.2	87.6	93.3	88.4	90.5	71.3
Minnesota												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
HealthPartners-High-Option	$25/$45	Nothing	$12	$45/$90	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
HealthPartners-Std-Option	$0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
Mississippi												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							

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

See page 51 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
Missouri					
Aetna Value Plan-Most of Missouri	877-459-6604	G54	G55	225.45	511.98
Aetna Open Access -high- Kansas City Area	877-459-6604	HY1	HY2	229.02	610.84
Blue Preferred Plus POS -high- St. Louis/Central/SW areas	888-811-2092	9G1	9G2	322.05	697.26
Coventry Health Care of Kansas -high- Kansas City Metro Area (KS and MO)	800-969-3343	HA1	HA2	239.92	563.84
Coventry Health Care of Kansas -std- Kansas City Metro Area (KS and MO)	800-969-3343	HA4	HA5	202.69	476.31
Humana Health Plan, Inc. -high- Kansas City	888-393-6765	MS1	MS2	429.74	956.17
Humana Health Plan, Inc. -std- Kansas City	888-393-6765	MS4	MS5	252.58	562.00
United Healthcare of the Midwest -high- St. Louis Area	877-835-9861	B91	B92	289.62	647.03
Montana					
Aetna Value Plan-South/Southeast/Western MT areas	877-459-6604	H44	H45	230.19	522.77
Nebraska					
Aetna Value Plan-All of Nebraska	877-459-6604	H44	H45	230.19	522.77
Nevada					
Aetna Value Plan-Las Vegas Area	877-459-6604	G54	G55	225.45	511.98
Aetna Open Access -high- Clark County and Las Vegas areas	877-459-6604	HF1	HF2	205.29	598.12
Health Plan of Nevada -high- Las Vegas/Esmeralda and Nye counties	877-545-7378	NM1	NM2	182.47	430.27
New Hampshire					
Aetna Value Plan-All of New Hampshire	877-459-6604	EP4	EP5	223.19	506.85

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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			67.7	85	85.4	93.5	85.2	87.7	66.4
Missouri												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes							
Blue Preferred Plus POS-In-Network	$25/$35	$500	$10	$30/$50/25%/ $50/25%	Yes	64.7	89.6	87.5	93.6	82.6	91.1	63.9
Blue Preferred Plus POS-Out-Network	30% after ded.	30% after ded.	N/A	N/A	No	64.7	89.6	87.5	93.6	82.6	91.1	63.9
Coventry Health Care of Kansas-High	$25/$60	25%	$3/$12	$50/$75	Yes	59.1	87.2	87	95.8	86.7	89.2	62.9
Coventry Health Care of Kansas-Std	$30/$60	30%	$3/$12	$50/20%	Yes	59.1	87.2	87	95.8	86.7	89.2	62.9
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	66.4	86.3	86.9	93.2	87.2	90.9	72.2
Humana Health Plan, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	66.4	86.3	86.9	93.2	87.2	90.9	72.2
United Healthcare of the Midwest, Inc.-High	$25/$40	$450	$7	$30/$60	Yes	71.4	91.1	89.4	96.7	87.9	92	69.5
Montana												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Nebraska												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Nevada												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
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	55.1	73.7	72.7	92.8	83.7	91.3	57.7
New Hampshire												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							

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

See page 51 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 Jersey					
Aetna Value Plan-All of New Jersey	877-459-6604	EP4	EP5	223.19	506.85
Aetna Open Access -high- Northern New Jersey	877-459-6604	JR1	JR2	425.04	977.69
Aetna Open Access -basic- Northern New Jersey	877-459-6604	JR4	JR5	312.75	721.94
Aetna Open Access -high- Southern NJ	877-459-6604	P31	P32	499.15	1204.37
Aetna Open Access -basic- Southern NJ	877-459-6604	P34	P35	372.11	859.25
GHI Health Plan -high- Northern New Jersey	212-501-4444	801	802	324.40	811.05
GHI Health Plan -std- Northern New Jersey	212-501-4444	804	805	237.23	553.80
New Mexico					
Aetna Value Plan-Albuquerque/Dona Ana/Hobbs Area	877-459-6604	G54	G55	225.45	511.98
Lovelace Health Plan -high- All of New Mexico	800-808-7363	Q11	Q12	219.88	516.71
Presbyterian Health Plan -high- All counties in New Mexico	800-356-2219	P21	P22	281.32	638.91

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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			67.7	85	85.4	93.5	85.2	87.7	66.4
New Jersey												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	67.1	89.4	89.3	92.2	87.4	83.8	62.8
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	67.1	89.4	89.3	92.2	87.4	83.8	62.8
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	67.1	89.4	89.3	92.2	87.4	83.8	62.8
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	67.1	89.4	89.3	92.2	87.4	83.8	62.8
GHI Health Plan-In-Network	$20/$20	$150max$450	$15	$40/$80	Yes	65.1	91.2	85.3	94.3	85.2	84.2	65.6
GHI Health Plan-Out-Network	+50% of sch.	+50% of sch.	N/A	N/A	No	65.1	91.2	85.3	94.3	85.2	84.2	65.6
GHI Health Plan-Std	$30/$30	$250/day x 3	$5	$40/$80	Yes	65.1	91.2	85.3	94.3	85.2	84.2	65.6
New Mexico												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Lovelace Health Plan-High	$20/$35	$250 after ded	$5	$35/$60/50%	Yes	63.4	80.2	78.2	90.3	77.5	88	73.1
Presbyterian Health Plan-High	$25/$35	$100 x 5 days	$10	$40/$75/30%	Yes	64.2	81.9	80.6	92.2	84.7	88.1	66.6

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

See page 51 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 Value Plan-Most of New York	877-459-6604	EP4	EP5	223.19	506.85
Aetna Open Access -high- NYC Area/Upstate NY	877-459-6604	JC1	JC2	377.58	929.43
Aetna Open Access -basic- NYC Area/Upstate NY	877-459-6604	JC4	JC5	322.08	782.61
Blue Choice -high- Rochester area	800-499-1275	MK1	MK2	325.82	755.31
Blue Choice -std- Rochester area	800-499-1275	MK4	MK5	271.10	676.62
CDPHP Universal Benefits -high- Upstate, Hudson Valley, Central New York	877-269-2134	SG1	SG2	284.40	720.26
CDPHP Universal Benefits -std- Upstate, Hudson Valley, Central New York	877-269-2134	SG4	SG5	212.85	549.12
GHI HMO -high- Brnx/Brklyn/Manhat/Queen/Richmon/Westchester	877-244-4466	6V1	6V2	234.95	600.04
GHI HMO -high- Capital/Hudson Valley Regions	877-244-4466	X41	X42	261.54	671.67
GHI Health Plan -high- All of New York	212-501-4444	801	802	324.40	811.05
GHI Health Plan -std- All of New York City	212-501-4444	804	805	237.23	553.80
HIP Health of Greater New York -High- New York City area including Long Island	1-800-447-8255	511	512	294.42	780.23
HIP Health of Greater New York -Std- New York City area including Long Island	1-800-447-8255	514	515	262.92	696.74
Independent Health Assoc -high- Western New York	800-501-3439	QA1	QA2	279.84	699.61
Independent Health Association-Std-Western New York	800-501-8439	C54	C55	271.48	678.69
MVP Health Care -high- Eastern Region	888-687-6277	GA1	GA2	258.30	646.58
MVP Health Care -std- Eastern Region	888-687-6277	GA4	GA5	236.01	586.03
MVP Health Care -high- Western Region	888-687-6277	GV1	GV2	220.83	552.59
MVP Health Care -std- Western Region	888-687-6277	GV4	GV5	197.07	493.10
MVP Health Care -high- Central Region	888-687-6277	M91	M92	275.31	690.09
MVP Health Care -std- Central Region	888-687-6277	M94	M95	250.21	625.87
MVP Health Care -high- Northern Region	888-687-6277	MF1	MF2	296.90	731.73
MVP Health Care -std- Northern Region	888-687-6277	MF4	MF5	238.45	596.67
MVP Health Care -high- Mid-Hudson Region	888-687-6277	MX1	MX2	270.15	676.16
MVP Health Care -std- Mid-Hudson Region	888-687-6277	MX4	MX5	244.15	613.30
North Carolina					
Aetna Value Plan-All of North Carolina	877-459-6604	F54	F55	229.60	521.41

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs: Level I	Prescription Drugs: Level II/ Level III	Prescription Drugs: Mail order discount	Member Survey Results: 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	67.7	85	85.4	93.5	85.2	87.7	66.4
New York												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	67	86	85.4	95.2	84.8	86.1	55.6
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	67	86	85.4	95.2	84.8	86.1	55.6
Blue Choice-High	$20/$20	$240	$10	$30/$50	No	70.6	85.6	87.1	93.9	84.1	88	67
Blue Choice-Std	$25/$40	$500	$7	$50/$100	No	70.6	85.6	87.1	93.9	84.1	88	67
CDPHP Universal Benefits, Inc.-High	$20/$30	$100 x 5	25%	25%/25%	No	72.9	89.6	90.9	96.2	90.6	91.1	74.3
CDPHP Universal Benefits, Inc.-Std	$25/$40	$500+10%	30%	30%/30%	No	72.9	89.6	90.9	96.2	90.6	91.1	74.3
GHI HMO Select-High	$25/$40	$500	$10	$30/$50	Yes							
GHI HMO Select-High	$25/$40	$500	$10	$30/$50	Yes							
GHI Health Plan-In-Network	$20/$20	$150max$450	$15	$40/$80	Yes	65.1	91.2	85.3	94.3	85.2	84.2	65.6
GHI Health Plan-Out-Network	+50% of sch	+50% of sch.	N/A	N/A	No	65.1	91.2	85.3	94.3	85.2	84.2	65.6
GHI Health Plan-Std	$30/$30	$250/day x 3	$5	$40/$80	Yes	65.1	91.2	85.3	94.3	85.2	84.2	65.6
HIP of Greater New York-High	$20/$40	None	$20/$100Ded	$30/$50/	Yes	73.8	79.8	79.6	91.8	85.3	89.8	55.5
HIP of Greater New York-Std	$20/$50	$500	$20 after Ded	$30/$50/$100Ded	Yes	73.8	79.8	79.6	91.8	85.3	89.8	55.5
Independent Health Assoc.-In-Network	$20/$20	$250	$10	$20/$35	No	75.4	87.6	89.1	92.4	89.1	90.2	76.6
Independent Health Assoc.-Out-Network	25%/25%	25%	N/A	N/A	No	75.4	87.6	89.1	92.4	89.1	90.2	76.6
Independent Health Association-In-Network	$25/$40	$500	$10	$30/$75	Yes							
Independent Health Association-Out-Network	30%/30%	30%	N/A	N/A	No							
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	68.3	90.1	93.1	95.8	91.6	88.9	79.5
North Carolina												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							

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

See page 51 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					
Aetna Value Plan-Most of North Dakota	877-459-6604	H44	H45	230.19	522.77
HealthPartners -High Option-Eastern North Dakota	800-883-2177	V31	V32	337.53	776.32
HealthPartners -Standard Option-Eastern North Dakota	800-883-2177	V34	V35	165.92	381.62
Heart of America Health Plan -high- Northcentral North Dakota	800-525-5661	RU1	RU2	227.97	585.89
Sanford Health Plan-High-North Dakota	800-752-5863	C91	C92	293.49	675.04
Sanford Health Plan-Std-North Dakota	800-752-5863	C94	C95	261.11	649.17
Ohio					
AultCare HMO -High- Stark/Carroll/Holmes/Tuscarawas/Wayne Co.	330-363-6360	3A1	3A2	249.67	613.00
Humana Health Plan of Ohio-High Greater Cincinnati Area	888-393-6765	A61	A62	239.99	533.98
Humana Health Plan of Ohio-Standard Greater Cincinnati Area	888-393-6765	A64	A65	215.99	480.57
Kaiser Foundation Health Plan of Ohio -High- Cleveland/Akron areas	800-686-7100	641	642	310.09	713.19
Kaiser Foundation Health Plan of Ohio -Standard- Cleveland/Akron areas	800-686-7100	644	645	213.72	491.57
The Health Plan of the Upper Ohio Valley -High-Eastern Ohio	800-624-6961	U41	U42	306.68	693.09
Oklahoma					
Globalhealth, Inc. -high- Oklahoma	877-280-5600	IM1	IM2	195.17	470.35
Oregon					
Aetna Value Plan-Most of Oregon	877-459-6604	H44	H45	230.19	522.77
Kaiser Foundation Health Plan of Northwest -High- Portland/Salem areas	800-813-2000	571	572	288.87	652.45
Kaiser Foundation Health Plan of Northwest -Std- Portland/Salem areas	800-813-2000	574	575	233.01	535.29
Kaiser Foundation Health Plan of Northwest -Basic- Portland/Salem areas	800-813-2000	B51	B52	214.17	492.01

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		67.7	85	85.4	93.5	85.2	87.7	66.4
North Dakota												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
HealthPartners-High-Option	$25/$45	Nothing	$12	$45/$90	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
HealthPartners-Std-Option	$0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
Heart of America Health Plan-High-In-Network	$15/$25	None	50%/ $600ded	50%/$600ded/ 50%/$600ded	No							
Heart of America Health Plan-High-Out-Network	20%/20%	20%	N/A	N/A	No							
Sanford HP-In-Network-High	$20/$30	$100/day x 5	$15	$30/$50	N0							
Sanford HP-Out-Network-High	40%/40%	40%	40%+	40%+	No							
Sanford HP-In-Network-Std	$25/$25	$100/day x 5	$15	$30/$50	No							
Sanford HP-Out-Network-Std	40%/40%	40%	40%+	40%+	No							
Ohio												
AultCare HMO-High	$15/$20	$150	$15	$30/$45	No	89.7	92.6	93	96	94.8	94.7	85.7
Humana HP of Ohio-High	$20/$35	$250 x 3 days	$10	$40/$60	Yes							
Humana HP of Ohio-Standard	$25/$40	$500 x 3 days	$10	$40/$60	Yes							
Kaiser Foundation HP of Ohio-High	$20/$20	$250	$10	$30/$30	Yes	76.5	82.7	86.9	92.9	83.3	87.1	71.8
Kaiser Foundation HP of Ohio-Std	$30/$40	$500	$15	$40/$40	Yes	76.5	82.7	86.9	92.9	83.3	87.1	71.8
The Health Plan of the Upper Ohio Valley-High	$10/$20	$250	$15	$30/$50	Yes	75.4	91.6	86.3	93.3	90.7	94.7	75.5
Oklahoma												
Globalhealth, Inc.-High	$15/$45	$250 day max $1000	$4/$10	$45/$65	Yes	62	77.2	85	92.5	85.8	88	70.7
Oregon												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Kaiser Foundation HP of Northwest-High	$20/$30	$200	$15	$40/$60	Yes	71.8	80.4	81	91.6	83.5	78	65.8
Kaiser Foundation HP of Northwest-Std	$25/$35	$500	$20	$40/$60	Yes	71.8	80.4	81	91.6	83.5	78	65.8
Kaiser Foundation HP of Northwest-Basic	$35/$45	$500	$20	$40/$60	Yes							

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

See page 51 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 Value Plan-All of Pennsylvania	877-459-6604	H44	H45	230.19	522.77
Aetna Open Access -High- Philadelphia	877-459-6604	P31	P32	499.15	1204.37
Aetna Open Access -Basic- Philadelphia	877-459-6604	P34	P35	372.11	859.25
Aetna Open Access -High- Pittsburgh and Western PA Areas	877-459-6604	YE1	YE2	239.49	599.04
Geisinger Health Plan -Std- Northeastern/Central/South Central areas	800-447-4000	GG4	GG5	297.50	684.27
HealthAmerica Pennsylvania -High- Greater Pittsburgh area	866-351-5946	261	262	275.44	647.29
UPMC Health Plan -High- Western Pennsylvania	877-648-9641	8W1	8W2	291.51	670.47
UPMC Health Plan -Std- Western Pennsylvania	877-648-9641	UW4	UW5	245.80	565.33
Puerto Rico					
Humana Health Plans of Puerto Rico, Inc. -high- Puerto Rico	800-314-3121	ZJ1	ZJ2	151.99	338.16
Triple-S Salud, Inc. -high- All of Puerto Rico	787-774-6060	891	892	154.88	348.47
Rhode Island					
Aetna Value Plan-All of Rhode Island	877-459-6604	EP4	EP5	223.19	506.85
South Dakota					
Aetna Value Plan-Rapid City/Sioux Falls Area	877-459-6604	G54	G55	225.45	511.98
HealthPartners -High Option-Eastern South Dakota	800-883-2177	V31	V32	337.53	776.32
HealthPartners -Standard Option-Eastern South Dakota	800-883-2177	V34	V35	165.92	381.62
Sanford Health Plan -High- Eastern/Central/Rapid City Areas	800-752-5863	AU1	AU2	303.08	697.32
Sanford Health Plan -std- Eastern/Central/Rapid City Areas	800-752-5863	AU4	AU5	291.47	670.40

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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		67.7	85	85.4	93.5	85.2	87.7	66.4
Pennsylvania												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	53.7	84.2	89.9	94	85.1	89	65.8
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	53.7	84.2	89.9	94	85.1	89	65.8
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	53.7	84.2	89.9	94	85.1	89	65.8
Geisinger Health Plan-Std	$20/$35	20%aftrDeduct	30% $5/$15	40% $40/$120/ 50% $60/$180	Yes	68.4	85	87.7	95.6	86.7	94.7	68.4
HealthAmerica Pennsylvania-High	$25/$50	15%	$5	$35/$60	Yes	71.2	89.7	93.2	95.4	87.2	89.6	68.6
UPMC Health Plan-High	10% after Ded	10% after Ded	$5	$35 after Ded/ $70 after Ded	Yes	79.4	87.8	88.2	95.2	86	89.9	69.7
UPMC Health Plan-Std	20% after Ded	20% after Ded	$5	$35/$70	Yes	79.4	87.8	88.2	95.2	86	89.9	69.7
Puerto Rico												
Humana HP of Puerto Rico -In-Network	$5/$5	None	$2.50	$10/$15	Yes	79.3	80.5	82.2	96.7	79.1	78.7	58.4
Humana HP of Puerto Rico -Out-Network	$10/$10	$50	N/A	N/A	No	79.3	80.5	82.2	96.7	79.1	78.7	58.4
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	75.7	86.1	84.2	96.7	77.7	78.3	56
Triple-S Salud, Inc.-Out-Network	$7.50+10%/$10+10%	10% +	N/A	N/A	No	75.7	86.1	84.2	96.7	77.7	78.3	56
Rhode Island												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
South Dakota												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
HealthPartners-High-Option	$25/$45	Nothing	$12	$45/$90	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
HealthPartners-Std-Option	$0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
Sanford Health Plan-In-Network-High	$20/$30	$100/day x 5	$15	$30/$50	No	52.3	83.9	86.6	96	83.1	91	65.6
Sanford Health Plan-Out-Network-High	40%/40%	40%	40%+	40%+	No	2.3	83.9	86.6	96	83.1	91	65.6
Sanford Health Plan-In-Network-Std	$25/$25	$100/day x 5	$15	$30/$50	No	52.3	83.9	86.6	96	83.1	91	65.6
Sanford Health Plan-Out-Network-Std	40%/40%	40%	40%+	40%+	No	52.3	83.9	86.6	96	83.1	91	65.6

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

See page 51 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
Tennessee					
Aetna Value Plan-Most of Tennessee	877-459-6604	F54	F55	229.60	521.41
Aetna Open Access -high- Memphis Area	877-459-6604	UB1	UB2	307.78	784.77
Humana Health Plan, Inc. -High- Knoxville	888-393-6765	GJ1	GJ2	252.63	562.09
Humana Health Plan, Inc. -Std- Knoxville	888-393-6765	GJ4	GJ5	215.99	480.58
Texas					
Aetna Open Access -High- Austin and San Antonio Areas	877-459-6604	P11	P12	367.33	925.38
Aetna Whole Health-Basic-Ft Bend, Harris, Montgomery counties	877-459-6604	ES1	ES2	223.24	588.46
Firstcare-High - Central Waco area	800-884-4901	B71	B72	181.62	544.88
Firstcare -high- West Texas	800-884-4901	CK1	CK2	184.78	554.34
Firstcare-High-Taylor/Callahan/Eastland	800-884-4901	CN1	CN2	219.95	659.88
Firstcare-High-Lubbock area	800-884-4901	CZ1	CZ2	214.04	642.15
Firstcare-High-Robertson/Brazos/Grimes/Madison/WA	800-884-4901	ET1	ET2	207.57	622.72
Humana Health Plan of Texas -High- Corpus Christi	888-393-6765	UC1	UC2	295.08	656.54
Humana Health Plan of Texas -Std- Corpus Christi	888-393-6765	UC4	UC5	252.63	562.09
Humana Health Plan of Texas -High- San Antonio	888-393-6765	UR1	UR2	412.87	918.63
Humana Health Plan of Texas -Std- San Antonio	888-393-6765	UR4	UR5	252.62	562.08
Humana Health Plan of Texas -High- Austin	888-393-6765	UU1	UU2	290.82	647.05
Humana Health Plan of Texas -Std- Austin	888-393-6765	UU4	UU5	252.63	562.09
UnitedHealthcare Benefits of Texas, Inc. -High- San Antonio	866-546-0510	GF1	GF2	286.22	658.55
Utah					
Aetna Value Plan-Most of Utah	877-459-6604	G54	G55	225.45	511.98
Altius Health Plans -High- Wasatch Front	800-377-4161	9K1	9K2	288.15	633.97
Altius Health Plans -Std- Wasatch Front	800-377-4161	DK4	DK5	208.43	458.53
SelectHealth -High- Urban and Suburban Utah	800-538-5038	SF1	SF2	285.34	636.52
SelectHealth -Basic- Urban and Suburban Utah	800-538-5038	SF4	SF5	255.09	569.04

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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			67.7	85	85.4	93.5	85.2	87.7	66.4
Tennessee												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	72.5	85.2	84.4	90.4	87.6	92.6	70.2
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							
Texas												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	62.8	87	86.9	90.3	82.2	88.9	62.7
Aetna Whole Health-In-Network	$25/$35	15%	$5	$35/$60	Yes							
Aetna Whole Health-Out-Network	50%/50%	50%	40%	40%/40%	No							
Firstcare-High	$30/$55	$250/day x 5	$10	$35/$70	No							
Firstcare-High	$30/$55	$250/day x 5	$10	$35/$70	No							
Firstcare-High	$30/$55	$250/day x 5	$10	$35/$70	No							
Firstcare-High	$30/$55	$250/day x 5	$10	$35/$70	No							
Firstcare-High	$30/$55	$250/day x 5	$10	$35/$70	No							
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	68.9	86	84.6	92.5	79.1	91.8	64.4
Humana Health Plan of Texas-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	68.9	86	84.6	92.5	79.1	91.8	64.4
Humana Health Plan of Texas-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	57.8	84.7	85.7	92.6	87	89.6	65.9
Humana Health Plan of Texas-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	57.8	84.7	85.7	92.6	87	89.6	65.9
UnitedHealthcare Benefits of Texas,Inc.-High	$20/$40	$250/day x 5	$10	$35/$60	Yes	66.7	81.7	85.5	93.4	80.9	89.3	56.9
Utah												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Altius Health Plans-High	$20/$30	$200	$7	$25/$50	Yes	60.8	86.5	89.6	94.7	82.1	88.3	60.7
Altius Health Plans-Standard	$20/$35	None	$7	$35/$60	Yes	60.8	86.5	89.6	94.7	82.1	88.3	60.7
SelectHealth-High	$15/$25	$100	$5/$25/$50	$25,$50/$50	Yes	62.7	85.2	84.5	94.2	92.3	92.4	67
SelectHealth-Standard	$20/$30	$100 after	$5/$25/$50	$25,$50/$50	Yes							

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

See page 51 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
Vermont					
Aetna Value Plan-All of Vermont	877-459-6604	EP4	EP5	223.19	506.85
Virgin Islands					
Triple-S Salud, Inc. -high- US Virgin Islands	800-981-3241	851	852	190.24	432.04
Virginia					
Aetna Value Plan-Most of Virginia	877-459-6604	F54	F55	229.60	521.41
Aetna Open Access -high- Northern/Central/Richmond Virginia Areas	877-459-6604	JN1	JN2	392.10	878.26
Aetna Open Access -basic- Northern/Central/Richmond Virginia Areas	877-459-6604	JN4	JN5	246.99	561.70
Aetna Whole Health-Basic-Various counties in Southwest Virginia	877-459-6604	D91	D92	211.40	588.46
CareFirst BlueChoice-High- Northern Virginia	888-789-9065	2G1	2G2	262.88	591.39
CareFirst BlueChoice-Std- Northern Virginia	888-789-9065	2G4	2G5	249.74	561.82
Kaiser Foundation Health Plan Mid-Atlantic States -high- Northern Virginia/Fredericksburg area	877-574-3337	E31	E32	261.37	601.15
Kaiser Foundation Health Plan Mid-Atlantic States -std- Northern Virginia/Fredericksburg area	877-574-3337	E34	E35	174.38	401.06
M.D. IPA -High- Northern Virginia	877-835-9861	JP1	JP2	267.90	617.78
Optima Health Plan -high- Hampton Roads and Richmond areas	800-206-1060	9R1	9R2	283.75	671.40
Optima Health Plan -std- Hampton Roads and Richmond areas	800-206-1060	9R4	9R5	180.91	428.07
Piedmont Community Healthcare -high- Lynchburg area	888-674-3368	2C1	2C2	237.78	544.48

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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		67.7	85	85.4	93.5	85.2	87.7	66.4
Vermont												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
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	75.7	86.1	84.2	96.7	77.7	78.3	56
Triple-S Salud, Inc.-Out-Network	$7.50 & 10%+/ $10 & 10%+	10%+	N/A	N/A	No	75.7	86.1	84.2	96.7	77.7	78.3	56
Virginia												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$15/$30	$150/day x3	$5	$35/$65	Yes	64.9	84.7	85.2	94.3	89.1	85.7	62.1
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$65	Yes	64.9	84.7	85.2	94.3	89.1	85.7	62.1
Aetna Whole Health-In-Network	$25/$35	15%	$5	$35/$60	Yes							
Aetna Whole Health-Out-Network	40%/40%	40%	40%	40%/40%	No							
CareFirst BlueChoice-High	$25/$35	$200	Nothing	$30/$50	Yes	63.1	84.3	87.3	91.5	79.8	85.9	55.8
CareFirst BlueChoice-In-Network	Nothing/$35	$200	Nothing	$30/$50	Yes	63.1	84.3	87.3	91.5	79.8	85.9	55.8
CareFirst BlueChoice-Out-Network	$70/$70	$500	Nothing	$30/$50	Yes	63.1	84.3	87.3	91.5	79.8	85.9	55.8
Kaiser Foundation HP Mid-Atlantic-High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	77.8	84.7	85.4	93.2	83.5	75.8	69.6
Kaiser Foundation HP-Mid-AtlanticStd	$20/$30	$250/day x 3	$12/$22Net	$35/$55/$50/$70	Yes	77.8	84.7	85.4	93.2	83.5	75.8	69.6
M.D. IPA-High	$25/$40	$150/day x 3	$7	$30/$60	Yes	57.4	83.5	88.1	92.3	86.1	87.2	67.9
Optima Health Plan-High	$15/$0 child<22/$30	$150 max $750	$10	$30/30%/50% up to $3,000	Yes	70.9	89.5	89.1	95.6	89.9	93.8	73.6
Optima Health Plan-Std	$20/$30	None	$10	$30/50%/50% up to $3,000	No	70.9	89.5	89.1	95.6	89.9	93.8	73.6
Piedmont Community HC-High	$35/$35	20%	$15	$40/$55	Yes							

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

See page 51 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					
Aetna Value Plan -Most of Washington	877-459-6604	G54	G55	225.45	511.98
Aetna Open Access -High- Seattle & Spokane	877-459-6604	C31	C32	250.56	684.00
Group Health Cooperative -High- Western WA/Central WA/Spokane/Pullman	888-901-4636	541	542	302.54	650.48
Group Health Cooperative -Std- Western WA/Central WA/Spokane/Pullman	888-901-4636	544	545	194.54	439.21
KPS Health Plans -Std- All of Washington	800-552-7114	L11	L12	204.94	442.37
KPS Health Plans -High- All of Washington	800-552-7114	VT1	VT2	316.54	691.67
Kaiser Foundation Health Plan of Northwest -High- Vancouver/Longview	800-813-2000	571	572	288.87	652.45
Kaiser Foundation Health Plan of Northwest -Std- Vancouver/Longview	800-813-2000	574	575	233.01	535.29
Kaiser Foundation Health Plan of the Northwest -Basic- Vancouver/Longview	800-813-2000	B51	B52	214.17	492.01
West Virginia					
Aetna Value Plan-Most of West Virginia	877-459-6604	F54	F55	229.60	521.41
The Health Plan of the Upper Ohio Valley -high- Northern/Central West Virginia	800-624-6961	U41	U42	306.68	693.09
Wisconsin					
Aetna Whole Health-Basic Various Counties in Southeastern WI	877-459-6604	F71	F72	184.62	508.71
Dean Health Plan -high- South Central Wisconsin	800-279-1301	WD1	WD2	287.50	718.73
Group Health Cooperative -high- South Central Wisconsin	800-650-4327	WJ1	WJ2	241.65	604.32
HealthPartners -High Option-Western Wisconsin	800-883-2177	V31	V32	337.53	776.32
HealthPartners -Standard Option-Western Wiscosin	800-883-2177	V34	V35	165.92	381.62
MercyCare HMO -High- South Central Wisconsin	800-895-2421	EY1	EY2	240.28	600.97
Physicians Plus -High- Dane County	800-545-5015	LW1	LW2	234.85	598.93
Wyoming					
Aetna Value Plan-All of Wyoming	877-459-6604	H44	H45	230.19	522.77
Altius Health Plans -high- Uinta County	800-377-4161	9K1	9K2	288.15	633.97
Altius Health Plans -std- Uinta County	800-377-4161	DK4	DK5	208.43	458.53

The information contained in this Guide is not the official statement of benefits. Each plan's Federal brochure is the official statement of benefits.

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	67.7	85	85.4	93.5	85.2	87.7	66.4
Washington												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes							
Group Health Cooperative-High	$25/$25	$350/day x 3	$20	$40/$60	Yes	70.9	82.8	86.2	92.1	85.5	91.5	71.3
Group Health Cooperative-Standard	4/$25-$25+20%	$500/day x 3	$20	$40/$60	Yes	70.9	82.8	86.2	92.1	85.5	91.5	71.3
KPS Health Plans-In-Network	$15/3 or 20%/20%	Nothing	$10	$35/50%/ $40max$100	Yes	77.3	92.1	92.1	95.6	91.7	94.7	68.2
KPS Health Plans-Out-Network	$15/3 +40%+diff/ 40%+diff	Nothing	Not Covered	Not Covered	No	77.3	92.1	92.1	95.6	91.7	94.7	68.2
KPS Health Plans-In-Network	$30/$30	None	$5	$25/ 50% or $100	Yes	77.3	92.1	92.1	95.6	91.7	94.7	68.2
KPS Health Plans-Out-Network	$30+40%+diff	None	Not covered	N/A	No	77.3	92.1	92.1	95.6	91.7	94.7	68.2
Kaiser Foundation HP of Northwest-High	$20/$30	$200	$15	$40/$60	Yes	71.8	80.4	81	91.6	83.5	78	65.8
Kaiser Foundation HP of Northwest-Standard	$25/$35	$500	$20	$40/$60	Yes	71.8	80.4	81	91.6	83.5	78	65.8
Kaiser Foundation HP of the NW-Basic	$35/$45	$500	$20	$40/$60	Yes							
West Virginia												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
The HP of the Upper Ohio Valley-High	$10/$20	$250	$15	$30/$50	Yes	75.4	91.6	86.3	93.3	90.7	94.7	75.5
Wisconsin												
Aetna Whole Health-In-Network	$25/$35	15%	$5	$35/$60	Yes							
Aetna Whole Health-Out-Network	40%/40%	40%	40%	40%/40%	No							
Dean Health Plan-High	$10/$10	None	$10	30%/$75max/50%	Yes	71.2	87.8	87.4	94	85.8	85.8	66
Group Health Cooperative-High	$10 /$10	None	$5	$20/$20	Yes	81.1	83.6	87.2	95.1	93.1	94.4	74.6
HealthPartners-High-Option	$25/$45	Nothing	$12	$45/$90	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
HealthPartners-Std-Option	$0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	60.3	85.7	88.2	97.8	90	89.2	68.9
MercyCare HMO-High	$10/$10	Nothing	$10	$20/$50	Yes	76.7	89.6	85.1	94.5	89.9	86.6	70
Physicians Plus-High	$10/$10	Nothing	$10	30%/50%	No	75.9	77.9	86.3	94.6	89.2	91.1	71.4
Wyoming												
Aetna Value Plan	$25/$40	20%	$10	30%/50%	Yes							
Altius Health Plans-High	$20/$30	$200	$7	$25/$50	Yes	60.8	86.5	89.6	94.7	82.1	88.3	60.7
Altius Health Plans-Std	$20/$35	None	$7	$35/$60	Yes	60.8	86.5	89.6	94.7	82.1	88.3	60.7

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 107)

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 covered in full. 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 $1,250 for Self Only and $2,500 for Self and Family coverage) and annual out-of-pocket limits (not to exceed $6,250 for Self Only and $12,500 for Self and 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 or IHS benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return. 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 2013 maximum contribution limits are $3,250 for Self Only coverage and $6,450 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.

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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 (HCFSA).

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

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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.

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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

The tables on the following pages highlight selected features that may help you narrow your choice of health plans. The tables do not show all of your possible out-of-pocket costs. All benefits are subject to the definitions, limitations, and exclusions set forth in each plan's federal brochure which is the official statement of benefits available under the plan's contract with the Office of Personnel Management. Always consult plan brochures before making your final decision.

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; TTY 1 866-260-7507. 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 2013 annual contribution limit, including the HDHP premium pass through, is $3,250 for Self Only and $6,450 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: $_____.00

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.

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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	800-718-1299	474	475	174.61	392.81
GEHA High Deductible Health Plan -HDHP - Nationwide	800-821-6136	341	342	193.77	442.59
MHBP Consumer Option -HDHP- Nationwide	800-694-9901	481	482	248.13	562.24

The information contained in this Guide is not the official statement of benefits. Each plan's Federal brochure is the official statement of benefits.

APWU Postal Support Employees (PSEs) are eligible for a 75% USPS premium contribution to the APWU CDHP upon reassignment to a 360-day appointment after an initial appointment of 360 days.

	Enrollment Code		Biweekly Premium Your Share	
	Self only	Self & family	Self only	Self & family
APWU CDHP	474	475	43.65	98.20

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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 categorized 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/N/A/N/A
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 D 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		**63.3**	**86**	**88.8**	**94.1**	**83.1**	**88**	**60.4**
Aetna Health Fund - Nationwide	22	68.1	88.2	86.9	93.9	82.7	85.7	60
GEHA High Deductible Health Plan - Nationwide	34	64.7	84.2	88.8	93.6	82.9	90.2	59.4
MHBP Consumer Option - Nationwide	48	57.1	85.5	90.7	94.8	83.6	88.2	61.8
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		**56.4**	**85.1**	**86**	**93.5**	**82.7**	**85.7**	**60.6**
Aetna Health Fund - Nationwide	22	68.1	88.2	86.9	93.9	82.7	85.7	60
APWU Health Plan - Nationwide	47	64.6	88.5	89.3	91.3	77.7	82.9	66.9
Humana Coverage First -TX	TP,TU,TV	64.5	83.7	84.3	93.5	81.8	84	55.7
Humana Coverage First - KS, MO	PH	44.1	81.6	88.8	95.9	88.4	90.6	63.6

The tables on the following pages highlight selected features that may help you narrow your choice of health plans. The tables do not show all of your possible out-of-pocket costs. All benefits are subject to the definitions, limitations, and exclusions set forth in each plan's Federal brochure which is the official statement of benefits available under the plan's contract with the Office of Personnel Management. Always consult plan brochures before making your final decision.

High Deductible and Consumer-Driven Health Plans

See pages 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
Aetna HealthFund -CDHP-AK, CA,HI,IN, OH, OK, SC, TX, & WI	877-459-6604	221	222	276.33	627.52
Aetna HealthFund -HDHP- All 50 States and DC	877-459-6604	224	225	191.55	419.48

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Alabama					
Aetna Healthfund CDHP-Most of Alabama	877-459-6604	F51	F52	264.09	599.73
Arizona					
Aetna Healthfund CDHP-All of Arizona	877-459-6604	G51	G52	268.08	608.80
Arkansas					
Aetna Healthfund CDHP-Most of Arkansas	877-459-6604	F51	F52	264.09	599.73
Colorado					
Aetna Healthfund CDHP-All of Colorado	877-459-6604	G51	G52	268.08	608.80
Connecticut					
Aetna Healthfund CDHP-All of Connecticut	877-459-6604	EP1	EP2	275.82	626.36

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	$5,000/$10,000	20%	20%	20%	Nothing	$10/30%/50%
Aetna HealthFund-Out-Network	$83.33/166.66	$1,000/$2,000	$6,000/$12,000	40%	40%	40%	Fund/Ded/40%	40%+/30%+/50%+
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
Alabama								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Arizona								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Arkansas								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Colorado								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Connecticut								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+

High Deductible and Consumer-Driven Health Plans

See pages 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
Delaware					
Aetna Healthfund CDHP-All of Delaware	877-459-6604	EP1	EP2	275.82	626.36
District of Columbia					
Aetna Healthfund CDHP-All of Washington D.C.	877-459-6604	F51	F52	264.09	599.73
CareFirst BlueChoice-HDHP-Washington D.C. Metro Area	888-789-9065	B61	B62	235.27	524.78
Florida					
Aetna Healthfund CDHP-Most of Florida	877-459-6604	F51	F52	264.09	599.73
Coventry Health Care of Florida -HDHP-Southern Florida	800-441-5501	J41	J42	239.62	594.59
Humana CoverageFirst -CDHP- Tampa Area	888-393-6765	MJ1	MJ2	238.73	531.18
Humana CoverageFirst -CDHP- South Florida Area	888-393-6765	QP1	QP2	204.63	455.30
Georgia					
Aetna Healthfund CDHP-All of Georgia	877-459-6604	F51	F52	264.09	599.73
Humana CoverageFirst -CDHP- Atlanta Area	888-393-6765	AD1	AD2	216.00	480.58
Humana CoverageFirst -CDHP- Macon Area	888-393-6765	LM1	LM2	227.36	505.89
Guam					
TakeCare -HDHP- Guam/N. Mariana Islands/Belau (Palau)	671-647-3526	KX1	KX2	138.27	363.22
Idaho					
Aetna Healthfund CDHP-Most of Idaho	877-459-6604	H41	H42	263.70	598.85
Altius Health Plans -HDHP- Southern Region	800-377-4161	9K4	9K5	160.70	332.92

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
Delaware								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
District of Columbia								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
CareFirst BlueChoice	$37.50/$75.00	$1500/$3000	$4000/$8000	Nothing	$300	Nothing	Nothing	0/$25/$45
CareFirst BlueChoice-Out of Network	$37.50/$75.00	$3000/$6000	$6000/$12000	$70	$500	$70	Ded, then Nothing	0/$25/$45
Florida								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Coventry Health Care of Florida	$83.34/$166.67	$2,500/$5,000	$5,000/$10,000	$10	Ded+20%	Ded+20%	Nothing	$5/$35/$50/20%
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+
Georgia								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
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	$71.50/$186.33	$3,000/$6,000	$5,000/$10,000	20% after Ded	20% after Ded	20% after Ded	Nothing	$20/$40/$80
TakeCare- Out-Network	$71.50/$186.33	$3,000/$6,000	$10,000/$20,000	30% after Ded	30% after Ded	30% after Ded	1st $300/ded	30% after Ded
Idaho								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Altius Health Plans	$45.83/$91.66	$1,250/$2,500	$5,000/$10,000	$20	10%	10%	Nothing	$7/$25/$50

High Deductible and Consumer-Driven Health Plans

See pages 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					
Aetna Healthfund CDHP-Most of Illinois	877-459-6604	H41	H42	263.70	598.85
Humana CoverageFirst -CDHP- Central Illinois	888-393-6765	GB1	GB2	238.73	531.17
Humana CoverageFirst -CDHP- Chicago Area	888-393-6765	MW1	MW2	227.36	505.89
Indiana					
Humana CoverageFirst -CDHP- Lake/Porter/LaPorte Counties	888-393-6765	MW1	MW2	227.36	505.89
Iowa					
Aetna Healthfund CDHP-All of Iowa	877-459-6604	H41	H42	263.70	598.85
Coventry Health Care of Iowa -HDHP- Central/Eastern/Western Iowa	800-257-4692	SV4	SV5	165.56	395.12
Kansas					
Aetna Healthfund CDHP-Most of Kansas	877-459-6604	G51	G52	268.08	608.80
Coventry Health Care of Kansas (Kansas City)-HDHP-Kansas City Metro Area (KS and MO)	800-969-3343	9H1	9H2	195.77	460.05
Humana CoverageFirst -CDHP- Kansas City Area	888-393-6765	PH1	PH2	204.63	455.30
Kentucky					
Aetna Healthfund CDHP-Most of Kentucky	877-459-6604	H41	H42	263.70	598.85
Humana CoverageFirst -CDHP- Lexington Area	888-393-6765	6N1	6N2	204.96	456.05
Louisiana					
Aetna Healthfund CDHP-Most of Louisiana	877-459-6604	F51	F52	264.09	599.73

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								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
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								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Coventry Health Care of Iowa	$66.67/$133.34	$2,100/$4,200	$5,000/$10,000	$20	15%	15%	Nothing	$3/$10/$40/$65
Kansas								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Coventry Health Care of Kansas (Kansas City)-HDHP	$83.33/$166.66	$2,500/$5,000	$3,500/$7,000	20%	20%	20%	Nothing	20%/20%/20%
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								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
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+
Louisiana								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+

High Deductible and Consumer-Driven Health Plans

See pages 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
Maine					
Aetna Healthfund CDHP-All of Maine	877-459-6604	EP1	EP2	275.82	626.36
Maryland					
Aetna Healthfund CDHP-All of Maryland	877-459-6604	F51	F52	264.09	599.73
CareFirst BlueChoice-HDHP-All of Maryland	888-789-9065	B61	B62	235.27	524.78
Coventry Health Care -HDHP- All of Maryland	800-833-7423	GZ1	GZ2	219.59	496.98
Massachusetts					
Aetna Healthfund CDHP-Most of Massachusetts	877-459-6604	EP1	EP2	275.82	626.36
Michigan					
Aetna Healthfund CDHP-All of Michigan	877-459-6604	G51	G52	268.08	608.80
Minnesota					
Aetna Healthfund CDHP-Most of Minnesota	877-459-6604	H41	H42	263.70	598.85
Mississippi					
Aetna Healthfund CDHP-Most of Mississippi	877-459-6604	H41	H42	263.70	598.85
Missouri					
Aetna Healthfund CDHP-Most of Missouri	877-459-6604	G51	G52	268.08	608.80
Coventry Health Care of Kansas (Kansas City)-HDHP-Kansas City Metro Area (KS and MO)	800-969-3343	9H1	9H2	195.77	460.05
Humana CoverageFirst -CDHP- Kansas City Area	888-393-6765	PH1	PH2	204.63	455.30

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
Maine								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Maryland								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
CareFirst BlueChoice-In-Network	$37.50/$75.00	$1500/$3000	$4000/$8000	Nothing	$300	Nothing	Nothing	0/$25/$45
CareFirst BlueChoice-Out-Network	$37.50/$75.00	$3000/$6000	$6000/$12000	$70	$500	$70	Ded, then Nothing	0/$25/$45
Coventry Health Care HDHP -In-Network	$41.67/$83.34	$2,000/$4,000	$4,000/$8,000	$15	Nothing	Nothing	Nothing	#3/$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
Massachusetts								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Michigan								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Minnesota								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Mississippi								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Missouri								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Coventry Health Care of Kansas (Kansas City)-HDHP	$83.33/$166.66	$2,500/$5,000	$3,500/$7,000	20%	20%	20%	Nothing	20%/20%/20%
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 pages 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
Montana					
Aetna Healthfund CDHP-South/Southeast/Western MT	877-459-6604	H41	H42	263.70	598.85
Nebraska					
Aetna Healthfund CDHP-All of Nebraska	877-459-6604	H41	H42	263.70	598.85
Nevada					
Aetna Healthfund CDHP-Las Vegas Area	877-459-6604	G51	G52	268.08	608.80
New Hampshire					
Aetna Healthfund CDHP-All of New Hampshire	877-459-6604	EP1	EP2	275.82	626.36
New Jersey					
Aetna Healthfund CDHP-All of New Jersey	877-459-6604	EP1	EP2	275.82	626.36
New Mexico					
Aetna Healthfund CDHP-Albuquerque/Dona Ana/Hobbs Area	877-459-6604	G51	G52	268.08	608.80
New York					
Aetna Healthfund CDHP-Most of New York	877-459-6604	EP1	EP2	275.82	626.36
Independent Health Assoc -HDHP- Western New York	800-501-3439	QA4	QA5	182.99	476.55
North Carolina					
Aetna Healthfund CDHP-All of North Carolina	877-459-6604	F51	F52	264.09	599.73

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
Montana								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Nebraska								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Nevada								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
New Hampshire								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
New Jersey								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
New Mexico								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
New York								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Independent Health Assoc.-In-Network	$66.42/$166.67	$2,000/$4,000	$5,000/$10,000	$15	Nothing	20%	Nothing	$7/$25/$40
Independent Health Assoc.-Out-Network	$66.42/$166.67	$2,000/$4,000	$5,000/$10,000	40%	40%	40%	Nothing	N/A
North Carolina								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+

High Deductible and Consumer-Driven Health Plans

See pages 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
North Dakota					
Aetna Healthfund CDHP-Most of North Dakota	877-459-6604	H41	H42	263.70	598.85
Ohio					
AultCare HMO -HDHP- Stark/Carroll/Holmes/Tuscarawas/Wayne Co.	330-363-6360	3A4	3A5	151.84	304.25
Oregon					
Aetna Healthfund CDHP-Most of Oregon	877-459-6604	H41	H42	263.70	598.85
Pennsylvania					
Aetna Healthfund CDHP-All of Pennsylvania	877-459-6604	H41	H42	263.70	598.85
HealthAmerica Pennsylvania-HDHP- Greater Pittsburgh Area	866-351-5946	Y61	Y62	219.96	506.41
UPMC Health Plan -HDHP- Western Pennsylvania	877-648-9641	8W4	8W5	228.80	515.02
Rhode Island					
Aetna Healthfund CDHP-All of Rhode Island	877-459-6604	EP1	EP2	275.82	626.36
South Dakota					
Aetna Healthfund CDHP-Rapid City/Sioux Falls Area	877-459-6604	G51	G52	268.08	608.80
Tennessee					
Aetna Healthfund CDHP-Most of Tennessee	877-459-6604	F51	F52	264.09	599.73

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
North Dakota								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Ohio								
AultCare HMO-In-Network	$79.08/$158.41	$2,000/$4,000	$4,000/$8,000	20%	20%	20%	Nothing	20%/20%/20%
AultCare HMO-Out-Network	$79.08/$158.41	$4,000/$8,000	$8,000/$16,000	40% UCR	40% UCR	40% UCR	50% UCR	20% Plan Allow
Oregon								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Pennsylvania								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
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	$83.33/$166.67	$2,000/$4,000	$3,000/$6,000	10% after Deduct	10% after Ded	100% after Ded	Nothing	$5/$35/$70
UPMC Health Plan-Out-Network	$83.33/$166.67	$2,000/$4,000	$6,000/$12,000	30% after Deduct	30% after Ded	30% after Ded	30%	N/A
Rhode Island								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
South Dakota								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Tennessee								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+

High Deductible and Consumer-Driven Health Plans

See pages 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
Texas					
Humana CoverageFirst -CDHP- Corpus Christi Area	888-393-6765	TP1	TP2	225.67	502.10
Humana CoverageFirst -CDHP- San Antonio Area	888-393-6765	TU1	TU2	227.36	505.89
Humana CoverageFirst -CDHP- Austin Area	888-393-6765	TV1	TV2	238.73	531.17
Utah					
Aetna Healthfund CDHP-Most of Utah	877-459-6604	G51	G52	268.08	608.80
Altius Health Plans -HDHP- Wasatch Front	800-377-4161	9K4	9K5	160.70	332.92
Vermont					
Aetna Healthfund CDHP-All of Vermont	877-459-6604	EP1	EP2	275.82	626.36
Virginia					
Aetna Healthfund CDHP-Most of Virginia	877-459-6604	F51	F52	264.09	599.73
CareFirst BlueChoice-HDHP-Northern Virginia	888-789-9065	B61	B62	235.27	524.78
Washington					
Aetna Healthfund CDHP-Most of Washington	877-459-6604	G51	G52	268.08	608.80
KPS Health Plans -HDHP- All of Washington	800-552-7114	L14	L15	185.02	404.30

The information contained in this Guide is not the official statement of benefits. Each plan's Federal brochure is the official statement of benefits.

Plan Name	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
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+
Utah								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Altius Health Plans	$45.83/$91.66	$1,250/$2,500	$5,000/$10,000	$20	10%	10%	Nothing	$7/$25/$50
Vermont								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%
Virginia								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
CareFirst BlueChoice-In-Network	$37.50/$75.00	$1,500/$3,000	$4,000/$8,000	Nothing	$300	Nothing	Nothing	0/$25/$45
CareFirst BlueChoice-Out-Network	$37.50/$75.00	$3,000/$6,000	$6,000/$12,000	$70	$500	$70	Ded, then Nothing	0/$25/$45
Washington								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
KPS Health Plans-In-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	20%	None	20%	Nothing	$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

High Deductible and Consumer-Driven Health Plans

See pages 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
West Virgina					
Aetna Healthfund CDHP-Most of West Virgina	877-459-6604	F51	F52	264.09	599.73
Wyoming					
Aetna Healthfund CDHP-All of Wyoming	877-459-6604	H41	H42	263.70	598.85
Altius Health Plans -HDHP- Uinta County	800-377-4161	9K4	9K5	160.70	332.92

The information contained in this Guide is not the official statement of benefits. Each plan's Federal brochure is the official statement of benefits.

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
West Virgina								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Wyoming								
Aetna Healthfund CDHP-In-Network	$83.33/$166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna Healthfund CDHP-Out-Network	$83.33/$166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%/40%+/40%+
Altius Health Plans	$45.83/$91.66	$1,250/$2,500	$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, 2012. You should contact your State for further information –

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

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
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on 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: http://www.kdheks.gov/hcf/
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.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html
Phone: 1-800-572-3839

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

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

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

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx
Phone: 1-877-255-3092

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: www.dhhs.nh.gov/ombp/index.htm
Phone: 603-271-5218

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

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

NORTH CAROLINA – Medicaid and CHIP
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

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

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

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

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

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

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

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

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

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

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 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: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

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

WYOMING – Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, 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)

Medical Loss Ratio
Premium Rebates

What is a Medical Loss Ratio?
A medical loss ratio (MLR) is the proportion of health insurance premiums collected by a health insurer that is spent on clinical services and quality improvement. The MLR for each insurer is calculated by dividing the amount of health insurance premiums spent on clinical services and quality improvement by the total amount of health insurance premiums collected.

What is the MLR requirement under the Affordable Care Act (ACA)?
Starting in 2011, the ACA requires each large group health insurer to spend at least 85% of collected health insurance premiums on clinical services and quality improvement each year or provide a rebate. This is often explained as a plan spending a minimum of $0.85 of every $1.00 paid in health insurance premiums on clinical services and quality improvement, and a maximum of $0.15 of every $1.00 on administrative costs. Each health insurer must reimburse policyholders any difference between the MLR and the 85% minimum expenditure. The MLR requirement is important because it requires health insurers to provide consumers with value for their premium payments.

Will every Federal Employees Health Benefit (FEHB) plan issue a rebate?
No. Only health insurers failing to meet the minimum MLR under the ACA will issue rebates to the policyholder. Although administrative costs in the FEHB Program are generally lower than other plans in the large group market, some insurers offering FEHB Plans will owe a rebate because the MLR for an insurer is calculated based on all of the insurer's business in each market within a state. The Office of Personnel Management (OPM) administers the FEHB Program, and is the policyholder for all plans within the FEHB Program. Health insurers for FEHB Plans that have met the MLR standard do not need to issue rebates. Health insurers for FEHB Plans that have not met the MLR standard will issue rebates to OPM and OPM will use these rebates to reduce future premiums, as described below.

Who receives the rebate?
OPM is the policyholder for all plans within the FEHB Program. Consistent with Federal Acquisition Regulation Section 31.201, any FEHB Program health insurer failing to meet the minimum MLR will issue rebates directly to OPM. These rebates will be used to reduce the cost of health insurance premiums for that insurer's FEHB Plan for the next plan year.

How will rebates be used?
Any rebates issued by health insurers participating in the FEHB Program will be sent to the Office of Personnel Management and will be deposited into the contingency reserve of the health plan offered by the insurer that paid the rebate and will be used to directly reduce the cost of the next year's health insurance premiums for participants in that insurer's FEHB Plan.

How will I know if my health insurer has issued a rebate?
Health insurers are required to mail notices to their enrollees notifying them if the insurer did or did not meet the MLR standard.

How much is the rebate?
The amount of the rebate depends on each health insurer's MLR. For example, the insurer for a large group plan that spent 80% of health insurance premiums on clinical services and quality improvement would reimburse each large group policyholder (OPM, for FEHB Plans) the 5% difference between actual expenses (80%) and the minimum requirement (85%). The total dollar amount varies by insurer.

Additional Information
For specific information about your FEHB Plan and the MLR requirement, please contact your health insurance plan.

Summary Information

	Newly Eligible Employees Can Enroll	Open Season	How to Enroll	Program Website
FEHB	Within 60 days of becoming eligible	Annual – November 12 to December 11, 2012 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 of becoming eligible	Annual – November 12 to December 10, 2012 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**
FLTCIP	Apply (not necessarily enroll) within 60 days of becoming eligible 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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