The **2014**

Guide To Benefits

For Information Technology/Accounting Services 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/healthcare-insurance

Healthcare and Insurance

RI 70 2IT
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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 2014, 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.
- Be sure to read the Health Insurance Marketplace letter and notice at the back of this guide.

Summary Information

	New Hires Can Enroll	Open Season	How to Enroll	Program Website
FEHB	Within 60 days from new hire date	Annual – November 11 to December 10, 2013 5 p.m. Central Time	*PostalEASE* https://liteblue.usps.gov 1-877-477-3273, option 1	**www.opm.gov/healthcare-insurance/healthcare**
FEDVIP	Within 60 days from new hire date	Annual – November 11 to December 9, 2013 11:59 p.m. Eastern Time	Go to www.BENEFEDS.com or call 1-877-888-3337 TTY 1-877-889-5680	**www.opm.gov/healthcare-insurance/dental-vision**
FSA	During 26th or 27th pay period after career appointment	Annual – November 11 to December 22, 2013 5 p.m. Central Time	*PostalEASE*	**https://liteblue.usps.gov**
FEGLI	Within 60 days from new hire date for optional insurance; automatically enrolled in Basic insurance until you take action to cancel	No annual Open Season	Via SF 2817 for new hires Others provide medical information on SF 2822	**www.opm.gov/healthcare-insurance/life-insurance**
FLTCIP	Apply (not necessarily enroll) within 60 days from new hire date with abbreviated underwriting	No annual Open Season	Go to www.LTCFEDS.com/usps or call 1-800-582-3337 TTY 1-800-843-3557	**www.opm.gov/healthcare-insurance/long-term-care**

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Introduction to Benefits and This Guide

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

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

Benefits Programs included in this Guide

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

- Federal Employees Health Benefits Program (FEHB)
- Federal Employees Dental and Vision Insurance Program (FEDVIP)
- USPS Flexible Spending Accounts Program (FSA)
- Federal Employees' Group Life Insurance Program (FEGLI)
- Federal Long Term Care Insurance Program (FLTCIP)

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.

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

Additional Information

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

Benefits Snapshot

New or Newly Eligible Employees

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

FEHB	1. See page 9 for general information on FEHB (including eligibility) and for guidance on choosing a plan; 2. If you decide to enroll, examine the 2014 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 2014 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 2014 FEDVIP Guide for USPS Employees for complete information.
FSA	1. See page 24 for general information on FSA (including eligibility) and for guidance on making a decision whether to participate; 2. See the USPS FSA brochure (November 2013) for complete information.
FEGLI	1. See page 28 for general information on FEGLI (including eligibility) and for guidance on making a decision whether to select optional insurance (Basic FEGLI is automatic); 2. See page 30 for information on how to enroll.
FLTCIP	1. See page 31 for general information on FLTCIP (including eligibility) and for guidance on making a decision whether to apply; 2. See page 32 for information on how to apply for coverage.

Open Season Snapshot

Current Employees

During Open Season, you have the opportunity to 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 2014 premiums and satisfaction survey results in Appendix F; 2. Examine your plan's 2014 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 2014, **do nothing** – your enrollment will continue automatically; 5. If **not** satisfied with your current plan for 2014, see Appendix B for guidance on choosing another plan. 6. See page 6 for information on FEHB and retirement.	1. See page 9 for general information on FEHB (including eligibility) and Appendix B for guidance on choosing a plan; 2. If you decide to enroll, examine the 2014 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 38-44 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 2014 premiums in the FEDVIP Guide and examine your plan's 2014 brochure for benefit and enrollment/service area changes; 2. If also enrolled in FEHB, check your 2014 FEHB brochure for any changes in dental and/or vision benefits; 3. Check the FEDVIP Guide for new plans available to you. 4. If satisfied with your plan's rates and benefits for 2014, **do nothing** – your enrollment will continue automatically; 5. If **not** satisfied with your current plan for 2014, see the FEDVIP Guide for guidance on choosing another plan and for information on how to change your enrollment; 6. 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. 7. See page 20 for information on FEDVIP and retirement.	1. See page 20 or general information on FEDVIP (including eligibility) and for guidance on choosing a FEDVIP plan; 2. If you decide to enroll, examine the 2014 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 2014 FEHB brochure for any changes in dental and/or vision benefits. 4. See page 20 and the 2014 FEDVIP Guide for information on how to enroll.
FSA	1. If you want to participate in 2014, **you must make a new election**. Keep in mind your election and enrollment do **not** carry over from year to year; see page 24 for information on how to enroll; 2. Check your 2014 FEHB and 2014 FEDVIP plan brochures to see how any benefit changes may affect your out-of-pocket health care expenses; 3. See the USPS FSA brochure for any updated information about the Program. 4. See page 24 for information on FSA and retirement.	1. See page 24 for general information on FSA (including eligibility) and for guidance on making a decision whether to participate; 2. See page 24 and the USPS FSA brochure (November 2013) 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.

FSA

- You may request payment only for the expenses of services or items received up to and including your retirement date.
- Exception: if you retire on December 31, you are eligible for the FSA Grace Period, so you may request payment for expenses through the following March 15.
- Your FSA claims will be processed if they are received at the FSA Customer Services Center by September 30 of the year following the plan year.
- You cannot continue your FSA coverage after you retire.
- You must pay a full period contribution for any pay period during which you are on Postal Service rolls, even if it is only the first day of the pay period. (The payroll system does not prorate your FSA contribution.)
- The collection of FSA contributions (including the collection of missed contributions) relates strictly to the amount of the contributions you were scheduled to make each pay period while you were an FSA participant.
- What you actually claim, whether it is more or less than what you were scheduled to contribute each pay period while you were an FSA participant, does not affect what you must pay in contributions.
- If you missed contributions you were scheduled to make from your paychecks because you were on Leave Without Pay (LWOP) or had low pay, you must make up the missed contributions.
- If you missed contributions, you cannot reduce what you owe by not filing claims. These rules apply to any type of retirement, including a disability retirement.
- Refer to brochure FSA BK1, *Flexible Spending Accounts* (November 2013), which is being mailed to all career employees for the FSA open season, for the details.

Benefits Facts *continued*

FEGLI

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

FLTCIP

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

Federal Employees Health Benefits (FEHB) Program

Overview

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

While FEHB eligibility, enrollment requirements and the plans available for 2014 are the same for federal and USPS employees alike, the Postal Service pays a higher percentage contribution towards career Postal employee premium rates than the rest of the federal government. All employee premium rates are calculated using the "Fair Share Formula."

What does this program offer?

The FEHB Program offers a wide variety of plans and coverage to help you meet your health care needs. It is group coverage available to employees, retirees and their eligible family members. If you continuously maintain your FEHB enrollment, or are covered by another FEHB enrollment as a family member, or a combination of both, for the five years of service immediately preceding your retirement, 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.

Federal Employees Health Benefits (FEHB) Program

Coverage

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?

The Postal Service pays the lesser of 81% of the average premium of all plans weighted by the number of enrollees in each plan but not more than 84.50% of the total premium for an 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.**

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 same-sex spouse whom you have legally married in a jurisdiction that permitted same-sex marriage, regardless of where you live and work.
- 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.

When Can I Enroll Or Change My Enrollment?

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

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

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

For new or newly eligible employees who elect to enroll, coverage will be effective on the first day of the first pay period that begins after the Human Resources Shared Service Center (HRSSC) 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 you have the opportunity to enroll or change enrollment during an Open Season. **The 2013 Open Season is from November 11 through December 10 at 5:00 p.m. Central Time.** Employees may make any one – or a combination – of the following changes:

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

If you decide to do any of the above actions, you MUST follow the instructions on the *PostalEASE* FEHB Worksheet contained in this Guide and enter your election in *PostalEASE* by 5:00 p.m. Central Time on December 10, 2013. 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 11, 2014, and the change in premium rate deductions will be seen on your January 31, 2014, 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 2014. If your plan is not participating in 2014 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 10, 2014.

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

Federal Employees Health Benefits (FEHB) Program

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 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. Be sure to read the section on the pre-tax payment of health insurance premium contributions, which specifies Internal Revenue Service (IRS) restrictions for reducing or canceling coverage (see pages 17 through 19 of this Guide). Also be sure to refer to the Table of Permissible Changes on pages 46 through 49 of this Guide. You can go to https://liteblue.usps.gov and download all of the Benefits Guides including the Guide for APWU, NALC, NPMHU and NRLCA Career Postal Service Employees, the Guide for U.S. Postal Service Inspectors, Office of Inspector General employees and Postal Career Executive Service Employees, the Guide for Information Technology/Accounting Services, the Guide for Nurses, 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/healthcare-insurance/healthcare.

After referring to these sources, if you still have questions regarding eligibility, 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.

How do I enroll or change my enrollment?

- Complete the *PostalEASE* FEHB Worksheet on pages 38 through 44.
- 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/healthcare-insurance/healthcare 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

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
- Separation
- Divorce
- Death
- LWOP Status*

*Leave Without Pay Status – FEHB Program regulations state that you may continue your FEHB coverage for up to 365 days while you are in a Leave Without Pay (LWOP) status, provided that you pay the employee share of the premium, either while on LWOP or when you return to a pay status.
The 365 days of continued enrollment during leave without pay status is not considered to be broken by any period(s) in pay status of less than 4 consecutive months. If you are in a pay status during any part of a pay period, the entire pay period is not counted toward the 365-day limit.

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

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

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

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

It is your responsibility to report life events that may cause you or your family member to lose eligibility. It is also your responsibility to complete and submit any required paperwork to the 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 46 through 49 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.

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/healthcare-insurance/special-initiatives/managing-my-own-health. 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/healthcare-insurance/healthcare/reference-materials/#url=HIT 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, the Postal Service expects that employees who make health benefits changes will get their new insurance cards more quickly. All the information you need for using *PostalEASE* is included in the FEHB *PostalEASE* Worksheet found on pages 38 – 44 of this Guide. Just follow the instructions to:

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

If you want to make a change for the 2014 plan year, you may do so during the annual FEHB Open Season, which is from November 11 through December 10, 2013, at 5:00 PM Central Time. If you currently have an FEHB enrollment and you do not want to make any changes, *do nothing*. Your coverage will continue automatically.

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

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

This Guide contains important FEHB policy information that used to be provided to you as part of the SF 2809 *Health Benefits Election Form*. Be sure you understand how your health benefits work, including information on which family members are eligible, how you pay for your health benefits premiums using pre-tax dollars, and the limitations on making a health benefits change outside of open season. As a reminder, to continue health benefits coverage during retirement, you must 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

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

Pre-Tax Withholding

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

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

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

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

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

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

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

Reducing Coverage

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

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

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

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

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

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

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

Contact the HRSSC 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.

How to Waive or Restore Pre-Tax Payments

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

If you wish to pay your premiums with after-tax money, you must contact the HRSSC and ask for Postal Service (PS) Form 8201, *Pre-tax Health Insurance Premium Waiver/Restoration Form*. During Open Season, complete the form and return it to the HRSSC by close of business December 10, 2013. If this is your initial opportunity to enroll in FEHB, you have 60 days to submit your election to the HRSSC. You also may make such an election when you have a qualifying life event which is shown in the chart on pages 46 to 49 of this Guide. Refer to the column labeled "Premium Conversion Election Change That May Be Permitted." You must also satisfy the time limits shown in the column labeled "Time Limits in Which Change May Be Permitted."

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

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

Your Right to More Information

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

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

Federal Employees Dental and Vision Insurance Program (FEDVIP)

What does this Program offer?

The Federal Employees Dental and Vision Insurance Program provides comprehensive dental and vision insurance at competitive group rates. There are ten dental plans and four 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 2014, provided you remain eligible for the program. Enrollment continues year to year, automatically. **Please Note**: your premiums and benefits may change for 2014.

Key FEDVIP facts

- FEDVIP is part of the annual Open Season.
- 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 of yourself or spouse 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 USPS 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 listed on the coverage.

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?

If you are a Federal or U.S. Postal Service employee eligible for the FEHB Program or the Health Insurance Marketplace (Exchange), you are eligible to enroll in FEDVIP. It does not matter if you are actually enrolled in FEHB or the Health Insurance Marketplace (Exchange) – eligibility is the key. 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 three regional dental plans 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/healthcare-insurance/dental-vision for premium and rating region information.

Federal Employees Dental and Vision Insurance Program (FEDVIP)

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 2013), will be mailed to all employees.

How do I get more information about this program?

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

USPS Flexible Spending Accounts Program (FSA)

Flexible Spending Accounts (FSA) Open Season

- Enrollment for 2014 FSAs begins: November 11, 2013
- Enrollment ends: December 22, 2013 (5:00 P.M. Central Time)
- Enrollments are effective: January 1, 2014

Who can enroll?

Only career employees are eligible to enroll in FSAs for 2014.

Which family members are eligible?

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

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

What Are FSAs for and how do they work?

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

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

You can get a tax break, though, by signing up for Flexible Spending Accounts (FSAs). You decide how much to contribute for 2014. Then, you contribute money every payday to an FSA, which is an account that allows you to cover your eligible health care expenses throughout the year with tax-free money. Meanwhile, whatever you contribute isn't subject to Federal income tax, or Social Security tax, or Medicare tax. Since, you get a tax break each payday, it's cheaper to pay for your health care expenses through an FSA. (Without an FSA, you pay for health care expenses using your checkbook or a credit card, and there's no tax break at all.)

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

The full amount that you sign up for is available to you beginning January 1, 2014, to cover your eligible expenses, even though FSA contributions are taken from your pay over the entire year. So, for example, if you have Lasik surgery in February and it costs you $2,000, you can withdraw the entire amount from your Health Care FSA even though you won't have had that much withheld from your pay at that time. It works the same way for the Dependent Care FSA too.

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

What are the contribution limits?

You can contribute up to $2,500 to the Health Care FSA. You can contribute up to $5,000 to the Dependent Care FSA (or $2,500 if you are married and file separately).

How do I enroll?

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

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

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

If you have a medical condition that interferes or for another reason cannot successfully complete your transaction using *PostalEASE*, contact the Human Resources Shared Service Center (HRSSC) for assistance at 1-877-477-3273, option 5; TTY 1-866-260-7507.

Details are in the mail

A leaflet and a brochure, FSA BK1, *Flexible Spending Accounts* (November 2013), with a *PostalEASE* FSA worksheet and a claim form included, are being mailed to all career employees. If you do not receive yours by November 29, 2013, contact the HRSSC.

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

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

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

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

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

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

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

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

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

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

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

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

Making a change

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

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

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

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

Questions

Hotline for FSA questions: 800-842-2026.

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

Federal Employees' Group Life Insurance (FEGLI) Program

What does this Program offer?

The FEGLI Program offers group term life insurance.

Key FEGLI facts

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

What coverage is available?

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

Optional insurance

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

How much does it cost?

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

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

Am I eligible to enroll?

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

Which family members are eligible?

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

When can I enroll or change my enrollment?

There is no annual Open Season for FEGLI.

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

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

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

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

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

Federal Employees' Group Life Insurance (FEGLI) Program

How do I enroll?

Contact the Human Resources Shared Service Center (HRSSC) on 1-877-477-3273, option 5; TTY 1-866-260-7507 for details on how you can enroll.

Who gets the benefits paid after my death?

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

How does my beneficiary file a claim?

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

How do I get more information about this Program?

Contact the HRSSC on 1-877-477-3273, option 5; TTY 1-866-260-7507. If you are retired, contact OPM's Retirement Operations Center at retire@opm.gov or by calling 1-888-767-6738. Neither OFEGLI nor OPM's Insurance Operations offices maintain records for active Postal Service employees or retirees.

Federal Long Term Care Insurance Program (FLTCIP)

What does this Program offer?

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

Key FLTCIP facts

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

How much does it cost?

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

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

Am I eligible to apply?

Most Postal Service employees are eligible to apply for coverage. If you are a Federal or U.S. Postal Service employee eligible for the FEHB Program or the Health Insurance Marketplace (Exchange), you are eligible to apply for coverage under FLTCIP. It does not matter if you are actually enrolled in FEHB or the Health Insurance Marketplace (Exchange) – eligibility is the key. 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.

Appendix A
FEHB Program Features

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

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

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

A Government contribution. The Postal Service pays the lesser of 81% of the average premium of all plans weighted by the number of enrollees in each plan but not more than 84.5% of the total premium for any individual plan.

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

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 45 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/healthcare-insurance/healthcare/plan-information/compare-plans/. You can also find help in selecting a plan using tools provided by PlanSmartChoice and Consumer's Checkbook at www.opm.gov/healthcare-insurance/healthcare/plan-information.

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/healthcare-insurance/healthcare/plan-information/quality-healthcare-scores .

    - 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:

- **O e a P a Sa fac** – 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.

- **Ge Needed Ca e** – How often was it easy to get an appointment, the care, tests, or treatment you thought you needed through your health plan?

- **Ge Ca e Q c** – 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?

- **H We D c C ca e** – 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?

- **C e Se ce** – 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?

- **C a P ce** – How often did your health plan handle your claims quickly and correctly?

- **P a I f a C** – 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 11, 2013 – December 10, 2013, 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 Postal Police and Non-Bargaining Management career USPS employees, **RI 70-2A** for APWU, NALC, NPMHU and NRLCA career USPS employees, **RI 70-2IN** for career U.S. Postal Inspectors, Office of the Inspector General and PCES employees, **RI 70-2IT** for IT/ASC career employees, **RI 70-2NU** for career USPS Nurse 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 HP105SLF 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 Postal Police and Non-Bargaining Management career USPS employees • RI 70-2A for APWU, NALC, NPMHU and NRLCA career employees
- RI 70-2IN for career U.S. Postal Inspectors, Office of the Inspector General, and PCES employees • RI 70-2IT for IT/ASC career employees,
- RI 70-2NU for career USPS Nurse 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, 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, 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, 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/healthcare-insurance/healthcare.

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 *Employees may enroll or change beginning 31 days before the event*	Yes	Yes	Yes	Yes	Yes	Within 60 days after change in family status
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 member 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 52 through 55)

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

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

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

Fee-for-Service plans open only to specific groups – Several Fee-for-Service plans that are sponsored or underwritten by an employee organization strictly limit enrollment to persons who are members of that organization. If you are not certain if you are eligible, check with the Human Resources Shared Service Center (HRSSC), 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 57.

The High Deductible Health Plan (HDHP) and Consumer-Driven Health Plan (CDHP) section begins on page 102.

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	39.12	88.45
Blue Cross and Blue Shield Service Benefit Plan (BCBS) -std	Local phone #	104	105	63.23	150.28
Blue Cross and Blue Shield Service Benefit Plan (BCBS) -basic	Local phone #	111	112	37.80	88.51
GEHA Benefit Plan (GEHA) -high	800-821-6136	311	312	69.18	168.27
GEHA Benefit Plan (GEHA) -std	800-821-6136	314	315	29.81	67.79
MHBP -std	800-410-7778	454	455	71.93	178.68
MHBP -Value Plan	800-410-7778	414	415	32.34	77.11
NALC -high	888-636-6252	321	322	49.82	96.35
NALC Value Option	888-636-6252	KM1	KM2	25.76	55.93
SAMBA -high	800-638-6589	441	442	102.44	270.02
SAMBA -std	800-638-6589	444	445	37.69	86.08
Plan Name: Open Only to Specific Groups					
Compass Rose Health Plan (CRHP) -high	888-438-9135	421	422	47.47	125.48
Foreign Service Benefit Plan (FS) -high	202-833-4910	401	402	35.87	88.38
Panama Canal Area Benefit Plan (PCABP) -high	800-424-8196	431	432	31.96	66.72
Rural Carrier Benefit Plan (Rural) -high	800-638-8432	381	382	62.70	86.45

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

Prescription Drug Payment Level Plans use terms such as Level (L I, L II) or Tier (T1, T2,) to show what you pay for generic or brand name prescription drugs. The payment levels that plans use follow: **L I or Tier 1** includes generic drugs, but may include some preferred brands. **L II or Tier 2** includes preferred brands and may include some generics. **L III or Tier 3** includes non-preferred brands, other covered drugs, and with some exceptions, specialty drugs. **L IV or Tier 4** includes mostly preferred specialty drugs. **L V or Tier 5** generally includes non-preferred specialty drugs.

Mail Order Discounts – If your plan has a Mail Order program (typically for maintenance drugs) and its response is **Ye** , in general, its Mail Order program is superior to its retail pharmacy benefit (e.g., you obtain a greater quantity for less cost than retail pharmacy purchases). If your plan does not have a Mail Order program or it does not offer a superior benefit to retail pharmacy purchases, the response will be **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% Medicare B 45%+ T1-T5	T2 30%/$80 T3 45%/$105 T4 30%/$35/$95 T5 30%/$55/$155	Yes Yes
BCBS -basic	PPO	None	None	$175/day $875 Max	$25	$200	Nothing	$10/30day $30/90day	T2 $45 T3 50%($55Min) T4 $50to$140 T5 $70to$195	N/A
GEHA -high	PPO Non-PPO	$350 $350	None None	$100 $300	$20 25%	10% 25%	Nothing Nothing	$10 $10	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%	$10 $10	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%+	30%/45% 45%+/45%+	Yes Yes
NALC Value	Non-PPO PPO	$4,000 $2,000	None None	50% 20%	50% 20%	50% 20%	50% 20%	50% $10	50%/50%+ $40/$60	No No
SAMBA -high	PPO Non-PPO	$300 $300	None None	$200 $300	$20 30%	10% 30%	Nothing 30%	$8 $8	20%($55 max)/35%($100 max) 20%($55 max)/35%($100 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%	$8 $8	30%($70 max)/40%($110 max) 30%($70 max)/40%($110 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%/$30min/30%/$50min 25%/$30min/30%/$50min	Yes Yes
PCABP	PPO Non-PPO	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 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						
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		**80.5**	**92.7**	**91.7**	**95.1**	**91.1**	**93.4**	**71.6**
APWU Health Plan -high	47 47	77.2	92.7	93.5	95.1	89	92.1	68.2
Blue Cross and Blue Shield Service Benefit Plan -std	10 10	83.5	94.6	91.7	95.5	92.6	95.6	70.3
Blue Cross and Blue Shield Service Benefit Plan -basic	11	75.7	89.6	89.1	95	92.1	93.6	64.3
GEHA Benefit Plan -high	31 31	83.8	93.4	92.2	96.1	91.2	92.9	69.9
GEHA Benefit Plan -std	31 31	72.5	90.7	89.5	94.9	87.5	92.6	68.8
MHBP -std	45 45	84	93.8	91.6	93.5	90.6	95.4	69.6
MHBP -Value Plan	41 41	63	90.8	85.7	92.9	86.6	88.7	63.6
NALC -high	32 32	85.6	93.6	92.2	95.9	93.4	96.5	77.1
NALC -Value Option	KM KM							
SAMBA -high	44 44	89.7	94.7	94.3	96	94.6	95.3	78.9
SAMBA -std	44 44	81.6	93	90.5	95.6	91.1	94.6	75.7

Plan Name: Open Only to Specific Groups

FFS National Average		**80.5**	**92.7**	**91.7**	**95.1**	**91.1**	**93.4**	**71.6**
Compass Rose Health Plan	42 42	83.7	94.1	94.5	96.2	94	92.7	74.7
Foreign Service Benefit Plan	40 40	79.8	89.8	90.9	93.5	89.2	88.9	72.1
Panama Canal Area Benefit Plan	43 43							
Rural Carrier Benefit Plan	38 38	86.5	94.6	94.7	96.7	92.8	96.6	77.3

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		**80.5**	**92.7**	**91.7**	**95.1**	**91.1**	**93.4**	**71.6**
Blue Cross and Blue Shield Service - Standard	Arizona	10	85.1	90.5	91.9	93.3	93.8	96.9	72.4
Benefit Plan - Basic		11	74.7	89.8	88.4	92.3	91.4	92.8	68.0
Blue Cross and Blue Shield Service - Standard	California	10	80.9	91.5	89.7	95.4	88.1	93.7	67.7
Benefit Plan - Basic		11	70.5	87.3	84.0	94.3	91.0	91.2	61.6
Blue Cross and Blue Shield Service - Standard	District of Columbia	10	76.8	93.5	93.0	95.1	88.2	89.8	65.7
Benefit Plan - Basic		11	69.1	89.3	87.4	94.0	88.1	92.2	62.2
Blue Cross and Blue Shield Service - Standard	Florida	10	86.4	94.2	92.2	95.2	93.4	95.4	73.3
Benefit Plan - Basic		11	80.6	91.6	89.4	94.7	91.6	93.7	66.0
Blue Cross and Blue Shield Service - Standard	Illinois	10	86.1	93.3	93.4	95.5	90.1	97.2	71.2
Benefit Plan - Basic		11	79.6	91.2	88.1	95.0	93.6	93.8	65.3
Blue Cross and Blue Shield Service - Standard	Maryland	10	85.7	93.1	91.7	95.4	89.7	95.6	71.3
Benefit Plan - Basic		11	77.0	89.7	89.8	94.0	92.1	96.7	66.6
Blue Cross and Blue Shield Service - Standard	Texas	10	88.7	93.4	93.1	95.0	93.6	95.7	72.1
Benefit Plan - Basic		11	82.5	89.8	88.3	95.5	91.0	96.7	61.7
Blue Cross and Blue Shield Service - Standard	Virginia	10	87.1	92.4	92.9	96.6	91.4	95.9	70.8
Benefit Plan - Basic		11	78.2	90.1	89.4	96.2	91.7	96.0	68.1

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.

Appendix F
FEHB Plan Comparison Charts

Health Maintenance Organization Plans and Plans Offering a Point-of-Service Product (Pages 58 through 95)

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

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

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

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

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

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

Prescription drug Payment Levels – Plans use terms such as Level (L I, L II) or Tier (T1, T2,) to show what you pay for generic or brand name prescription drugs. The payment levels that plans use follow: **L I or Tier 1** includes generic drugs, but may include some preferred brands. **L II or Tier 2** includes preferred brands and may include some generics. **L III or Tier 3** includes non-preferred brands, other covered drugs, and with some exceptions, specialty drugs. **L IV or Tier 4** includes mostly preferred specialty drugs. **L V or Tier 5** generally includes non-preferred specialty drugs.

Mail Order Discounts If your plan has a Mail Order program (typically for maintenance drugs) and its response is **"Yes"**, in general, its Mail Order program is superior to its retail pharmacy benefit (e.g., you obtain a greater quantity for less cost than retail pharmacy purchases). If your plan does not have a Mail Order program or it does not offer a superior benefit to retail pharmacy purchases, the response will be **"No"**.

Member Survey Results – See Appendix C for a description.

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Alabama					
Aetna Value Plan- Most of Alabama	877-459-6604	F54	F55	37.37	84.86
Alaska					
Aetna Value Plan- Most of Alaska	877-459-6604	JS4	JS5	55.06	135.18
Arizona					
Aetna Value Plan- All of Arizona	877-459-6604	G54	G55	36.69	83.33
Aetna Open Access-High-Phoenix and Tucson Areas	877-459-6604	WQ1	WQ2	129.94	356.94
Health Net of Arizona, Inc. -high- Maricopa/Pima/Other AZ counties	800-289-2818	A71	A72	97.94	315.93
Health Net of Arizona, Inc. -std- Maricopa/Pima/Other AZ counties	800-289-2818	A74	A75	65.45	233.65
Humana Health Plan, Inc. -High- Phoenix	888-393-6765	BF1	BF2	39.72	88.37
Humana Health Plan, Inc. -Std- Phoenix	888-393-6765	BF4	BF5	35.74	79.53
Humana Health Plan, Inc. -High- Tucson	888-393-6765	C71	C72	48.45	107.81
Humana Health Plan, Inc. -Std- Tucson	888-393-6765	C74	C75	37.63	83.72
Arkansas					
Aetna Value Plan- Most of Arkansas	877-459-6604	F54	F55	37.37	84.86
QualChoice -High- All of Arkansas	800-235-7017	DH1	DH2	115.50	296.33
QualChoice -Std- All of Arkansas	800-235-7017	DH4	DH5	41.39	122.77

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			67.9	86.4	84.9	94.2	87.7	87.5	64.9
Alabama													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Alaska													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Arizona													
Aetna Value Plan	In-Network	$25/$40	20%	$10		Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	60.2	83.8	86.1	92.3	84.9	91.8	63.6
Health Net of Arizona, Inc.-High		$20/$40	$250/dayx5	$10	$30/50%	Yes	67.6	88.8	84.3	93.9	88.4	92.1	68.6
Health Net of Arizona, Inc.-Standard		$25/$50	25%	$10	$40/50%	Yes	67.6	88.8	84.3	93.9	88.4	92.1	68.6
Humana Health Plan, Inc.-High		$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-High		$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes							
Arkansas													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
QualChoice	In-Network	$20/$30	$100max$500	$0	$40/$60	Yes							
QualChoice	Out-Network	40%/40%	40%	N/A	N/A	N/A							
QualChoice	In-Network	$20/$40	$200max$1,000	$5	$40/$60	Yes							

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
California					
Aetna Value Plan- Most of California	877-459-6604	JS4	JS5	55.06	135.18
Aetna HMO - Los Angeles and San Diego Areas	877-459-6604	2X1	2X2	48.98	138.08
Anthem Blue Cross Select HMO -High- Southern California	800-235-8631	B31	B32	59.38	147.57
Blue Shield of CA Access+HMO -High- Southern Region	800-880-8086	SI1	SI2	60.54	141.76
Health Net of California -High- Northern Region	800-522-0088	LB1	LB2	332.98	789.15
Health Net of California -Std- Northern Region	800-522-0088	LB4	LB5	304.97	724.41
Health Net of California -High- Southern Region	800-522-0088	LP1	LP2	117.04	289.90
Health Net of California -Std- Southern Region	800-522-0088	LP4	LP5	100.15	250.83
Kaiser Foundation Health Plan - Basic Option - Northern California	800-464-4000	KC1	KC2	59.84	165.48
Kaiser Foundation Health Plan of California -High- Northern California	800-464-4000	591	592	138.54	366.57
Kaiser Foundation Health Plan of California -Std- Northern California	800-464-4000	594	595	80.51	213.84
Kaiser Foundation Health Plan of California -High- Southern California	800-464-4000	621	622	40.27	108.19
Kaiser Foundation Health Plan of California -Std- Southern California	800-464-4000	624	625	25.81	59.65
UnitedHealthcare of California -High- Central and Southern California	866-546-0510	CY1	CY2	80.73	197.76
UnitedHealthcare of California -Std- Central and Southern California	866-546-0510	CY4	CY5	37.51	85.95
Colorado					
Aetna Value Plan- All of Colorado	877-459-6604	G54	G55	36.69	83.33
Kaiser Foundation Health Plan of Colorado -High- Denver/Boulder/Southern Colorado areas	800-632-9700	651	652	85.87	201.83
Kaiser Foundation Health Plan of Colorado -Std- Denver/Boulder/Southern Colorado areas	800-632-9700	654	655	28.29	63.94
Connecticut					
Aetna Value Plan- All of Connecticut	877-459-6604	EP4	EP5	36.32	82.49
Delaware					
Aetna Value Plan- All of Delaware	877-459-6604	EP4	EP5	36.32	82.49
Aetna Open Access -High- Kent/New Castle/Sussex areas	877-459-6604	P31	P32	274.49	703.88
Aetna Open Access -Basic- Kent/New Castle/Sussex areas	877-459-6604	P34	P35	204.15	490.04

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						**67.9**	**86.4**	**84.9**	**94.2**	**87.7**	**87.5**	**64.9**
California												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$100	Yes	57.9	76.6	78.1	89.6	76.9	84.9	64.8
Anthem Blue Cross Select HMO-High	$25/$35	$250max4days	$5,$40,$60	$5,$40,$70/$60	Yes							
Blue Shield of CA Access+HMO-High	$20/$30	$200/ x 3 days	$10	$35/50%	Yes	72.6	84.4	80.2	93.7	90	85.5	64.6
Health Net of California-High	$20/$30	$150/dayx5	$10	$35/$60	Yes	67	81.6	81	93	83.1	84.1	63.8
Health Net of California-Standard	$30/$50	$750	$15	$35/$65	Yes	67	81.6	81	93	83.1	84.1	63.8
Health Net of California-High	$20/$30	$150/dayx5	$10	$35/$60	Yes	67	81.6	81	93	83.1	84.1	63.8
Health Net of California-Standard	$30/$50	$750	$15	$35/$65	Yes	67	81.6	81	93	83.1	84.1	63.8
Kaiser Foundation HP - Basic Option	$25/$35	20%	$15	$35/$35	Yes							
Kaiser Foundation HP of California-High	$15/$25	$250	$10	$30/$30	Yes	79.8	88.4	84.8	92.5	87.2	79.3	63
Kaiser Foundation HP of California-Standard	$30/$40	$500	$15	$35/$35	Yes	79.8	88.4	84.8	92.5	87.2	79.3	63
Kaiser Foundation HP of California-High	$15/$25	$250	$10	$30/$30	Yes	83.3	82.8	80.7	93.2	87.8	77.1	68.7
Kaiser Foundation HP of California-Standard	$30/$40	$500	$15	$35/$35	Yes	83.3	82.8	80.7	93.2	87.8	77.1	68.7
UnitedHealthcare of California-High	$20/$35	$150/day x 4	$10	$35/$60	Yes	70.1	80	80.4	92.3	82.5	88.9	57
UnitedHealthcare of California-Standard	$25/$40	30%	$10	$25/$50	Yes	70.1	80	80.4	92.3	82.5	88.9	57
Colorado												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Kaiser Foundation HP of Colorado-High	$20/$40	$250x3	$10	$35/$60	Yes	72.2	88.4	87.3	93.6	87.6	87.9	62.2
Kaiser Foundation HP of Colorado-Standard	$20/$40	10%	$15	$40/$80	Yes	72.2	88.4	87.3	93.6	87.6	87.9	62.2
Connecticut												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Delaware												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$100	Yes	60.2	86.2	85.5	97.2	86.5	87.2	61.8
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$100	Yes	60.2	86.2	85.5	97.2	86.5	87.2	61.8

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
District of Columbia					
Aetna Value Plan- All of Washington DC	877-459-6604	F54	F55	37.37	84.86
Aetna Open Access -High- Washington, DC Area	877-459-6604	JN1	JN2	191.72	432.73
Aetna Open Access -Basic- Washington, DC Area	877-459-6604	JN4	JN5	40.12	89.71
CareFirst BlueChoice -High- Washington, D.C. Metro Area	888-789-9065	2G1	2G2	73.15	170.04
CareFirst BlueChoice -Std- Washington, D.C. Metro Area	888-789-9065	2G4	2G5	45.95	108.82
Kaiser Foundation Health Plan Mid-Atlantic States -High- Washington, DC area	877-574-3337	E31	E32	53.53	139.72
Kaiser Foundation Health Plan Mid-Atlantic States -Std- Washington, DC area	877-574-3337	E34	E35	27.60	63.49
M.D. IPA -High- Washington, DC area	877-835-9861	JP1	JP2	68.85	176.64
Florida					
Aetna Value Plan- Most of Florida	877-459-6604	F54	F55	37.37	84.86
AvMed Health Plans -High- Broward, Dade and Palm Beach	800-882-8633	ML1	ML2	69.27	205.05
AvMed Health Plans -Std- Broward, Dade and Palm Beach	800-882-8633	ML4	ML5	36.07	86.57
Capital Health Plan -High- Tallahassee area	850-383-3311	EA1	EA2	33.42	88.56
Coventry Health Plan of Florida -High- Southern Florida	800-441-5501	5E1	5E2	52.32	164.30
Coventry Health Plan of Florida -Std- Southern Florida	800-441-5501	5E4	5E5	35.77	85.86
Humana Value Plan - Tampa Area	888-393-6765	MJ4	MJ5	29.32	64.95
Humana Value Plan - South Florida Area	888-393-6765	QP4	QP5	29.32	64.95
Humana Medical Plan, Inc. -High- Orlando	888-393-6765	E21	E22	37.63	83.72
Humana Medical Plan, Inc. -Std- Orlando	888-393-6765	E24	E25	33.86	75.35
Humana Medical Plan, Inc. -High- South Florida	888-393-6765	EE1	EE2	82.27	183.06
Humana Medical Plan, Inc. -Std- South Florida	888-393-6765	EE4	EE5	48.45	107.81
Humana Medical Plan, Inc. -High- Daytona	888-393-6765	EX1	EX2	39.72	88.37
Humana Medical Plan, Inc. -Std- Daytona	888-393-6765	EX4	EX5	35.74	79.53
Humana Medical Plan, Inc. -High- Tampa	888-393-6765	LL1	LL2	200.27	445.60
Humana Medical Plan, Inc. -Std- Tampa	888-393-6765	LL4	LL5	48.45	107.80

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						**67.9**	**86.4**	**84.9**	**94.2**	**87.7**	**87.5**	**64.9**
District of Columbia												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High	$15/$30	$150/day x3	$5	$35/$100	Yes	69	84.4	87.2	94.2	86.5	91.4	56.7
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$100	Yes	69	84.4	87.2	94.2	86.5	91.4	56.7
CareFirst BlueChoice-High	$25/$35	$200	Nothing	$35/$65	Yes	64.8	86	83.3	92.5	84.6	90.2	54
CareFirst BlueChoice In-Network	Nothing/$35	$200	Nothing	$35/$65	Yes	64.8	86	83.3	92.5	84.6	90.2	54
CareFirst BlueChoice Out-Network	$70/$70	$500	Nothing	$35/$65	Yes							
Kaiser Foundation HP Mid-Atlantic States-High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	83	86.7	83.1	92.7	81.3	83.6	70.2
Kaiser Foundation HP Mid-Atlantic States-Standard	$20/$30	$250/dayx3	$12/$22Net	$35/$55/$50/$70	Yes	83	86.7	83.1	92.7	81.3	83.6	70.2
M.D. IPA-High	$25/$40	$150/day x 3	$7	$30/$60	Yes	58.3	84.6	87.6	93.7	86.7	84.1	67.7
Florida												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
AvMed Health Plans-High	$15/$40	$250/dayx3	$5	$30/$50/30%	No	74.6	87.7	84.7	95.7	91.9	87	68
AvMed Health Plans-Standard	$25/$45	$300/dayx3	$10	$40/$60/30%	No	74.6	87.7	84.7	95.7	91.9	87	68
Capital Health Plan-High	$15/$25	$250	$15 Tier 1	$30 Tier 2/$50 Tier 3	No	85.5	90.5	90.5	95.3	93.8	94.6	75.5
Coventry Health Plan of Florida-High	$15/$30	Ded + $150x3	$3/$20	$40/$60/20%	No	51.4	80.8	76.4	92.1	82.7	78.3	53.5
Coventry Health Plan of Florida-Standard	$20/$50	Ded + $150x5	$3/$10	$50/$70/20%	No	51.4	80.8	76.4	92.1	82.7	78.3	53.5
Humana Value Plan In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Value Plan In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
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							
Humana Medical Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	52.9	86	82.4	93.7	84.6	84.3	68.7
Humana Medical Plan, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes	52.9	86	82.4	93.7	84.6	84.3	68.7
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							
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							

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Georgia					
Aetna Value Plan- All of Georgia	877-459-6604	F54	F55	37.37	84.86
Aetna Open Access -High- Atlanta and Athens Areas	877-459-6604	2U1	2U2	179.10	426.37
Humana Value Plan - Atlanta Area	888-393-6765	AD4	AD5	29.32	64.95
Humana Value Plan - Macon Area	888-393-6765	LM4	LM5	29.32	64.95
Humana Employers Health of Georgia, Inc. -High- Columbus	888-393-6765	CB1	CB2	48.45	107.81
Humana Employers Health of Georgia, Inc. -Std- Columbus	888-393-6765	CB4	CB5	39.72	88.37
Humana Employers Health of Georgia, Inc. -High- Atlanta	888-393-6765	DG1	DG2	48.45	107.81
Humana Employers Health of Georgia, Inc. -Std- Atlanta	888-393-6765	DG4	DG5	37.63	83.72
Humana Employers Health of Georgia, Inc. -High- Macon	888-393-6765	DN1	DN2	48.45	107.81
Humana Employers Health of Georgia, Inc. -Std- Macon	888-393-6765	DN4	DN5	39.72	88.37
Kaiser Foundation Health Plan of Georgia -High- Atlanta, Athens,Columbus,Macon,Savannah	888-865-5813	F81	F82	44.71	115.44
Kaiser Foundation Health Plan of Georgia -Std- Atlanta, Athens,Columbus,Macon,Savannah	888-865-5813	F84	F85	28.75	65.69
Guam					
Calvos Selectcare -High- Guam, Northern Mariana Islands, Palau	671 479-7982	B41	B42	34.19	89.85
TakeCare -High- Guam/N.MarianaIslands/Belau(Palau)	671-647-3526	JK1	JK2	35.62	111.54
TakeCare -Std- Guam/N.MarianaIslands/Belau(Palau)	671-647-3526	JK4	JK5	29.21	77.15
Hawaii					
Aetna Value Plan- All of Hawaii	877-459-6604	JS4	JS5	55.06	135.18
HMSA -High- All of Hawaii	800-776-4672	871	872	32.56	72.47
Kaiser Foundation Health Plan of Hawaii -High- Hawaii/Kauai/Lanai/Maui/Molokai/Oahu	808-432-5955	631	632	42.40	95.66
Kaiser Foundation Health Plan of Hawaii -Std- Hawaii/Kauai/Lanai/Maui/Molokai/Oahu	808-432-5955	634	635	21.61	48.20

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							**67.9**	**86.4**	**84.9**	**94.2**	**87.7**	**87.5**	**64.9**
Georgia													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	59	90	87.8	94.1	86	85.7	62
Humana Value Plan	In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan	Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Value Plan	In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan	Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Employers Health of Georgia -High		$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia -Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia -High		$20/$35	$250/day x 3	$10	$40/$60	Yes	51.4	88.3	83.7	94.1	85.9	84.9	55.6
Humana Employers Health of Georgia -Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia -High		$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia -Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes							
Kaiser Foundation HP of Georgia-High		$15/$30	$250/dayx3	$10/$20 Comm	$40/$50 Comm	Yes	79.4	84.5	85	93.5	88.4	83.9	62.5
Kaiser Foundation HP of Georgia-Standard		$20/$35	$250/dayx3	$15/$25 Comm	$40/$50 Comm	Yes	79.4	84.5	85	93.5	88.4	83.9	62.5
Guam													
Calvos Selectcare	In-Network	$15/$40	$200	$10	$25/50% of AWP	Yes							
Calvos Selectcare	Out-Network	30%/30%	30%	N/A	N/A	N/A							
TakeCare-High		$5 at FHP/$40	$100/day for 5	$10	$25/$50	Yes	68.7	66.9	68.6	90.4	79.2	78.6	57.1
TakeCare-Standard		$5 at FHP/$40	$150/day for 5	$15	$40/$80	Yes	68.7	66.9	68.6	90.4	79.2	78.6	57.1
Hawaii													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
HMSA	In-Network	$15/$15	$100	$7	$30/$65	Yes	84.2	91.4	88.4	95.5	87.8	93.1	62.8
HMSA	Out-Network	30%/30%	30%	$7 + 20%	$30 + 20%/ $65 + 20%	No							
Kaiser Foundation HP of Hawaii-High		$20/$20	$100	$10	$45/$45	Yes	75.4	82.6	81.5	94	87.5	81.1	61.3
Kaiser Foundation HP of Hawaii-Standard		$30/$30	10%	$15	$50/$50	Yes	75.4	82.6	81.5	94	87.5	81.1	61.3

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Idaho					
Aetna Value Plan- Most of Idaho	877-459-6604	H44	H45	37.47	85.08
Altius Health Plans -High- Southern Region	800-377-4161	9K1	9K2	66.88	141.65
Altius Health Plans -Std- Southern Region	800-377-4161	DK4	DK5	33.76	74.27
Group Health Cooperative -High- most of Washington State&Northern Idaho	888-901-4636	541	542	100.35	199.19
Group Health Cooperative -Std- most of Washington State&Northern Idaho	888-901-4636	544	545	33.60	75.86
SelectHealth -High- Idaho	801-442-7497	SF1	SF2	64.07	144.20
SelectHealth -Std- Idaho	801-442-7497	SF4	SF5	35.58	79.38
Illinois					
Aetna Value Plan- Most of Illinois	877-459-6604	H44	H45	37.47	85.08
Blue Cross and Blue Shield of Illinois -High- Illinois	855-676-4482	A21	A22	116.10	273.55
Blue Preferred Plus POS -High- Madison and St. Clair counties	888-811-2092	9G1	9G2	123.83	254.85
Health Alliance HMO -High- Central/E.Central/N.Cent/South/West Ill	800-851-3379	FX1	FX2	99.71	255.89
Health Alliance HMO -Std- Central/E.Central/N.Cent/South/West Ill	800-851-3379	K84	K85	69.21	184.80
Humana Benefit Plan of Illinois, Inc. -High- Central and Northwestern Illinois	888-393-6765	9F1	9F2	214.51	477.29
Humana Benefit Plan of Illinois, Inc. -Std- Central and Northwestern Illinois	888-393-6765	AB4	AB5	48.45	107.81
Humana Value Plan - Central Illinois	888-393-6765	GB4	GB5	29.32	64.95
Humana Value Plan - Chicago Area	888-393-6765	MW4	MW5	29.32	64.95
Humana Health Plan, Inc. -High- Chicago	888-393-6765	751	752	162.97	362.59
Humana Health Plan, Inc. -Std- Chicago	888-393-6765	754	755	48.45	107.81
Union Health Service -High- Chicago area	312-423-4200	761	762	40.37	101.24
United Healthcare of the Midwest, Inc. -High- Southwest Illinois	877-835-9861	B91	B92	128.05	288.10
UnitedHealthcare Plan of the River Valley Inc. -High- West Central Illinois	800-747-1446	YH1	YH2	40.32	122.21

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						**67.9**	**86.4**	**84.9**	**94.2**	**87.7**	**87.5**	**64.9**
Idaho												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Altius Health Plans-High	$20/$30	$200	$7	$25/$50	No	55.2	85.2	81.3	94.8	88.3	89.5	58.8
Altius Health Plans-Standard	$20/$40	None	$7	$35/$60	None	55.2	85.2	81.3	94.8	88.3	89.5	58.8
Group Health Cooperative-High	$25/$25	$350	$20	$40/$60	Yes	65.9	86	86.9	94.1	91.2	88.1	69.2
Group Health Cooperative-Standard	$25/$35	$500	$20	$40/$60	Yes	65.9	86	86.9	94.1	91.2	88.1	69.2
SelectHealth-High	$15/$25	$100	$5, $25,$50	$25,$50/$50	Yes	62.9	87.6	85.1	95.8	91.2	90.3	64
SelectHealth-Standard	$20/$30	$100 after	$5	$25/$50	Yes	62.9	87.6	85.1	95.8	91.2	90.3	64
Illinois												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Blue Cross and Blue Shield of Illinois-High	$20/$35	Nothing	$10 copay	$40/$60	Yes							
Blue Preferred Plus POS In-Network	$25/$35	$500	$5	$40/$60/25%/ $60/25%	Yes	64.7	89.1	86.1	96.1	84	86.4	68.5
Blue Preferred Plus POS Out-Network	30% after ded.	30% after ded.	N/A	N/A	N/A							
Health Alliance HMO-High	$25/$50	$200/day x 5	$7	$35/$70	Yes	74.5	91.5	88	96.2	87.8	86.8	67
Health Alliance HMO-Standard	$25/$50	20%	$7	$35/$70	Yes							
Humana Benefit Plan of Illinois, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Benefit Plan of Illinois, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Value Plan In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Value Plan In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	64.7	82.2	78.8	94.3	85.9	83.4	66
Humana Health Plan, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes	64.7	82.2	78.8	94.3	85.9	83.4	66
Union Health Service-High	$15/$15	None	$10	$35/$60	Yes							
United Healthcare of the Midwest, Inc.-High	$25/$40	$450	$7	$30/$60	Yes	66.5	91.9	90.2	95.7	89.2	89.8	73.2
UnitedHealthcare Plan of the River Valley -High	$25/$50	20%	$10	$35/$50	Yes	57.7	89.6	86	95.6	91.4	91.8	62.3

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Indiana					
Aetna Value Plan- All of Indiana	877-459-6604	JS4	JS5	55.06	135.18
Health Alliance HMO -High- Western Indiana	800-851-3379	FX1	FX2	99.71	255.89
Health Alliance HMO -Std- Western Indiana	800-851-3379	K84	K85	69.21	184.80
Humana Value Plan - Lake/Porter/LaPorte Counties	888-393-6765	MW4	MW5	29.32	64.95
Humana Health Plan of Ohio -High- Portions of Indiana	888-393-6765	A61	A62	39.72	88.37
Humana Health Plan of Ohio -Std- Portions of Indiana	888-393-6765	A64	A65	35.74	79.53
Humana Health Plan, Inc. -High- Lake/Porter/LaPorte Counties	888-393-6765	751	752	162.97	362.59
Humana Health Plan, Inc. -Std- Lake/Porter/LaPorte Counties	888-393-6765	754	755	48.45	107.81
Humana Health Plan, Inc. -High- Southern Indiana	888-393-6765	MH1	MH2	48.45	107.81
Humana Health Plan, Inc. -Std- Southern Indiana	888-393-6765	MH4	MH5	39.72	88.37
Physicians Health Plan of Northern Indiana -High- Northeast Indiana	260-432-6690	DQ1	DQ2	117.50	261.72
Iowa					
Aetna Value Plan- All of Iowa	877-459-6604	H44	H45	37.47	85.08
Coventry Health Care of Iowa -High- Central/Eastern/Western Iowa	800-257-4692	SV1	SV2	38.21	89.79
Coventry Health Care of Iowa -Std- Central/Eastern/Western Iowa	800-257-4692	SY4	SY5	28.04	65.89
Health Alliance HMO -High- Central and Eastern Iowa	800-851-3379	FX1	FX2	99.71	255.89
Health Alliance HMO -Std- Central and Eastern Iowa	800-851-3379	K84	K85	69.21	184.80
HealthPartners High Option -Northern Iowa	800-883-2177	V31	V32	99.40	245.22
HealthPartners Standard Option -Northern Iowa	800-883-2177	V34	V35	25.46	58.56
Sanford Health Plan -High- Northwestern Iowa	800-752-5863	AU1	AU2	96.21	238.17
Sanford Health Plan -Std- Northwestern Iowa	800-752-5863	AU4	AU5	84.55	211.12
UnitedHealthcare Plan of the River Valley Inc. -High- Eastern and Central Iowa	800-747-1446	YH1	YH2	40.32	122.21

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						**67.9**	**86.4**	**84.9**	**94.2**	**87.7**	**87.5**	**64.9**
Indiana												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Health Alliance HMO-High	$25/$50	$200/day x 5	$7	$35/$70	Yes	74.5	91.5	88	96.2	87.8	86.8	67
Health Alliance HMO-Standard	$25/$50	20%	$7	$35/$70	Yes							
Humana Value Plan In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Health Plan of Ohio-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan of Ohio-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	64.7	82.2	78.8	94.3	85.9	83.4	66
Humana Health Plan, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes	64.7	82.2	78.8	94.3	85.9	83.4	66
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Physicians Health Plan of Northern Indiana-High	$15/$15	20%	$10	$25/$50	Yes	56.2	87.8	81.5	93.4	86.8	89.3	59.3
Iowa												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Coventry Health Care of Iowa-High	$25/$50	20%	$3/ $10	$45/$70/$100	Yes	56.2	90.5	88.8	96.4	83.7	90.3	65.2
Coventry Health Care of Iowa-Standard	$25/$50	20%	$3/ $10	30%/$5,000 Max	No	56.2	90.5	88.8	96.4	83.7	90.3	65.2
Health Alliance HMO-High	$25/$50	$200/day x 5	$7	$35/$70	Yes	74.5	91.5	88	96.2	87.8	86.8	67
Health Alliance HMO-Standard	$25/$50	20%	$7	$35/$70	Yes							
HealthPartners High Option	$25/$45	Nothing	$12	$45/$90	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
HealthPartners Standard Option	$0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
Sanford Health Plan In-Network	$20/$30	$100/day x 5	$15	$30/$50	N/A	53.5	90.3	89	97.7	90.2	91.2	55.8
Sanford Health Plan Out-Network	40%/40%	40%	40%+	40%+/40%+	N/A							
Sanford Health Plan In-Network	$25/$25	$100/day x 5	$15	$30/$50	N/A	53.5	90.3	89	97.7	90.2	91.2	55.8
Sanford Health Plan Out-Network	40%+/40%+	40%+	40%+	40%+/40%+	N/A							
UnitedHealthcare Plan of the River Valley -High	$25/$50	20%	$10	$35/$50	Yes	57.7	89.6	86	95.6	91.4	91.8	62.3

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Kansas					
Aetna Value Plan- Most of Kansas	877-459-6604	G54	G55	36.69	83.33
Aetna Open Access -High- Kansas City area	877-459-6604	HY1	HY2	38.85	176.25
Coventry Health Care of Kansas -High- Kansas City Metro Area (KS and MO)	800-969-3343	HA1	HA2	38.69	94.24
Coventry Health Care of Kansas -Std- Kansas City Metro Area (KS and MO)	800-969-3343	HA4	HA5	35.96	84.52
Humana Value Plan - Kansas City Area	888-393-6765	PH4	PH5	29.32	64.95
Humana Health Plan, Inc. -High- Kansas City	888-393-6765	MS1	MS2	263.97	587.35
Humana Health Plan, Inc. -Std- Kansas City	888-393-6765	MS4	MS5	48.45	107.81
Kentucky					
Aetna Value Plan- Most of Kentucky	877-459-6604	H44	H45	37.47	85.08
Humana Health Plan of Ohio -High- Portions of Kentucky	888-393-6765	A61	A62	39.72	88.37
Humana Health Plan of Ohio -Std- Portions of Kentucky	888-393-6765	A64	A65	35.74	79.53
Humana Health Plan, Inc. -High- Louisville	888-393-6765	MH1	MH2	48.45	107.81
Humana Health Plan, Inc. -Std- Louisville	888-393-6765	MH4	MH5	39.72	88.37
Humana Health Plan, Inc. -High- Lexington	888-393-6765	MI1	MI2	65.22	145.11
Humana Health Plan, Inc. -Std- Lexington	888-393-6765	MI4	MI5	39.72	88.37
Louisiana					
Aetna Value Plan- Most of Louisiana	877-459-6604	F54	F55	37.37	84.86
Coventry Health Care of Louisiana -High- New Orleans Area	800-341-6613	BJ1	BJ2	64.06	170.32
Coventry Health Care of Louisiana -Std- New Orleans Area	800-341-6613	BJ4	BJ5	37.30	86.62
Humana Health Benefit Plan of Louisiana, Inc. -High- Baton Rouge	888-393-6765	AE1	AE2	48.45	107.81
Humana Health Benefit Plan of Louisiana, Inc. -Std- Baton Rouge	888-393-6765	AE4	AE5	37.63	83.72
Humana Health Benefit Plan of Louisiana, Inc. -High- New Orleans	888-393-6765	BC1	BC2	39.72	88.37
Humana Health Benefit Plan of Louisiana, Inc. -Std- New Orleans	888-393-6765	BC4	BC5	35.74	79.53

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						**67.9**	**86.4**	**84.9**	**94.2**	**87.7**	**87.5**	**64.9**
Kansas												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$100	Yes	63.9	86.2	86.2	94	83.8	90.1	53.8
Coventry Health Care of Kansas-High	$30/$60	25%	$3/ $12	$50/$75	Yes	60.2	90.6	88	96	89.4	88.4	66.3
Coventry Health Care of Kansas-Standard	$30/$60	30%	$3/ $12	$50/20%	Yes	60.2	90.6	88	96	89.4	88.4	66.3
Humana Value Plan In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	67.6	90.3	90.1	95.1	88.1	91.8	72.9
Humana Health Plan, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes	67.6	90.3	90.1	95.1	88.1	91.8	72.9
Kentucky												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Humana Health Plan of Ohio-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan of Ohio-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Louisiana												
Aetna Value Plan In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Coventry Health Care of Louisiana-High	$25/$45	Ded+$100	$5	$40/$100	Yes	57.3	87.4	82.3	96.8	83.1	82.7	62.5
Coventry Health Care of Louisiana-Standard	$30/$55	Ded+30%	$5	$40/$100	Yes	57.3	87.4	82.3	96.8	83.1	82.7	62.5
Humana Health Benefit Plan of LA -High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Benefit Plan of LA -Standard	$35/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Health Benefit Plan of LA -High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Benefit Plan of LA -Standard	$35/$40	$500/day x 3	$10	$40/$60	Yes							

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Maine					
Aetna Value Plan- All of Maine	877-459-6604	EP4	EP5	36.32	82.49
Maryland					
Aetna Value Plan- All of Maryland	877-459-6604	F54	F55	37.37	84.86
Aetna Open Access -High- Northern/Central/Southern Maryland Areas	877-459-6604	JN1	JN2	191.72	432.73
Aetna Open Access -Basic- Northern/Central/Southern Maryland Areas	877-459-6604	JN4	JN5	40.12	89.71
CareFirst BlueChoice -High- All of Maryland	888-789-9065	2G1	2G2	73.15	170.04
CareFirst BlueChoice -Std- All of Maryland	888-789-9065	2G4	2G5	45.95	108.82
Coventry Health Care -High- All of Maryland	800-833-7423	IG1	IG2	44.63	119.23
Coventry Health Care -Std- All of Maryland	800-833-7423	IG4	IG5	37.96	87.30
Kaiser Foundation Health Plan Mid-Atlantic States -High- Baltimore/Washington, DC areas	877-574-3337	E31	E32	53.53	139.72
Kaiser Foundation Health Plan Mid-Atlantic States -Std- Baltimore/Washington, DC areas	877-574-3337	E34	E35	27.60	63.49
M.D. IPA -High- All of Maryland	877-835-9861	JP1	JP2	68.85	176.64
Massachusetts					
Aetna Value Plan - Most of Massachusetts	877-459-6604	EP4	EP5	36.32	82.49
Fallon Community Health Plan -Basic - Central/Eastern Massachusetts	800-868-5200	JG1	JG2	110.81	314.73

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		67.9	86.4	84.9	94.2	87.7	87.5	64.9
Maine													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Maryland													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$15/$30	$150/day x3	$5	$35/$100	Yes	69	84.4	87.2	94.2	86.5	91.4	56.7
Aetna Open Access-Basic		$20/$35	10% Plan Allow	$10	$35/$100	Yes	69	84.4	87.2	94.2	86.5	91.4	56.7
CareFirst BlueChoice-High		$25/$35	$200	Nothing	$35/$65	Yes	64.8	86	83.3	92.5	84.6	90.2	54
CareFirst BlueChoice	In-Network	Nothing/$35	$200	Nothing	$35/$65	Yes	64.8	86	83.3	92.5	84.6	90.2	54
CareFirst BlueChoice	Out-Network	$70/$70	$500	Nothing	$35/$65	Yes							
Coventry Health Care-High		$20/$40	$200/day x 3	$3/$15	$30/$60	Yes	56.3	86.4	86.4	96.9	89.2	87.1	60.6
Coventry Health Care-Standard		$20/$40	$200/day x 3	$3/$15	$30/$60	Yes	56.3	86.4	86.4	96.9	89.2	87.1	60.6
Kaiser Foundation HP Mid-Atlantic States-High		$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	83	86.7	83.1	92.7	81.3	83.6	70.2
Kaiser Foundation HP Mid-Atlantic States-Standard		$20/$30	$250/dayx3	$12/$22Net	$35/$55/$50/$70	Yes	83	86.7	83.1	92.7	81.3	83.6	70.2
M.D. IPA-High		$25/$40	$150/day x 3	$7	$30/$60	Yes	58.3	84.6	87.6	93.7	86.7	84.1	67.7
Massachusetts													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Fallon Community Health Plan-Basic		$25/$35	$150 to $750max	$10	$30/$60	Yes	62.7	85.1	88.2	92.9	88.3	80.1	64.9

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Michigan					
Aetna Value Plan- All of Michigan	877-459-6604	G54	G55	36.69	83.33
Bluecare Network of MI -High- East Region	800-662-6667	K51	K52	77.20	188.04
Bluecare Network of MI -High- Southeast Region	800-662-6667	LX1	LX2	58.74	179.52
Grand Valley Health Plan -High- Grand Rapids area	616-949-2410	RL1	RL2	87.03	229.11
Grand Valley Health Plan -Std- Grand Rapids area	616-949-2410	RL4	RL5	66.13	180.21
Health Alliance Plan -High- Southeastern Michigan/Flint Area	800-556-9765	521	522	68.23	202.48
Health Alliance Plan -Std- Southeastern Michigan/Flint Area	800-556-9765	GY4	GY5	53.75	167.72
HealthPlus of MI -High- East Michigan	800-332-9161	X51	X52	39.82	175.19
Total Health Care USA -High- Michigan	800-826-2862	A51	A52	39.12	176.61
Minnesota					
Aetna Value Plan- Most of Minnesota	877-459-6604	H44	H45	37.47	85.08
HealthPartners High Option - Minnesota	800-883-2177	V31	V32	99.40	245.22
HealthPartners Standard Option - Minnesota	800-883-2177	V34	V35	25.46	58.56
Mississippi					
Aetna Value Plan - Most of Mississippi	877-459-6604	H44	H45	37.47	85.08

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		67.9	86.4	84.9	94.2	87.7	87.5	64.9
Michigan													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Bluecare Network of MI-High		$15/$25	Nothing	$10	$30/$60	Yes	65.1	89.9	87.5	93.3	88.4	93.7	67.2
Bluecare Network of MI-High		$15/$25	Nothing	$10	$30/$60	Yes	65.1	89.9	87.5	93.3	88.4	93.7	67.2
Grand Valley Health Plan-High		$10/$10	Nothing	$5	$15/$15	No	74.2	90	91.2	95.2	88.3	83.6	79.5
Grand Valley Health Plan-Standard		$20/$20	$500x3	$10	N/A/$40	No	74.2	90	91.2	95.2	88.3	83.6	79.5
Health Alliance Plan-High		$10/$20	Nothing	$5	$50/$50	Yes	79.3	88.8	86.2	94.3	89.9	90.2	65.6
Health Alliance Plan-Standard		$15/$30	Nothing	$15	$50/$50	Yes	79.3	88.8	86.2	94.3	89.9	90.2	65.6
HealthPlus of MI-High		$10/$20	None	$0/$8	$40/$60	Yes	79.3	91.9	92	95.1	94.6	91.9	65.8
Total Health Care USA-High		$15/$15	None	$10	$40/$40	Yes							
Minnesota													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
HealthPartners High Option		$25/$45	Nothing	$12	$45/$90	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
HealthPartners Standard Option		$0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
Mississippi													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Missouri					
Aetna Value Plan- Most of Missouri	877-459-6604	G54	G55	36.69	83.33
Aetna Open Access -High- Kansas City area	877-459-6604	HY1	HY2	38.85	176.25
Blue Preferred Plus POS -High- StLouis/Central/SW areas	888-811-2092	9G1	9G2	123.83	254.85
Coventry Health Care of Kansas -High- Kansas City Metro Area (KS and MO)	800-969-3343	HA1	HA2	38.69	94.24
Coventry Health Care of Kansas -Std- Kansas City Metro Area (KS and MO)	800-969-3343	HA4	HA5	35.96	84.52
Humana Value Plan - Kansas City Area	888-393-6765	PH4	PH5	29.32	64.95
Humana Health Plan, Inc. -High- Kansas City	888-393-6765	MS1	MS2	263.97	587.35
Humana Health Plan, Inc. -Std- Kansas City	888-393-6765	MS4	MS5	48.45	107.81
United Healthcare of the Midwest, Inc. -High- St. Louis Area	877-835-9861	B91	B92	128.05	288.10
Montana					
Aetna Value Plan- South/Southeast/Western MT Areas	877-459-6604	H44	H45	37.47	85.08
Nebraska					
Aetna Value Plan- All of Nebraska	877-459-6604	H44	H45	37.47	85.08
Nevada					
Aetna Value Plan- Las Vegas Area	877-459-6604	G54	G55	36.69	83.33
Aetna Open Access -High- Clark County and Las Vegas areas	877-459-6604	HF1	HF2	32.24	113.72
Health Plan of Nevada -High- Las Vegas/Esmeralda and Nye counties	877-545-7378	NM1	NM2	28.28	66.68
New Hampshire					
Aetna Value Plan- All of New Hampshire	877-459-6604	EP4	EP5	36.32	82.49

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		67.9	86.4	84.9	94.2	87.7	87.5	64.9
Missouri													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	63.9	86.2	86.2	94	83.8	90.1	53.8
Blue Preferred Plus POS	In-Network	$25/$35	$500	$5	$40/$60/ 25%/$60/25%	Yes	64.7	89.1	86.1	96.1	84	86.4	68.5
Blue Preferred Plus POS	Out-Network	30% after ded.	30% after ded.	N/A	N/A	N/A							
Coventry Health Care of Kansas-High		$30/$60	25%	$3/ $12	$50/$75	Yes	60.2	90.6	88	96	89.4	88.4	66.3
Coventry Health Care of Kansas-Standard		$30/$60	30%	$3/ $12	$50/20%	Yes	60.2	90.6	88	96	89.4	88.4	66.3
Humana Value Plan	In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan	Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Health Plan, Inc.-High		$20/$35	$250/day x 3	$10	$40/$60	Yes	67.6	90.3	90.1	95.1	88.1	91.8	72.9
Humana Health Plan, Inc.-Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes	67.6	90.3	90.1	95.1	88.1	91.8	72.9
United Healthcare of the Midwest, Inc.-High		$25/$40	$450	$7	$30/$60	Yes	66.5	91.9	90.2	95.7	89.2	89.8	73.2
Montana													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Nebraska													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Nevada													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	60.2	83.8	86.1	92.3	84.9	91.8	63.6
Health Plan of Nevada-High		$10/$25	$300	$7	$35/$55/$100	Yes	51.6	69.6	66	89.2	89.2	91.2	52.9
New Hampshire													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
New Jersey					
Aetna Value Plan- All of New Jersey	877-459-6604	EP4	EP5	36.32	82.49
Aetna Open Access -High- Northern New Jersey	877-459-6604	JR1	JR2	217.05	515.95
Aetna Open Access -Basic- Northern New Jersey	877-459-6604	JR4	JR5	133.18	325.87
Aetna Open Access -High- Southern NJ	877-459-6604	P31	P32	274.49	703.88
Aetna Open Access -Basic- Southern NJ	877-459-6604	P34	P35	204.15	490.04
GHI Health Plan -High- Northern New Jersey	212-501-4444	801	802	125.83	375.51
GHI Health Plan -Std- Northern New Jersey	212-501-4444	804	805	40.45	100.25
New Mexico					
Aetna Value Plan- Albuquerque/Dona Ana/Hobbs Area	877-459-6604	G54	G55	36.69	83.33
Lovelace Health Plan -High- All of New Mexico	800-808-7363	Q11	Q12	37.48	88.09
Presbyterian Health Plan -High- All counties in New Mexico	800-356-2219	P21	P22	85.90	205.31

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		67.9	86.4	84.9	94.2	87.7	87.5	64.9
New Jersey													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	63.1	85.2	83.7	92.8	89.5	80.9	62.3
Aetna Open Access-Basic		$15/$35	20% Plan Allow	$5	$35/$100	Yes	63.1	85.2	83.7	92.8	89.5	80.9	62.3
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	63.1	85.2	83.7	92.8	89.5	80.9	62.3
Aetna Open Access-Basic		$15/$35	20% Plan Allow	$5	$35/$100	Yes	63.1	85.2	83.7	92.8	89.5	80.9	62.3
GHI Health Plan	In-Network	$20/$20	$150max$450	$20	$45/$85	Yes	66.3	84.4	85.1	93.6	86	82.8	64.2
GHI Health Plan	Out-Network	50% of sch	+50% of sch.	N/A	N/A	No							
GHI Health Plan-Standard		$30/$30	$250/day x 3	$10	$45/$85	Yes	66.3	84.4	85.1	93.6	86	82.8	64.2
New Mexico													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Lovelace Health Plan-High		$25/$35	$250 after ded	$5	$35/$60/50%	Yes	65.1	79.6	75.3	91.8	82.8	93.9	65.6
Presbyterian Health Plan-High		$25/$40	$100 x 5 days	$10	$40/$75/50%	Yes	65.5	82.4	78.3	91.7	84.8	85.2	61.6

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
New York					
Aetna Value Plan- Most of New York	877-459-6604	EP4	EP5	36.32	82.49
Aetna Open Access -High- NYC Area/Upstate NY	877-459-6604	JC1	JC2	160.94	448.53
Aetna Open Access -Basic- NYC Area/Upstate NY	877-459-6604	JC4	JC5	95.44	277.24
CDPHP Universal Benefits, Inc. -High- Upstate, Hudson Valley, Central NY	877-269-2134	SG1	SG2	81.34	274.08
CDPHP Universal Benefits, Inc. -Std- Upstate, Hudson Valley, Central NY	877-269-2134	SG4	SG5	35.18	93.24
GHI HMO Select -High- Brnx/Brklyn/Manhat/Queen/Richmon/Westche	877-244-4466	6V1	6V2	65.63	226.80
GHI HMO Select -High- Capital/Hudson Valley Regions	877-244-4466	X41	X42	40.54	165.15
GHI Health Plan -High- All of New York	212-501-4444	801	802	125.83	375.51
GHI Health Plan -Std- All of New York	212-501-4444	804	805	40.45	100.25
HIP Health of Greater New York -High- New York City area including Long Island	800-447-8255	511	512	53.87	236.80
HIP Health of Greater New York -Std- New York City area including Long Island	800-447-8255	514	515	34.93	104.82
Independent Health Association -High- Western New York	800-501-3439	QA1	QA2	61.24	213.92
Independent Health Association -Std- Western New York	800-501-3439	C54	C55	42.12	166.16
MVP Health Care -High- Eastern Region	888-687-6277	GA1	GA2	51.96	191.70
MVP Health Care -Std- Eastern Region	888-687-6277	GA4	GA5	38.28	128.41
MVP Health Care -High- Western Region	888-687-6277	GV1	GV2	37.32	110.09
MVP Health Care -Std- Western Region	888-687-6277	GV4	GV5	32.03	80.14
MVP Health Care -High- Central Region	888-687-6277	M91	M92	54.38	198.58
MVP Health Care -Std- Central Region	888-687-6277	M94	M95	39.43	142.15
MVP Health Care -High- Northern Region	888-687-6277	MF1	MF2	92.72	293.35
MVP Health Care -Std- Northern Region	888-687-6277	MF4	MF5	78.56	257.92
MVP Health Care -High- Mid-Hudson Region	888-687-6277	MX1	MX2	61.86	216.06
MVP Health Care -Std- Mid-Hudson Region	888-687-6277	MX4	MX5	39.08	140.74

Plan Name – Location		Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs Level I	Level II/ Level III	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	67.9	86.4	84.9	94.2	87.7	87.5	64.9
New York													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	66.2	84.8	84.9	93.7	88.8	87.4	54.7
Aetna Open Access-Basic		$15/$35	20% Plan Allow	$5	$35/$100	Yes	66.2	84.8	84.9	93.7	88.8	87.4	54.7
CDPHP Universal Benefits, Inc.-High		$20/$30	$100 x 5	25%	25%/25%	No	72.9	92.8	90	94.9	92.2	92.4	70
CDPHP Universal Benefits, Inc.-Standard		$25/$40	$500+10%	30%	30%/30%	No	72.9	92.8	90	94.9	92.2	92.4	70
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	$20	$45/$85	Yes	66.3	84.4	85.1	93.6	86	82.8	64.2
GHI Health Plan	Out-Network	50% of sch	+50% of sch.	N/A	N/A	No							
GHI Health Plan-Standard		$30/$30	$250/day x 3	$10	$45/$85	Yes	66.3	84.4	85.1	93.6	86	82.8	64.2
HIP Health of Greater New York-High		$20/$40	None	$15	$35/$75/ $75/$100Ded	Yes	72.9	81.4	78.6	88.8	78.7	84.8	60
HIP Health of Greater New York-Standard		$30/$50	$1,000	$15/$100Ded	$35/$75	Yes	72.9	81.4	78.6	88.8	78.7	84.8	60
Independent Health Assoc	In-Network	$25/$25	$250	$10	$30/$75	No	73.5	93.3	92.3	95.2	92	91.6	75.5
Independent Health Assoc	Out-Network	25%/25%	25%	N/A	N/A	No							
Independent Health Association	In-Network	$30/$50	$750	$10	$50/50%	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	73.9	93.4	89	96.2	89.6	92	76.8
MVP Health Care-Standard		$30/$50	$750	$5	$45/$90	Yes	73.9	93.4	89	96.2	89.6	92	76.8
MVP Health Care-High		$25/$25	$500	$5	$35/$70	Yes	73.9	93.4	89	96.2	89.6	92	76.8
MVP Health Care-Standard		$30/$50	$750	$5	$45/$90	Yes	73.9	93.4	89	96.2	89.6	92	76.8
MVP Health Care-High		$25/$25	$500	$5	$35/$70	Yes	73.9	93.4	89	96.2	89.6	92	76.8
MVP Health Care-Standard		$30/$50	$750	$5	$45/$90	Yes	73.9	93.4	89	96.2	89.6	92	76.8
MVP Health Care-High		$25/$25	$500	$5	$35/$70	Yes	73.9	93.4	89	96.2	89.6	92	76.8
MVP Health Care-Standard		$30/$50	$750	$5	$45/$90	Yes	73.9	93.4	89	96.2	89.6	92	76.8
MVP Health Care-High		$25/$25	$500	$5	$35/$70	Yes	73.9	93.4	89	96.2	89.6	92	76.8
MVP Health Care-Standard		$30/$50	$750	$5	$45/$90	Yes	73.9	93.4	89	96.2	89.6	92	76.8

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
North Carolina					
Aetna Value Plan- All of North Carolina	877-459-6604	F54	F55	37.37	84.86
North Dakota					
Aetna Value Plan- Most of North Dakota	877-459-6604	H44	H45	37.47	85.08
HealthPartners High Option - Eastern North Dakota	800-883-2177	V31	V32	99.40	245.22
HealthPartners Standard Option -Eastern North Dakota	800-883-2177	V34	V35	25.46	58.56
Sanford Heart of America Health Plan -High- Northcentral North Dakota	800-525-5661	RU1	RU2	39.50	162.62
Sanford Health Plan -High- North Dakota	800-752-5863	C91	C92	72.22	182.72
Sanford Health Plan -Std- North Dakota	800-752-5863	C94	C95	40.47	156.85
Ohio					
Aetna Value Plan- All of Ohio	877-459-6604	JS4	JS5	55.06	135.18
AultCare HMO -High- Stark/Carroll/Holmes/Tuscarawas/Wayne Co.	330-363-6360	3A1	3A2	40.96	151.50
Humana Health Plan of Ohio -High- Greater Cincinnati Area	888-393-6765	A61	A62	39.72	88.37
Humana Health Plan of Ohio -Std- Greater Cincinnati Area	888-393-6765	A64	A65	35.74	79.53
Kaiser Foundation Health Plan of Ohio -High- Cleveland/Akron areas	800-686-7100	641	642	108.14	265.35
Kaiser Foundation Health Plan of Ohio -Std- Cleveland/Akron areas	800-686-7100	644	645	37.53	86.31
The Health Plan of the Upper Ohio Valley -High- Eastern Ohio	800-624-6961	U41	U42	96.66	226.17
Oklahoma					
Aetna Value Plan- All of Oklahoma	877-459-6604	JS4	JS5	55.06	135.18
Globalhealth, Inc. -High- Oklahoma	877-280-5600	IM1	IM2	33.79	81.44

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		67.9	86.4	84.9	94.2	87.7	87.5	64.9
North Carolina													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
North Dakota													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
HealthPartners High Option		$25/$45	Nothing	$12	$45/$90	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
HealthPartners Standard Option		$0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
Sanford Heart of America Health Plan	In-Network	$15/$25	None	50%/$600ded	50%/$600 ded	None							
Sanford Heart of America Health Plan	Out-Network	20%/20%	20%	N/A	N/A	N/A							
Sanford Health Plan	In-Network	$20/$30	$100/day x 5	$15	$30/$50	N/A	53.5	90.3	89	97.7	90.2	91.2	55.8
Sanford Health Plan	Out-Network	40%/40%	40%	40%+	40%+/40%+	N/A							
Sanford Health Plan	In-Network	$25/$25	$100/day x 5	$15	$30/$50	N/A	53.5	90.3	89	97.7	90.2	91.2	55.8
Sanford Health Plan	Out-Network	40%+/40%+	40%+	40%+	40%+/40%+	N/A							
Ohio													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
AultCare HMO-High		$15/$20	$150	$15	$30/$40/$55	No	87.7	92.2	90.7	94.1	94.4	93.5	85.3
Humana Health Plan of Ohio-High		$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan of Ohio-Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes							
Kaiser Foundation HP of Ohio-High		$20/$20	$250	$10	$30/$30	Yes	78.8	84.5	88.9	92.2	93.5	90.6	70.8
Kaiser Foundation HP of Ohio-Standard		$30/$40	$500	$15	$40/$40	Yes	78.8	84.5	88.9	92.2	93.5	90.6	70.8
The Health Plan of the Upper Ohio Valley-High		$10/$20	$250	$15	$30/$50	Yes	74.4	90.9	87.6	95.1	92.9	94.4	74.5
Oklahoma													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Globalhealth, Inc.-High		$15/$45	$250dymx1,000	$4/$10	$45/$70	Yes	59.2	81.6	83.9	91.6	89.3	87.2	72.7

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Oregon					
Aetna Value Plan- Most of Oregon	877-459-6604	H44	H45	37.47	85.08
Kaiser Foundation Health Plan of Northwest -High- Portland/Salem areas	800-813-2000	571	572	80.05	188.28
Kaiser Foundation Health Plan of Northwest -Std- Portland/Salem areas	800-813-2000	574	575	38.97	89.52
Pennsylvania					
Aetna Value Plan- All of Pennsylvania	877-459-6604	H44	H45	37.47	85.08
Aetna Open Access -High- Philadelphia	877-459-6604	P31	P32	274.49	703.88
Aetna Open Access -Basic- Philadelphia	877-459-6604	P34	P35	204.15	490.04
Aetna Open Access -High- Pittsburgh and Western PA Areas	877-459-6604	YE1	YE2	64.04	221.33
Geisinger Health Plan -Std- Northeastern/Central/South Central areas	800-447-4000	GG4	GG5	53.04	138.61
HealthAmerica Pennsylvania -High- Greater Pittsburgh Area	866-351-5946	261	262	57.63	163.07
UPMC Health Plan -High- Western Pennsylvania	888-876-2756	8W1	8W2	77.57	195.00
UPMC Health Plan -Std- Western Pennsylvania	888-876-2756	UW4	UW5	38.19	87.83
Puerto Rico					
Humana Health Plans of Puerto Rico, Inc. -High- Puerto Rico	800-314-3121	ZJ1	ZJ2	22.97	52.41
Triple-S Salud, Inc. -High- All of Puerto Rico	787-774-6060	891	892	25.26	56.85
Rhode Island					
Aetna Value Plan- All of Rhode Island	877-459-6604	EP4	EP5	36.32	82.49
South Carolina					
Aetna Value Plan- All of South Carolina	877-459-6604	JS4	JS5	55.06	135.18

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		67.9	86.4	84.9	94.2	87.7	87.5	64.9
Oregon													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Kaiser Foundation HP of Northwest-High		$20/$30	$200	$15	$40/$60	Yes	76.8	84.4	84.7	91.6	92.7	89	68.3
Kaiser Foundation HP of Northwest-Standard		$30/$40	$500	$20	$40/$60	Yes	76.8	84.4	84.7	91.6	92.7	89	68.3
Pennsylvania													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	57.9	86.1	83.5	93.5	88.7	89.9	63.1
Aetna Open Access-Basic		$15/$35	20% Plan Allow	$5	$35/$100	Yes	57.9	86.1	83.5	93.5	88.7	89.9	63.1
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	57.9	86.1	83.5	93.5	88.7	89.9	63.1
Geisinger Health Plan-Standard		$20/$35	20%aftrDeduct	30% $5/$15	40% $40/$120/ 50% $85/$250	Yes	66.8	86.8	85	93.8	90.6	90.2	67.7
HealthAmerica Pennsylvania-High		$25/$50	15% after ded	$5	$35/$60	Yes	69.9	87.3	88.5	95.7	86	92.1	67.1
UPMC Health Plan-High		10% after Deduct	10% after deduct	$5 after ded	$35/$75	Yes	75.4	90.8	89.9	97	91.3	90.4	67.8
UPMC Health Plan-Standard		20% after Deduct	20%after Deduct	$5 after ded	$35/$75/$100	Yes	75.4	90.8	89.9	97	91.3	90.4	67.8
Puerto Rico													
Humana Health Plans of PR	In-Network	$5/$5	None	$2.50	$10/$15	Yes	80.6	80.3	82	93.8	88.7	70	54.1
Humana Health Plans of PR	Out-Network	$10/$10	$50	N/A	N/A	Yes							
Triple-S Salud, Inc.	In-Network	$7.50/$10	None	$5 or $12	Greater of $15 or 20%/25% up to $100/$175max	Yes	69.1	87.4	84.4	96.3	87.2	75	58.6
Triple-S Salud, Inc.	Out-Network	$7.50 & 10% +/ $10 & 10% +	10% +	N/A	N/A/N/A	No							
Rhode Island													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
South Carolina													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
South Dakota					
Aetna Value Plan- Rapid City/Sioux Falls Area	877-459-6604	G54	G55	36.69	83.33
HealthPartners High Option - Eastern South Dakota	800-883-2177	V31	V32	99.40	245.22
HealthPartners Standard Option -Eastern South Dakota	800-883-2177	V34	V35	25.46	58.56
Sanford Health Plan -High- Eastern/Central/Rapid City Areas	800-752-5863	AU1	AU2	96.21	238.17
Sanford Health Plan -Std- Eastern/Central/Rapid City Areas	800-752-5863	AU4	AU5	84.55	211.12
Tennessee					
Aetna Value Plan- Most of Tennessee	877-459-6604	F54	F55	37.37	84.86
Aetna Open Access -High- Memphis Area	877-459-6604	UB1	UB2	88.86	298.45
Humana Health Plan, Inc. -High- Knoxville	888-393-6765	GJ1	GJ2	48.45	107.81
Humana Health Plan, Inc. -Std- Knoxville	888-393-6765	GJ4	GJ5	35.74	79.53

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		67.9	86.4	84.9	94.2	87.7	87.5	64.9
South Dakota													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
HealthPartners High Option		$25/$45	Nothing	$12	$45/$90	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
HealthPartners Standard Option		$0 for 3, then 20%	20% in/40% out	$9	$40/$70	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
Sanford Health Plan	In-Network	$20/$30	$100/day x 5	$15	$30/$50	N/A	53.5	90.3	89	97.7	90.2	91.2	55.8
Sanford Health Plan	Out-Network	40%/40%	40%	40%+	40%+/40%+	N/A	53.5						
Sanford Health Plan	In-Network	$25/$25	$100/day x 5	$15	$30/$50	N/A	53.5	90.3	89	97.7	90.2	91.2	55.8
	Sanford Health Plan	Out-Network	40%+/40%+	40%+	40%+	40%+/40%+	N/A						
Tennessee													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes	66	87.5	86.8	95.9	88.9	91.4	69
Humana Health Plan, Inc.-High		$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan, Inc.-Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes							

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Texas					
Aetna Value Plan- All of Texas	877-459-6604	JS4	JS5	55.06	135.18
Aetna Whole Health -Basic- Houston, TX Area	877-459-6604	ES1	ES2	36.68	131.45
Firstcare -High- Waco area	800-884-4901	B71	B72	31.64	120.13
Firstcare -High- West Texas	800-884-4901	CK1	CK2	30.93	106.36
Firstcare -High- Taylor/Callahan/Eastland	800-884-4901	CN1	CN2	38.32	249.39
Firstcare -High- Lubbock area	800-884-4901	CZ1	CZ2	37.29	229.45
Firstcare -High- Bryan/College Station Area	800-884-4901	ET1	ET2	36.16	207.62
Humana Value Plan - Corpus Christi Area	888-393-6765	TP4	TP5	29.32	64.95
Humana Value Plan - San Antonio Area	888-393-6765	TU4	TU5	29.32	64.95
Humana Value Plan - Austin Area	888-393-6765	TV4	TV5	29.32	64.95
Humana Health Plan of Texas -High- Houston	888-393-6765	EW1	EW2	39.72	88.37
Humana Health Plan of Texas -Std- Houston	888-393-6765	EW4	EW5	35.74	79.53
Humana Health Plan of Texas -High- Corpus Christi	888-393-6765	UC1	UC2	58.02	129.09
Humana Health Plan of Texas -Std- Corpus Christi	888-393-6765	UC4	UC5	39.72	88.37
Humana Health Plan of Texas -High- San Antonio	888-393-6765	UR1	UR2	229.35	510.30
Humana Health Plan of Texas -Std- San Antonio	888-393-6765	UR4	UR5	39.72	88.37
Humana Health Plan of Texas -High- Austin	888-393-6765	UU1	UU2	97.83	217.68
Humana Health Plan of Texas -Std- Austin	888-393-6765	UU4	UU5	48.45	107.81
Scott & White Health Plan -Std- Central TX & Some SE and SW Counties	800-321-7947	A84	A85	44.21	117.27
UnitedHealthcare Benefits of Texas, Inc. -High- San Antonio	866-546-0510	GF1	GF2	125.48	306.04

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			**67.9**	**86.4**	**84.9**	**94.2**	**87.7**	**87.5**	**64.9**
Texas													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Whole Health	In-Network	$5/$25/$35	15%	$5	$35/$60	Yes							
Aetna Whole Health	Out-Network	40%/40%	40%	40%	40%/40%	No							
Firstcare-High		$30/$55	$250/day x 5	$10	$35/$70	Yes							
Firstcare-High		$30/$55	$250/day x 5	$10	$35/$70	Yes							
Firstcare-High		$30/$55	$250/day x 5	$10	$35/$70	Yes							
Firstcare-High		$30/$55	$250/day x 5	$10	$35/$70	Yes							
Firstcare-High		$30/$55	$250/day x 5	$10	$35/$70	Yes							
Humana Value Plan	In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan	Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Value Plan	In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan	Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Value Plan	In-Network	$35/$55	20%	$10	$40/$60	Yes							
Humana Value Plan	Out-Network	50%/50%	50%	$10+	$40+/$60+	No							
Humana Health Plan of Texas-High		$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan of Texas-Standard		$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							
Humana Health Plan of Texas-Standard		$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	63	83.5	76.4	93.1	86.4	85.6	67.3
Humana Health Plan of Texas-Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes	63	83.5	76.4	93.1	86.4	85.6	67.3
Humana Health Plan of Texas-High		$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan of Texas-Standard		$25/$40	$500/day x 3	$10	$40/$60	Yes							
Scott & White Health Plan-Standard		$20/$45	10%	$5	$45/$100	Yes							
UnitedHealthcare Benefits of Texas, Inc.-High		$20/$40	$250/day x 5	$10	$35/$60	Yes	70.2	86.2	86.3	93.7	87.5	87	56.9

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Utah					
Aetna Value Plan- Most of Utah	877-459-6604	G54	G55	36.69	83.33
Altius Health Plans -High- Wasatch Front	800-377-4161	9K1	9K2	66.88	141.65
Altius Health Plans -Std- Wasatch Front	800-377-4161	DK4	DK5	33.76	74.27
SelectHealth -High- Urban and Suburban Utah	800-538-5038	SF1	SF2	64.07	144.20
SelectHealth -Std- Urban and Suburban Utah	800-538-5038	SF4	SF5	35.58	79.38
Vermont					
Aetna Value Plan- All of Vermont	877-459-6604	EP4	EP5	36.32	82.49
Virgin Islands					
Triple-S Salud, Inc. -High- US Virgin Islands	800-981-3241	851	852	29.49	66.97

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		67.9	86.4	84.9	94.2	87.7	87.5	64.9
Utah													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Altius Health Plans-High		$20/$30	$200	$7	$25/$50	No	55.2	85.2	81.3	94.8	88.3	89.5	58.8
Altius Health Plans-Standard		$20/$40	None	$7	$35/$60	None	55.2	85.2	81.3	94.8	88.3	89.5	58.8
SelectHealth-High		$15/$25	$100	$5,$25,$50	$25,$50/$50	Yes	62.9	87.6	85.1	95.8	91.2	90.3	64
SelectHealth-Standard		$20/$30	$100 after	$5,$25,$50	$25, $50/$50	Yes	62.9	87.6	85.1	95.8	91.2	90.3	64
Vermont													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Virgin Islands													
Triple-S Salud, Inc.	In-Network	$7.50/$10	None	$5 or $12	30%to$600/50% to$1200	Yes	69.1	87.4	84.4	96.3	87.2	75	58.6
Triple-S Salud, Inc.	Out-Network	$7.50 & 10% +/ $10 & 10% +	10% +	N/A	N/A/N/A	No							

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Virginia					
Aetna Value Plan- Most of Virginia	877-459-6604	F54	F55	37.37	84.86
Aetna Open Access -High- Northern/Central/Richmond Virginia Areas	877-459-6604	JN1	JN2	191.72	432.73
Aetna Open Access -Basic- Northern/Central/Richmond Virginia Areas	877-459-6604	JN4	JN5	40.12	89.71
Aetna Whole Health -Basic- Roanoke, VA area	877-459-6604	D91	D92	34.73	131.45
Aetna Whole Health -Basic- Newport News, VA area	877-459-6604	J91	J92	32.28	84.03
CareFirst BlueChoice -High- Northern Virginia	888-789-9065	2G1	2G2	73.15	170.04
CareFirst BlueChoice -Std- Northern Virginia	888-789-9065	2G4	2G5	45.95	108.82
HealthKeepers, Inc. -High- Virginia	855-580-1200	A91	A92	69.69	162.26
Kaiser Foundation Health Plan Mid-Atlantic States -High- Northern Virginia/Fredericksburg area	877-574-3337	E31	E32	53.53	139.72
Kaiser Foundation Health Plan Mid-Atlantic States -Std- Northern Virginia/Fredericksburg area	877-574-3337	E34	E35	27.60	63.49
M.D. IPA -High- Northern Viginia	877-835-9861	JP1	JP2	68.85	176.64
Optima Health Plan -High- Hampton Roads and Richmond areas	800-206-1060	9R1	9R2	99.37	266.37
Optima Health Plan -Std- Hampton Roads and Richmond areas	800-206-1060	9R4	9R5	32.25	76.30
Piedmont Community Healthcare -High- Lynchburg area	888-674-3368	2C1	2C2	35.01	80.17
Washington					
Aetna Value Plan- Most of Washington	877-459-6604	G54	G55	36.69	83.33
Aetna Open Access -High- Seattle and Spokane areas	877-459-6604	C31	C32	44.33	232.72
Group Health Cooperative -High- Western WA/Central WA/Spokane/Pullman	888-901-4636	541	542	100.35	199.19
Group Health Cooperative -Std- Western WA/Central WA/Spokane/Pullman	888-901-4636	544	545	33.60	75.86
KPS Health Plans -Std- All of Washington	800-552-7114	L11	L12	35.56	76.75
KPS Health Plans -High- All of Washington	800-552-7114	VT1	VT2	121.49	256.65
Kaiser Foundation Health Plan of Northwest -High- Vancouver/Longview	800-813-2000	571	572	80.05	188.28
Kaiser Foundation Health Plan of Northwest -Std- Vancouver/Longview	800-813-2000	574	575	38.97	89.52

Plan Name – Location		Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
				Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average			67.9	86.4	84.9	94.2	87.7	87.5	64.9
Virginia													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$15/$30	$150/day x3	$5	$35/$100	Yes	69	84.4	87.2	94.2	86.5	91.4	56.7
Aetna Open Access-Basic		$20/$35	10% Plan Allow	$10	$35/$100	Yes	69	84.4	87.2	94.2	86.5	91.4	56.7
Aetna Whole Health	In-Network	$25/$35	15%	$5	$35/$60	Yes							
Aetna Whole Health	Out-Network	40%/40%	40%	40%	40%/40%	No							
Aetna Whole Health	In-Network	$5/$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	$35/$65	Yes	64.8	86	83.3	92.5	84.6	90.2	54
CareFirst BlueChoice	In-Network	Nothing/$35	$200	Nothing	$35/$65	Yes	64.8	86	83.3	92.5	84.6	90.2	54
CareFirst BlueChoice	Out-Network	$70/$70	$500	Nothing	$35/$65	Yes			83.3				
HealthKeepers, Inc.-High		$0/$35/30% Non-Network	$200 x3 days	$0	$30/$50/$50	Yes							
Kaiser Foundation HP Mid-Atlantic States-High		$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	83	86.7	83.1	92.7	81.3	83.6	70.2
Kaiser Foundation HP Mid-Atlantic States-Standard		$20/$30	$250/dayx3	$12/$22Net	$35/$55/$50/$70	Yes	83	86.7	83.1	92.7	81.3	83.6	70.2
M.D. IPA-High		$25/$40	$150/day x 3	$7	$30/$60	Yes	58.3	84.6	87.6	93.7	86.7	84.1	67.7
Optima Health Plan-High		$20/$0child <22/$30	$150max$750	$10	$35/30%/50% up to $3000	Yes	69.2	86.4	88.6	96.9	87	91.6	67.4
Optima Health Plan-Standard		$25/$30	$200/20%	$10	$35/50%/50% up to $3,000	Yes	69.2	86.4	88.6	96.9	87	91.6	67.4
Piedmont Community Healthcare-High		$35/$35	20%	$15	$40/$55	No							
Washington													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$100	Yes							
Group Health Cooperative-High		$25/$25	$350	$20	$40/$60	Yes	65.9	86	86.9	94.1	91.2	88.1	69.2
Group Health Cooperative-Standard		$25/$35	$500	$20	$40/$60	Yes	65.9	86	86.9	94.1	91.2	88.1	69.2
KPS Health Plans	In-Network	$15/4 or 20%/20%	Nothing	$10	$35/$50 30day $100 90day	Yes	79.8	94	92.8	95.7	93.1	89.7	65
KPS Health Plans	Out-Network	$15/4+40%+diff/ 40%+diff	Nothing	Not Covered	Not Covered	No							
KPS Health Plans	In-Network	$30/$30	None	$5	$25/$50 30day $100 90day	Yes	79.8	94	92.8	95.7	93.1	89.7	65
KPS Health Plans	Out-Network	$30+40%+diff	None	Not Covered	N/A	No							
Kaiser Foundation HP of Northwest-High		$20/$30	$200	$15	$40/$60	Yes	76.8	84.4	84.7	91.6	92.7	89	68.3
Kaiser Foundation HP of Northwest-Standard		$30/$40	$500	$20	$40/$60	Yes	76.8	84.4	84.7	91.6	92.7	89	68.3

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

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
West Virginia					
Aetna Value Plan- Most of West Virginia	877-459-6604	F54	F55	37.37	84.86
The Health Plan of the Upper Ohio Valley -High- Northern/Central West Virginia	800-624-6961	U41	U42	96.66	226.17
Wisconsin					
Aetna Value Plan- All of Wisconsin	877-459-6604	JS4	JS5	55.06	135.18
Aetna Whole Health -Basic- Milwaukee, WI Area	877-459-6604	F71	F72	30.33	83.58
Dean Health Plan -High- South Central Wisconsin	800-279-1301	WD1	WD2	87.94	280.70
Group Health Cooperative -High- South Central Wisconsin	800-605-4327	WJ1	WJ2	48.84	183.15
HealthPartners High Option - Western Wisconsin	800-883-2177	V31	V32	99.40	245.22
HealthPartners Standard Option - Western Wisconsin	800-883-2177	V34	V35	25.46	58.56
MercyCare HMO -High- South Central Wisconsin	800-895-2421	EY1	EY2	42.78	168.11
Physicians Plus -High- All of WI	800-545-5015	LW1	LW2	51.82	203.55
Wyoming					
Aetna Value Plan -Basic- All of Wyoming	877-459-6604	H44	H45	37.47	85.08
Altius Health Plans -High- Uinta County	800-377-4161	9K1	9K2	66.88	141.65
Altius Health Plans -Std- Uinta County	800-377-4161	DK4	DK5	33.76	74.27

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		67.9	86.4	84.9	94.2	87.7	87.5	64.9
West Virginia													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
The Health Plan of the Upper Ohio Valley-High		$10/$20	$250	$15	$30/$50	Yes	74.4	90.9	87.6	95.1	92.9	94.4	74.5
Wisconsin													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
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		$25/$25	None	$10		Yes	68.2	90.9	90	97	83.4	87.9	58.8
Group Health Cooperative - High		$10/$10	None	$5	$20/$20	Yes	78.5	83.4	83.4	95.3	92.9	93.2	71.8
HealthPartners High Option		$25/$45	Nothing	$12	$45/$90	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
HealthPartners Standard Option		$0 for 3,then 20%	20% in/40% out	$9	$40/$70	Yes	64.7	89.3	87.5	95.1	92	91.1	72.5
MercyCare HMO-High		$10/$10	Nothing	$10	$20/$50	Yes	78.4	88.8	85.4	93.8	88.8	87	68.4
Physicians Plus-High		$10/$10	Nothing	$10	30%/50%	No	60.1	85.7	82.2	96	86.3	86.6	68.6
Wyoming													
Aetna Value Plan	In-Network	$25/$40	20%	$10	30%to$600/50% to$1200	Yes							
Aetna Value Plan	Out-Network	40%/40%	40%	50%+	50%+/50%+	No							
Altius Health Plans-High		$20/$30	$200	$7	$25/$50	No	55.2	85.2	81.3	94.8	88.3	89.5	58.8
Altius Health Plans-Standard		$20/$40	None	$7	$35/$60	None	55.2	85.2	81.3	94.8	88.3	89.5	58.8

Appendix F
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement (Pages 102 through 121)

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 $6,350 for Self Only and $12,700 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.treasury.gov/resource-center/faqs/taxes/pages/health-savings-accounts.aspx for more information. The 2014 maximum contribution limits are $3,300 for Self Only coverage and $6,550 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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FEHB Plan Comparison Charts

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

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

Features of an HSA include:

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

Health Reimbursement Arrangement (HRA)

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

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

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

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

Features of an HRA include:

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

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FEHB Plan Comparison Charts

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

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

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

Appendix F
FEHB Plan Comparison Charts

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

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

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 or IHS 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 2014 annual contribution limit, including the HDHP premium pass through, is $3,300 for Self Only and $6,550 for Family enrollment. Employees who are age 55 and older may contribute an additional pre-tax catch-up amount of $1,000.
Visit www.treasury.gov/resources-center/faqs/taxes/pages/health-savings-account.aspx 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.

Appendix F
FEHB Plan Comparison Charts

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

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

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

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

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

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

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

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self &family
APWU Health Plan -CDHP- Nationwide	800-718-1299	474	475	27.88	62.71
GEHA High Deductible Health Plan -HDHP- Nationwide	800-821-6136	341	342	31.54	72.03
MHBP - Consumer Option -HDHP- Nationwide	800-694-9901	481	482	39.04	88.46
NALC -CDHP- Nationwide	888-636-6252	324	325	29.91	64.96

Employees in Rate Schedule Codes (RSCs) C, G, K, N and P who have been on Postal Service rolls and were enrolled in FEHB as of November 21, 2006, are entitled to the APWU CDHP Preferred Rate. Employees who were not enrolled in FEHB as of November 21, 2006, but who subsequently are enrolled in FEHB for one full year become eligible immediately for the APWU CDHP Preferred Rate.

Appendix F
FEHB Plan Comparison Charts

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

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

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

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

Prescription Drugs – Prescription Drug Payment Levels Plans use terms such as Level (L I, L II) or Tier (T1, T2,) to show what you pay for generic or brand name prescription drugs. The payment levels that plans use follow: **L I or Tier 1** includes generic drugs, but may include some preferred brands. **L II or Tier 2** includes preferred brands and may include some generics. **L III or Tier 3** includes non-preferred brands, other covered drugs, and with some exceptions, specialty drugs. **L IV or Tier 4** includes mostly preferred specialty drugs. **L V or Tier 5** generally includes non-preferred specialty drugs.

Mail Order Discounts – If your plan has a Mail Order program (typically for maintenance drugs) and its response is **"Yes"**, in general, its Mail Order program is superior to its retail pharmacy benefit (e.g., you obtain a greater quantity for less cost than retail pharmacy purchases). If your plan does not have a Mail Order program or it does not offer a superior benefit to retail pharmacy purchases, the response will be **"No"**.

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 CDHP	In-Network	$1,200/$2,400	$600/$1,200	$3,000/$4,500	15%	None	15%	Nothing	25%/25%/25%
APWU Health Plan CDHP	Out-Network	$1,200/$2,400	$600/$1,200	$9,000/$9,000	40%+diff.	None	40%+diff.	Nothing up to $1200	Not Covered
GEHA HDHP	In-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	5%	5%	5%	Nothing	25%/25%/25%
GEHA HDHP	Out-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	25%	25%	25%	Ded/25%	25%+/25%+/25%+
MHBP - Consumer Option	In-Network	$70/$141	$2,000/$4,000	$5,000/$10,000	$15	$75 day-$750	Nothing	Nothing	$10/$25/$40
MHBP - Consumer Option	Out-Network	$70/$141	$2,000/$4,000	$7,500/$15,000	40%	40%	40%	Not Covered	Not Covered
NALC	In-Network	$1,200/$2,400	$2,000/$4,000	$4,000/$8,000	20%	20%	20%	Nothing	$10/$40/$60
NALC	Out-Network	$1,200/$2,400	$4,000/$8,000	$8,000/$16,000	50%	50%	50%	50%	50%/50%/50%+

The APWU CDHP Preferred Rate for Enrollment Code 474 is $8.99 bi-weekly and the Preferred Rate for Enrollment Code 475 is $20.23 bi-weekly.

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

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

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

		Member Survey Results						
High Deductible Health Plans **Plan Name**	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
HDHP National Average		**61.4**	**88.5**	**86.6**	**92.9**	**86.0**	**87.6**	**58.5**
Aetna HealthFund - Nationwide	22	60.6	89.1	88.8	95.2	83.0	87.9	56.3
GEHA High Deductible Health Plan - Nationwide	34	62.3	87.3	85.1	92.3	86.3	86.5	60.2
Mail Handlers Benefit Plan Consumer Option - Nationwide	48	61.4	89.1	85.9	91.2	88.7	88.5	59.0
Consumer-Driven Health Plans **Plan Name**	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
CDHP National Average		**57.9**	**88.1**	**86.5**	**93.9**	**85.0**	**84.7**	**58.5**
Aetna HealthFund - Nationwide	22	60.6	89.1	88.8	95.2	83.0	87.9	56.3
APWU Health Plan - Nationwide	47	66.4	90.9	90.7	92.5	87.1	84.5	68.0
Humana CoverageFirst - TX	TP, TU, TV	56.6	84.9	86.4	93.2	84.3	85.3	54.2
Humana Coverage First - IN	MW	47.8	87.5	80.1	94.8	85.6	81.2	55.5

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 page 102 and 103 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 -HDHP- All 50 States and DC	877-459-6604	224	225	33.93	74.30

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	50.74	125.40
Alaska					
Aetna HealthFund -CDHP- Most of Alaska	877-459-6604	JS1	JS2	80.58	193.15
Arizona					
Aetna HealthFund -CDHP- All of Arizona	877-459-6604	G51	G52	76.84	184.66
Arkansas					
Aetna HealthFund -CDHP- Most of Arkansas	877-459-6604	F51	F52	50.74	125.40
California					
Aetna HealthFund -CDHP- Most of California	877-459-6604	JS1	JS2	80.58	193.15
Colorado					
Aetna HealthFund -CDHP- All of Colorado	877-459-6604	G51	G52	76.84	184.66

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 HDHP	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund HDHP	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%+
Alaska									
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%+
California									
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%+

High Deductible and Consumer-Driven Health Plans

See page 102 and 103 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
Connecticut					
Aetna HealthFund -CDHP- All of Connecticut	877-459-6604	EP1	EP2	68.52	165.78
Delaware					
Aetna HealthFund -CDHP- All of Delaware	877-459-6604	EP1	EP2	68.52	165.78
District of Columbia					
Aetna HealthFund -CDHP- All of Washington DC	877-459-6604	F51	F52	50.74	125.40
CareFirst BlueChoice -HDHP- Washington, D.C. Metro Area	888-789-9065	B61	B62	40.11	89.48
Florida					
Aetna HealthFund -CDHP- Most of Florida	877-459-6604	F51	F52	50.74	125.40
Coventry Health Plan of Florida -HDHP- Southern Florida	800-441-5501	J41	J42	40.00	148.05
Humana CoverageFirst -CDHP- Tampa Area	888-393-6765	MJ1	MJ2	36.68	81.61
Humana CoverageFirst -CDHP- South Florida Area	888-393-6765	QP1	QP2	31.44	69.96
Georgia					
Aetna HealthFund -CDHP- All of Georgia	877-459-6604	F51	F52	50.74	125.40
Humana CoverageFirst -CDHP- Atlanta Area	888-393-6765	AD1	AD2	50.74	125.40
Humana CoverageFirst -CDHP- Macon Area	888-393-6765	LM1	LM2	34.93	77.73
Guam					
TakeCare -HDHP- Guam/N. Mariana Islands/Belau (Palau)	671-647-3526	KX1	KX2	19.52	51.22

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
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%+
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	In-Network	$37.50/$75.00	$1,500/$3,000	$4,000/$8,000	Nothing	$300	Nothing	Nothing	Nothing/$30/$60
CareFirst BlueChoice	Out-NetWork	$37.50/$75.00	$3,000/$6,000	$6,000/$12,000	$70	$500	$70	Nothing	Nothing/$30/$60
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 Plan 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	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst-out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	30%	$10+/$40+/$60+	
Humana CoverageFirst	In-Network	$83.33	$1,000/$2,000	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	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	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	30%	$10+/$40+/$60+
Humana CoverageFirst	In-Network	$83.33	$1,000/$2,000	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	30%	$10+/$40+/$60+
Guam									
TakeCare	In-Network	$86.66/$222.08	$3000/$6000	$5,000/$10,000	20% after Ded	20% after Ded	20% after Ded	Nothing	$20/$40/$150
TakeCare	Out-NetWork	$86.66/$222.08	$3000/$6000	$10,000/$20,000	30% after Ded	30% after Ded	30% after Ded	1st $300/ded	30% after Ded/30% after Ded/30% after Ded

High Deductible and Consumer-Driven Health Plans

See page 102 and 103 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
Hawaii					
Aetna HealthFund -CDHP- All of Hawaii	877-459-6604	JS1	JS2	80.58	193.15
Idaho					
Aetna HealthFund -CDHP- Most of Idaho	877-459-6604	H41	H42	50.35	124.50
Altius Health Plans -HDHP- Southern Region	800-377-4161	9K4	9K5	24.91	51.60
Illinois					
Aetna HealthFund -CDHP- Most of Illinois	877-459-6604	H41	H42	50.35	124.50
Humana CoverageFirst -CDHP- Central Illinois	888-393-6765	GB1	GB2	34.93	77.73
Humana CoverageFirst -CDHP- Chicago Area	888-393-6765	MW1	MW2	34.93	77.73
Indiana					
Aetna HealthFund -CDHP- All of Indiana	877-459-6604	JS1	JS2	80.58	193.15
Humana CoverageFirst -CDHP- Lake/Porter/LaPorte Counties	888-393-6765	MW1	MW2	34.93	77.73
Iowa					
Aetna HealthFund -CDHP- All of Iowa	877-459-6604	H41	H42	50.35	124.50
Coventry Health Care of Iowa -HDHP- Central/Eastern/Western Iowa	800-257-4692	SV4	SV5	25.67	61.26
Kansas					
Aetna HealthFund -CDHP- Most of Kansas	877-459-6604	G51	G52	76.84	184.66
Coventry Health Care of Kansas (Kansas City)Kansas City Metro Area	800-969-3343	9H1	9H2	36.48	85.72
Humana CoverageFirst -CDHP- Kansas City Area	888-393-6765	PH1	PH2	31.44	69.96

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
Hawaii									
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%+
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		$52.08/$104.15	$1,250/$2,500	$5,000/$10,000	$20	10%	10%	Nothing	$7/$25/$50
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	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	30%	$10+/$40+/$60+
Humana CoverageFirst	In-Network	$83.33	$1,000/$2,000	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	30%	$10+/$40+/$60+
Indiana									
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	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	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		$83.33/$166.66	$2,100/$4,200	$5,000/$10,000	25%	15%	45%	Nothing	$3/ $10/$45/$70
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		$66.66/$133.33	$2,500/$5,000	$4,000/$8,000	20%	20%	20%	Nothing	20%/20%/20%
Humana CoverageFirst	In-Network	$83.33	$1,000/$2,000	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	30%	$10+/$40+/$60+

High Deductible and Consumer-Driven Health Plans

See page 102 and 103 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
Kentucky					
Aetna HealthFund -CDHP- Most of Kentucky	877-459-6604	H41	H42	50.35	124.50
Humana CoverageFirst -CDHP- Lexington Area	888-393-6765	6N1	6N2	31.44	69.96
Louisiana					
Aetna HealthFund -CDHP- Most of Louisiana	877-459-6604	F51	F52	50.74	125.40
Maine					
Aetna HealthFund -CDHP- All of Maine	877-459-6604	EP1	EP2	68.52	165.78
Maryland					
Aetna HealthFund -CDHP- All of Maryland	877-459-6604	F51	F52	50.74	125.40
CareFirst BlueChoice -HDHP- All of Maryland	888-789-9065	B61	B62	40.11	89.48
Coventry Health Care HDHP- All of Maryland	800-833-7423	GZ1	GZ2	34.28	76.79
Massachusetts					
Aetna HealthFund -CDHP- Most of Massachusetts	877-459-6604	EP1	EP2	68.52	165.78
Michigan					
Aetna HealthFund -CDHP- All of Michigan	877-459-6604	G51	G52	76.84	184.66
Minnesota					
Aetna HealthFund -CDHP- Most of Minnesota	877-459-6604	H41	H42	50.35	124.50
Mississippi					
Aetna Regional CDHP-Most of Mississippi	877-459-6604	H41	H42	50.35	124.50

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
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	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	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%+
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	$1,500/$3,000	$4,000/$8,000	Nothing	$300	Nothing	Nothing	Nothing/$30/$60
CareFirst BlueChoice	Out-Network	$37.50/$75.00	$3,000/$6,000	$6,000/$12,000	$70	$500	$70	Nothing	Nothing/$30/$60
Coventry Health Care HDHP	In-Network	$41.67/$83.34	$2,000/$4,000	$4,000/$8,000	Nothing	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/N/A/ 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%+

High Deductible and Consumer-Driven Health Plans

See page 102 and 103 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self &family
Missouri					
Aetna HealthFund -CDHP- Most of Missouri	877-459-6604	G51	G52	76.84	184.66
Coventry Health Care of Kansas (Kansas City)-HDHP Kansas City Metro Area (KS and MO)	800-969-3343	9H1	9H2	36.48	85.72
Humana CoverageFirst -CDHP- Kansas City Area	888-393-6765	PH1	PH2	31.44	69.96
Montana					
Aetna HealthFund CDHP - South/Southeast/Western MT Areas	877-459-6604	H41	H42	50.35	124.50
Nebraska					
Aetna HealthFund -CDHP- All of Nebraska	877-459-6604	H41	H42	50.35	124.50
Nevada					
Aetna HealthFund -CDHP- Las Vegas Area	877-459-6604	G51	G52	76.84	184.66
New Hampshire					
Aetna HealthFund -CDHP- All of New Hampshire	877-459-6604	EP1	EP2	68.52	165.78
New Jersey					
Aetna HealthFund -CDHP- All of New Jersey	877-459-6604	EP1	EP2	68.52	165.78
New Mexico					
Aetna HealthFund -CDHP- Albuquerque/Dona Ana/Hobbs Area	877-459-6604	G51	G52	76.84	184.66
New York					
Aetna HealthFund -CDHP- Most of New York	877-459-6604	EP1	EP2	68.52	165.78
Independent Health Assoc -HDHP- Western New York	800-501-3439	QA4	QA5	27.40	71.31

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Missouri									
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	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	In-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	30%	$10+/$40+/$60+
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	$2000/$4000	$5000/$10000	$15	Nothing	20%	Nothing	$7/$25/$40
Independent Health Assoc	Out-Network	$66.42/$166.67	$2000/$4000	$5000/$10000	40%	40%	40%	Nothing	N/A/N/A/N/A

High Deductible and Consumer-Driven Health Plans

See page 102 and 103 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 Carolina					
Aetna HealthFund -CDHP- All of North Carolina	877-459-6604	F51	F52	50.74	125.40
North Dakota					
Aetna HealthFund -CDHP- Most of North Dakota	877-459-6604	H41	H42	50.35	124.50
Ohio					
Aetna HealthFund -CDHP- All of Ohio	877-459-6604	JS1	JS2	80.58	193.15
AultCare HMO -HDHP- Stark/Carroll/Holmes/Tuscarawas/Wayne Co.	330-363-6360	3A4	3A5	24.81	50.08
Oklahoma					
Aetna HealthFund -CDHP- All of Oklahoma	877-459-6604	JS1	JS2	80.58	193.15
Oregon					
Aetna HealthFund -CDHP- Most of Oregon	877-459-6604	H41	H42	50.35	124.50
Pennsylvania					
Aetna HealthFund -CDHP- All of Pennsylvania	877-459-6604	H41	H42	50.35	124.50
HealthAmerica Pennsylvania - HDHP - Greater Pittsburgh Area	866-351-5946	Y61	Y62	35.19	81.11
UPMC Health Plan -HDHP- Western Pennsylvania	888-876-2756	8W4	8W5	35.62	80.28
Rhode Island					
Aetna HealthFund -CDHP- All of Rhode Island	877-459-6604	EP1	EP2	68.52	165.78
South Carolina					
Aetna HealthFund -CDHP- All of South Carolina	877-459-6604	JS1	JS2	80.58	193.15

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 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%+
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									
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%+
AultCare HMO	In-Network	$83.33/$166.66	$2,000/$4,000	$4,000/$8,000	20%	20%	20%	Nothing	20%/20%/20%
AultCare HMO	Out-Network	$83.33/$166.66	$4,000/$8,000	$8,000/$16,000	40% UCR	40% UCR	40% UCR	50% UCR	20%PlanAllow/20%Plan Allow/20% Plan Allow
Oklahoma									
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%+
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		$62.50/$125	$1,500/$3,000	$4,000/$8,000	$15	Nothing	Nothing	Nothing	$5/$35/$50
UPMC Health Plan	In-Network	$83.33/$$166.67	$2,000/$4,000	$3000/$6000	10%After Deduct	10% after deduct	10%after deduct	Nothing	$5 after deduct/
UPMC Health Plan	Out-NetWork	$83.33/$166.67	$2000/$4,000	$6000/$12000	30%After Deduct	30% after deduct	30%of Decut	30%	$35 after deduct/$75 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 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 page 102 and 103 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
South Dakota					
Aetna HealthFund -CDHP- Rapid City/Sioux Falls Area	877-459-6604	G51	G52	76.84	184.66
Tennessee					
Aetna HealthFund -CDHP- Most of Tennessee	877-459-6604	F51	F52	50.74	125.40
Texas					
Aetna HealthFund -CDHP- All of Texas	877-459-6604	JS1	JS2	80.58	193.15
Humana CoverageFirst -CDHP- Corpus Christi Area	888-393-6765	TP1	TP2	34.93	77.73
Humana CoverageFirst -CDHP- San Antonio Area	888-393-6765	TU1	TU2	34.93	77.73
Humana CoverageFirst -CDHP- Austin Area	888-393-6765	TV1	TV2	38.43	85.50
Utah					
Aetna HealthFund -CDHP- Most of Utah	877-459-6604	G51	G52	76.84	184.66
Altius Health Plans -HDHP- Wasatch Front	800-377-4161	9K4	9K5	24.91	51.60
Vermont					
Aetna HealthFund -CDHP- All of Vermont	877-459-6604	EP1	EP2	68.52	165.78
Virginia					
Aetna HealthFund -CDHP- Most of Virginia	877-459-6604	F51	F52	50.74	125.40
CareFirst BlueChoice -HDHP- Northern Virginia	888-789-9065	B61	B62	40.11	89.48

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
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%+
Texas									
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	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	30%	$10+/$40+/$60+
Humana CoverageFirst	In-Network	$83.33	$1,000/$2,000	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	30%	$10+/$40+/$60+
Humana CoverageFirst	In-Network	$83.33	$1,000/$2,000	$4,000/$8,000	$25	10%	10%	Nothing	$10/$40/$60
Humana CoverageFirst	Out-Network	N/A	$3,000/$6,000	$7,000/$14,000	40%	40%	40%	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		$52.08/$104.15	$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	Nothing/$30/$60
CareFirst BlueChoice	Out-NetWork	$37.50/$75.00	$3,000/$6,000	$6,000/$12,000	$70	$500	$70	Nothing	Nothing/$30/$60

High Deductible and Consumer-Driven Health Plans

See page 102 and 103 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
Washington					
Aetna HealthFund -CDHP- Most of Washington	877-459-6604	G51	G52	76.84	184.66
KPS Health Plans -HDHP- All of Washington	800-552-7114	L14	L15	29.37	64.17
West Virgina					
Aetna HealthFund -CDHP- Most of West Virginia	877-459-6604	F51	F52	50.74	125.40
Wisconsin					
Aetna HealthFund -CDHP- All of Wisconsin	877-459-6604	JS1	JS2	80.58	193.15
Wyoming					
Aetna HealthFund -CDHP- All of Wyoming	877-459-6604	H41	H42	50.35	124.50
Altius Health Plans -HDHP- Uinta County	800-377-4161	9K4	9K5	24.91	51.60

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
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	$1,300/$2,600	$4,000/$8,000	20%	None	20%	Nothing	
KPS Health Plans	Out-NetWork	$62.50/$125	$1,300/$2,600	$4,000/$8,000	40%	None	40%	Not Covered	
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%+
Wisconsin									
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		$52.08/$104.15	$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 or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

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, 2013. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**KANSAS** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
ALASKA – Medicaid	**KENTUCKY** – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ARIZONA – CHIP	**LOUISIANA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447
COLORADO – Medicaid	**MAINE** – Medicaid
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY: 1-800-977-6741
FLORIDA – Medicaid	**MASSACHUSETTS** – Medicaid and CHIP
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
GEORGIA – Medicaid	**MINNESOTA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payent (HIPP) Phone: 1-800-869-1150	Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629
IDAHO – Medicaid and CHIP	**MISSOURI** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
INDIANA – Medicaid	**MONTANA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
IOWA – Medicaid	**NEBRASKA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: www.ACCESSNebraska.ne.gov Phone: 1-877-383-4278

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

NEVADA – Medicaid	**SOUTH CAROLINA** – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	**SOUTH DAKOTA** – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	**TEXAS** – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH** – Medicaid and CHIP
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH CAROLINA – Medicaid	**VERMONT**– Medicaid
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	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
OKLAHOMA – Medicaid and CHIP	**WASHINGTON** – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
OREGON – Medicaid and CHIP	**WEST VIRGINIA** – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
PENNSYLVANIA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND – Medicaid	**WYOMING** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	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, 2013, 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)

Dear U.S. Postal Service Employee:

The Patient Protection and Affordable Care Act, Public Law 111-148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (collectively, the Affordable Care Act) establishes the Health Insurance Marketplace under Section 1311(b).

Section 1512 of the Patient Protection Affordable Care Act created a new Fair Labor Standards Act (FLSA) section 18B requiring a notice from employers to their employees about coverage options available through the Health Insurance Marketplace. You are receiving this notice from the Postal Service because it is required by the aforementioned law.

The Health Insurance Marketplace does not affect the Federal Employees Health Benefits (FEHB) Program.

If you are ineligible to enroll in the FEHB Program, or if you are eligible to enroll in the FEHB Program but you are not enrolled due to affordability issues or concerns, or if you are enrolled in the FEHB Program and have affordability issues or concerns, then you may wish to visit the health insurance marketplace to review marketplace coverage options at www.healthcare.gov. Please be aware that there is no government or employer contribution to the premiums for Health Insurance Marketplace plans. Also, premiums are paid on an after-tax basis for Health Insurance Marketplace plans.

The attached notice entitled "New Health Insurance Marketplace Coverage Options and Your Health Coverage" provides general information about the new Health Insurance Marketplace.

The Affordable Care Act establishes a minimum value standard of benefits for employer- sponsored health plans. All health plans in the FEHB Program are eligible employer-sponsored health plans. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. Therefore, the minimum value standard is 60% (actuarial value). **The health coverage of all the plans in the FEHB Program meets the Affordable Care Act's minimum value standard for the benefits that each FEHB plan provides.**

As a comparison point, the actuarial value of most FEHB plans meets or exceeds the actuarial value of the silver plan in the health insurance marketplace.

If you are a career U.S. Postal Service employee who is eligible to enroll in the FEHB Program but you do not enroll, or if you cancel your FEHB enrollment, you should be aware of the consequences of such actions including the following but not limited to:

- If you die, you will not have an FEHB Self and Family enrollment for your survivors to continue, even if they are eligible for a survivor annuity.

- If you retire, you will not have an FEHB enrollment to continue into retirement. Also, to be eligible to continue FEHB coverage after retirement, a retiring employee must be enrolled or covered under the FEHB Program for the five years of service immediately before retirement, or, if less than five years, for all service since the first opportunity to enroll. Employees can count their coverage under TRICARE toward meeting this requirement. However, the employee must be enrolled in an FEHB health plan on the date of retirement to continue coverage.

For more information about your FEHB health insurance coverage, please visit:
www.opm.gov/healthcare-insurance/healthcare or look on liteblue.usps.gov under MyHR—Benefits.

The direct link is: https://liteblue.usps.gov/humanresources/benefits/insurance/benefits_insurance_fehb.shtml? for FEHB information on LiteBlue.

Notice Required by Patient Protection and Affordable Care Act
New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information
When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your Federal Employees Health Benefits (FEHB) Program health insurance coverage offered by your employer, please visit: www.opm.gov/healthcare-insurance/healthcare
or: https://liteblue.usps.gov under MyHR—Benefits. The direct link is:
https://liteblue.usps.gov/humanresources/benefits/insurance/benefits_insurance_fehb.shtml? for FEHB information on LiteBlue.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit: www.healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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Summary Information

	New Hires Can Enroll	Open Season	How to Enroll	Program Website
FEHB	Within 60 days from new hire date	Annual – November 11 to December 10, 2013 5 p.m. Central Time	*PostalEASE* https://liteblue.usps.gov 1-877-477-3273, option 1	**www.opm.gov/healthcare-insurance/healthcare**
FEDVIP	Within 60 days from new hire date	Annual – November 11 to December 9, 2013 11:59 p.m. Eastern Time	Go to www.BENEFEDS.com or call 1-877-888-3337 TTY 1-877-889-5680	**www.opm.gov/healthcare-insurance/dental-vision**
FSA	During 26th or 27th pay period after career appointment	Annual – November 11 to December 22, 2013 5 p.m. Central Time	*PostalEASE*	**https://liteblue.usps.gov**
FEGLI	Within 60 days from new hire date for optional insurance; automatically enrolled in Basic insurance until you take action to cancel	No annual Open Season	Via SF 2817 for new hires Others provide medical information on SF 2822	**www.opm.gov/healthcare-insurance/life-insurance**
FLTCIP	Apply (not necessarily enroll) within 60 days from new hire date with abbreviated underwriting	No annual Open Season	Go to www.LTCFEDS.com/usps or call 1-800-582-3337 TTY 1-800-843-3557	**www.opm.gov/healthcare-insurance/long-term-care**

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1. Find health plans available in your ZIP Code™.
2. Choose plans to compare.
3. See a simple summary of benefits.
4. See your biweekly premium cost **in this Guide**.
   Note: Rates displayed on the Web may not apply to you.
5. Choose the best value plan for your needs.
6. If you want to make a change, enroll during open season using PostalEASE.