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*The* **1999** Guide to  
Federal  
Employees  
Health Benefits Plans

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**for**  
**United States**  
**Postal Service Employees**



United States  
Office of  
Personnel  
Management

Retirement and  
Insurance  
Service

RI 70-2  
Revised November 1998

# FEHB Commitment to Our Customers

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- Your choice of health benefits plans will compare favorably for value and selection with the private sector.
- When you use the FEHB Guide and plan benefit brochures, you will find they are clear, factual and give you the information you need.
- When you change plans or options, your new plan will issue your identification card within 15 days after it gets your enrollment form from your agency.
- Your fee-for-service plan should pay your claims within 20 work days; if more information is needed, it should pay within 60 days.
- If you ask OPM, Office of Insurance Programs, to review a claim dispute with your plan, the decision will be fair and easy to understand, and will be sent to you within 60 days. If you need to do more before the review of a claim dispute, OPM will tell you within 14 work days what you still need to do.
- When you write to OPM about other matters, you will have a response within 30 days after receipt of your letter. If more time is needed to give a complete response, you will be notified.



*Better Information*  
*Better Choices*  
*Better Health*

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## Things to Remember

- The list of qualified life status changes has been expanded — the new list is found on page 8 of this Guide.
- A number of plans withdrew from the FEHB Program. Make sure your plan will be offered in 1999.
  - Be aware of 1999 benefit changes.
  - Check the 1999 premium.

# About This Guide

## Overview

The purpose of this 1999 Guide to Federal Employees Health Benefits Plans (FEHB Guide) is to provide information about enrollment and premium features that United States Postal Service (USPS) career employees must consider when selecting a health insurance plan under the Federal Employees Health Benefits (FEHB) Program.

Also provided are the results of a customer satisfaction survey conducted by the Office of Personnel Management and an accreditation of plans evaluated by the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), nationally-recognized leaders in evaluating managed care plans.

All plans available under FEHB are listed in this booklet. The following categories of plans and services are available for 1999: (1) managed fee-for-service; (2) plans with a point of service product; and (3) health maintenance organizations.

While FEHB eligibility, enrollment requirements, and the plans available for 1999 are the same for federal and USPS employees alike, there are some important differences in premium costs and withholding of premium contributions that apply to Postal employees only.

### NOTE

*Certain restrictions, explained on pages 8 and 9, may affect your ability to cancel coverage outside of FEHB Open Season. Read the section on pre-tax payment—it applies to all USPS career employees, and there are advantages and disadvantages to the pre-tax payment of premium contributions that you need to understand.*

This FEHB Guide (RI 70-2) contains provisions for USPS career employees who are not U.S. Postal Service Inspectors (IS) and Office of Inspector General (OIG) employees. Other versions of the 1999 Guide relative to provisions for IS/OIG employees and temporary employees, are available as follows:

RI 70-2 IN, 1999 Guide to Federal Employees Health Benefits Plans for United States Postal Service Inspectors and Office of Inspector General Employees.

RI 70-8 PS, 1999 Guide to Federal Employees Health Benefits Plans for Certain Temporary United States Postal Service Employees.

These FEHB Guides, links to plan brochures, plan websites and other information are available on USPS's Intranet website at <http://blue.usps.gov/hrisp/comp>. or the Office of Personnel Management's Internet website at <http://www.opm.gov/insure>.

*The information in the 1999 Guide to Federal Employees Health Benefits (FEHB) Plans gives you an overview of the FEHB Program and its participating plans. Before making any final decisions about health plans, be sure to check the plans' brochure.*

### NOTE

*Information you provide by enrolling in the Federal Employees Health Benefits Program may also be used for computer matching with Federal, State or local agencies' files to determine whether you qualify for benefits, payments, or eligibility in the Federal Employees Health Benefits Program, Medicare, or other Government benefits programs.*

# FEHB Program Information

## Definitions and Explanations

The following definitions are provided to help you understand the terms used in this Guide.

**Brochure**—A plan’s description of benefits, limitations, exclusions and definitions under the FEHB Program. OPM assigns a number to each brochure. Use the assigned number when you ask your personnel office to see a particular plan’s brochure. They are also available at OPM’s Internet website at <http://www.opm.gov/insure> or from USPS’s Intranet website at <http://blue.usps.gov/hrisp/comp>.

**Catastrophic limit**—The maximum amount of certain covered expenses you have to pay out of your own pocket during the year.

**Coinsurance**—The ratio you and your FEHB plan share for the cost of covered medical expenses. For example, a 20% coinsurance means you pay 20% of most covered charges. The plan pays 80%.

**Copayment**—A fixed dollar amount you pay as your share of a service or benefit (sometimes call a copay).

**Covered charges**—The charges for medical care or supplies your plan is responsible for before deductibles, coinsurance and copayments are applied. Information about covered benefits expenses and services are included in each plan’s brochure.

**Deductible**—The amount of covered charges you must pay before the plan begins to pay.

**Health Maintenance Organization (HMO)**—A health plan that provides care through a network of physicians and hospitals located in particular geographic or service areas. HMOs coordinate the health care services you receive. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work. Some HMOs have agreements with providers in other service areas for non-emergency care if you travel and are away from home for extended periods.

- The HMO provides a comprehensive set of services—as long as you use the doctors and providers in the HMO network. You may have to pay something when you get care, for example, a \$10 copayment per office visit.
- Most HMOs ask you to choose a doctor or medical group to be your primary care provider (PCP). Your PCP takes care of most of your medical needs. In many HMOs, you must get permission

or a “referral” from your PCP in order to see other providers in the network.

- Care received from a non-network provider, other than emergency care, is generally not covered.

See pages 28-55 for a list of participating HMOs.

**Managed Fee-for-Service (FFS)**—A traditional type of insurance that lets you use any doctor or hospital, but you usually must pay a deductible and coinsurance. These plans are called FFS because doctors and other providers are paid for each service, such as an office visit, or test. They help control costs by managing some aspects of patient care. Most also provide access to PPOs. See pages 14-16 for managed fee-for-service plans.

**Preferred Provider Organization (PPO)**—A managed fee-for-service option where you can choose plan-selected providers who have agreements with the plan. When you use a PPO provider, you pay less money out-of-pocket for medical services than when you use a non-PPO provider.

**Point of Service (POS) Product**—A product offered by an HMO or FFS plan that has features of both. In an HMO, the POS product lets you use providers who are not part of the HMO network. However, there is a greater cost associated with choosing these non-network providers. You usually pay deductibles and coinsurances that are substantially higher than the payments when you use a plan provider. You will also need to file a claim for reimbursement, like in an FFS plan. The HMO plan wants you to use its network of providers, but recognizes that sometimes enrollees want to choose their own provider.

In an FFS plan, the plan’s regular benefits include deductibles and coinsurance. But in some locations, the plan has set up a POS network of providers similar to what you would find in an HMO. The plan encourages you to use these providers, usually by waiving the deductibles and applying a copayment that is smaller than the normal coinsurance. Generally, there is no paperwork when you use a network provider. See pages 18-26 for POS choices.

**Provider**—As used in this Guide and plan brochures, a provider means an individual or institution that provides medical or health services, such as doctors, hospitals, nurse-midwives, or therapists. “Covered” providers are those the plan will reimburse.

# FEHB Program Information

## Coverage

The USPS provides health benefits to its career employees by participating in the FEHB Program which is administered by the U.S. Office of Personnel Management (OPM), Office of Insurance Programs. FEHB 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 your plan—and almost 300 other health plans—that pay claims and provide care to covered members.

New employees have the opportunity to select a health plan when hired and current employees have an opportunity to select or change plans when certain life events occur and during an open season that occurs each fall. These elections are made without requiring a medical examination or restrictions because of your age or physical condition.

Your choice of plans and options includes self only coverage just for you, or self and family coverage for you, your spouse and unmarried dependent children under age 22 (and in some cases, a disabled child 22 years old or older who is incapable of self-support). Further information for determining family members eligibility appears on page 2 of the Health Benefits Registration Form (SF 2809).

On the occurrence of certain life events, the FEHB Program offers a continuation of coverage, either temporarily or permanent conversion to a private plan. Such events include but are not limited to separation from service, retirement, divorce, death, relocation and leave without pay. It is your responsibility to understand and report life events that may cause you or your family member to lose eligibility. Certain rules about coverage and premium amounts apply. If you have questions, see your personnel office.

### 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.*

## FEHB Open Season

The 1998 Open Season is from **November 9 through close of business December 14**. Employees may make any one—or a combination—of the following changes:

- enroll if not enrolled
- change from one plan to another plan
- change from one option to another option
- change from self only to self and family
- change from self and family to self only
- cancel enrollment

If you decide to enroll or to change your enrollment, you must submit a registration form (Standard Form 2809) to your personnel services office by close of business on **December 14, 1998**.

Your new enrollment or any changes that you make to your existing coverage will take effect on January 2, 1999. If you decide **NOT** to change your enrollment, **DO NOTHING**, and your present enrollment will continue automatically unless your plan will not participate in 1999. In that event you must choose another plan. Ask your personnel office for a list of the plans that will terminate on January 1, 1999, the last day of the 1998 plan year.

If you decide to cancel your coverage, you must submit a Standard Form 2809 that clearly reflects your acceptance of the consequences of cancellation. A cancellation generally is effective at the end of the pay period in which it is received by the personnel services office. However, if cancellation is elected during open season, it will become effective on January 1, 1999.

Should you cancel coverage, you may not enroll again until the next open season unless an event occurs that permits enrollment, for example, a change in marital status.

In deciding whether to enroll in or to cancel FEHB insurance, remember that you will not be eligible for FEHB coverage when you retire if you have not been continuously covered, either as an enrollee or eligible family member, for the 5 years preceding retirement, or, if less than 5 years, for the entire period since your first opportunity to enroll.

# FEHB Program Information

## Selecting a Plan

You are fortunate to be able to choose from among many different health plans competing for your business. Reading the information contained in this Guide will help you compare the costs, benefits and features of different plans to select the health care plan best suited to your needs. The FEHB Program offers a variety of health plans and products to enhance your choices and to make your health care dollar go further.

**Type of Plan.** You can choose from among Managed Fee-for-Service plans, regardless of where you live, or plans offering a Point of Service Product and Health Maintenance Organizations, if you live (or sometimes if you work) within the area serviced by the plan.

❑ Managed fee-for-service (FFS) plans reimburse you or your health care provider for covered services (generally on a percentage basis) and allow you to choose your own doctors, hospitals, and allow you to see specialists without a referral. Managed care is an important part of the FEHB Program. It is a system of health care that integrates the financing, delivery, and prospective review of health services. Common features of managed care are pre-approval of hospital stays, the use of primary care physicians as “gatekeepers” to coordinate your medical care, and physicians and other providers working in organized networks.

A comparison chart of managed fee-for-service plans begins on page 14. These plans are “nationwide” in the sense that they are available to employees regardless of where they live, and “managed” in that all contain common managed care features. If you are willing to pay a little more in total costs for the widest choice of doctors, a FFS plan might be for you. Most FFS plans have a Preferred Provider Organization (PPO) feature.

The general information shown in the FFS chart can help you to compare plan benefits, your share of plan premiums, and other factors that may influence your decision about which plan to select for the coming year. Some employee organization plans require you to become full or associate members in the organizations that sponsor the plans. Membership requirements and/or limitations also apply to any Point of Service (POS) product the FFS plan may be offering. “Restricted” plans enroll only employees in certain occupational groups or agencies.

❑ Prepaid plans (HMOs) provide health care from designated physicians and hospitals located in particular geographic or service areas. Your eligibility to enroll in a prepaid plan is determined by where you live, or in some plans, where you work. Some prepaid plans have “reciprocity agreements” with providers in other service areas for providing non-emergency care, if you travel and are away from home for extended periods. A listing of prepaid plans begins on page 28. When you look at the chart of prepaid plans, the first thing you should do is to make sure that you live or work within the general area of any plan that you are interested in joining.

❑ Due to changes in the health insurance industry, the two types of plans are beginning to blend their features. In many geographical locations, Point of Service (POS) and Preferred Provider Organization (PPO) plan features are offered to provide enhanced health care services through selected providers. PPO is a product of fee-for-service plans, while POS is offered by fee-for-service and prepaid plans (see page 18). In an HMO, the POS product functions like a FFS plan. The HMO’s enrollees may use non-affiliated (out of network) providers if they wish, but the services will cost them more—in terms of deductibles and coinsurance—than if they used plan providers. In FFS plans, the POS product acts like an HMO. If they agree to let their medical care be managed by a plan-affiliated gatekeeper physician (in network), plan enrollees will get a better benefit, usually in the form of richer benefits and lower copays or coinsurance.

**Cost.** Certainly the premium you pay is an important consideration, but there are some other things you should consider. When thinking about premiums, what can you afford biweekly? Should you enroll in a High Option — and pay High Option premiums — if a Standard Option would do?

If you need to go to the hospital, how much will you have to pay? Do you know how much you will pay for an emergency room visit? If you have children, what will it cost for you for a well-child care visit?

Do you have to pay a deductible for the services you might use? Your share of medical expenses is either a coinsurance (a percentage of the bill) or a copayment (a fixed dollar amount). Which option do you prefer and what does the plan require? Does the plan limit the dollar amount it will pay for certain services?

# FEHB Program Information

Within any plan, there are things you can do to minimize your out-of-pocket costs and make the plan work best for you.

An easy way to save money is to use a plan's mail order drug program, if it has one. Request generic drugs instead of brand name drugs. Almost all FFS Plans have PPOs. Using a PPO will reduce out-of-pocket expenses. If you do not use a PPO provider, your plan will base its payment on a "usual and customary" allowance which may be less than the actual billed charge. This means you might have to pay the difference. You can reduce the chance of this happening by discussing fees in advance with your provider. Remember that plans set their own allowances.

**Plan Services.** Check to see if the plan offers the services you think you might need. If you're 65 or over, how does the plan coordinate coverage with Medicare? If you regularly see an allergist, do you pay extra for the allergy serum? Does the plan offer a prenatal program? Given the trend toward reducing hospital stays, will your plan pay for home health care? Because health care is expensive, pay attention to the plan's catastrophic coverage to see how you are protected. See if there are limits on the number of visits for the services you need.

It is also important to note that all of the services provided in a PPO hospital may not be covered by PPO arrangements. Room and board will be covered, but the anesthesia and radiology services may not be. The only way to find out is to ask in advance.

## More Information

While this guide gives a general overview of health benefits, the official brochure for each plan explains the contractual terms of coverage that determine how claims are paid or services are provided for each plan.

Check your bulletin board or contact your personnel services office for guidance about obtaining brochures of the health plans that interest you. You may also get brochures by contacting the plans directly at the phone numbers listed in the "Plan Report Cards" section of this Guide starting on page 14 or on the World Wide Web. Plans that have a  in the column labeled "Website" have their own website. You may visit the USPS Intranet website at <http://blue.usps.gov/hrisp/comp> to link to plan brochures and plan websites from OPM's Internet website at <http://www.opm.gov/insure>.

Look over the brochures carefully, especially the "Changes" page of your current plan to see how benefits have changed from last year. No one has a greater stake in your health than you. Understand how a plan works and don't be shy about asking questions. An informed consumer is a better decision maker. If you have specific questions on plan benefits and coverage after reviewing a plan's brochure, contact the health plan.

It is your responsibility to be informed about your health benefits. You should thoroughly read this Guide, the brochures of plans that interest you, and the bulletin board notices on health benefits topics. These include family member eligibility, the option to continue or terminate an enrollment during periods of nonpay 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 begins on page 8.

After referring to these sources, if you still have questions regarding eligibility, enrollment criteria, continued coverage after certain life events, or if you need a registration form (SF 2809), contact your personnel services office.

# FEHB Plan Information

## Details of 1998 Customer Satisfaction Survey

The results of the 1998 Customer Satisfaction Survey show how enrollees in the FEHB Program rate their health plan. If you're considering joining a FFS plan, chances are you'll file a claim. How quickly does the plan process claims? Will the plan be responsive to your questions? As an HMO enrollee, you might be most interested in how the plan is rated in access to care and choice of doctors.

If a plan is not rated in this Guide, it is because the plan is new to the FEHB Program or the number of respondents was too small to reliably include their opinions.

**The Ratings.** Enrollees were surveyed and asked to rate various aspects of their health plan on a five-point scale of *poor*, *fair*, *good*, *very good*, and *excellent*. Plans that enrollees rated significantly better than average in any category have a ●, average ratings get a ◐, and significantly below average get a ○. The average rating for all plans of the same type is shown in the column heading. For more detailed information about ratings, visit OPM's Internet web site at [www.opm.gov/insure](http://www.opm.gov/insure).

The categories shown in this Guide were chosen because of their importance to most people in selecting a plan (some categories apply only to POS and HMO plans or only to FFS plans):

- Ability to see the same doctor on most visits,
- Access to medical care (arranging for and getting care),
- Access to medical care in an emergency (POS and HMO only),
- Choice of doctors available through the plan (being able to find doctors you are satisfied with),
- Costs you personally have to pay (FFS only),
- Coverage (range of services covered),
- Explanation of care (what is wrong, what is being done, and what to expect),
- Getting appointments when sick,
- Getting claims processed quickly (FFS only),
- Quality of care (from doctors and other medical professionals), and
- Results of care.

**Overall Satisfaction.** Enrollees were also asked about their overall satisfaction with their health plan:

*All things considered, how satisfied are you with your current health plan?*

A bar graph for each plan shows the percentage of plan enrollees who indicated they were *extremely satisfied*, *very satisfied* or *satisfied*.

Example: 

19	45	22
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In the example, 19% of respondents are *extremely satisfied*, 45% are *very satisfied*, and 22% are *satisfied*.

The numbers in the bar add to 86, meaning 86% of respondents were at least satisfied with the plan. The remainder were less than satisfied with the plan overall.

Plans with an overall satisfaction score that is significantly higher than the average overall score are identified with a ✓ in the column labeled "Top rated plans".

# FEHB Plan Information

## Accreditation

HMO accreditations reflect the independent evaluations of nationally-recognized organizations. These organizations evaluate health plans and health care organizations and confer accreditation, much like educational accrediting organizations confer accreditation on schools. OPM encourages all FEHB plans to get accreditation from national accrediting organizations. We have listed the accreditation status of the FEHB plans that requested review from two large, nationally-recognized accrediting organizations — NCQA and JCAHO. Plans willing to go through an accreditation review show a commitment to continuous quality improvement and accountability. Plans willing to go through an accreditation review show a commitment to continuous quality improvement and accountability.

### National Committee for Quality Assurance

**(NCQA)** The NCQA accreditation process evaluates how well an HMO manages all parts of its delivery system including physicians, hospitals, other providers, and administrative services. NCQA evaluations are used to assess the quality of a plan's operations.

- ★ **Full Accreditation** is granted for a period of three years to those plans that have excellent programs for continuous quality improvement and meet NCQA's rigorous standards.
- **One-Year Accreditation** is granted to plans that have well-established quality improvement programs and meet most NCQA standards. NCQA reviews the plans again after a year to determine if their accreditation status should be changed.
- ◐ **Provisional Accreditation** is granted for one year to plans that have adequate quality improvement programs and meet some NCQA standards. When these plans demonstrate progress, they can qualify for a higher level of accreditation.
- ⊗ **Denial** indicates that a plan was reviewed but did not qualify for any of the above categories.

### Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The JCAHO accreditation process evaluates an HMO's level of performance in key functional areas, such as care and treatment of patients, patient rights, improving organizational performance, and organizational ethics. JCAHO standards set performance expectations about the quality of patient care.

- ★ **Accreditation With Commendation** is granted to those plans that have demonstrated exemplary performance in complying with JCAHO standards.
- **Accreditation** is granted when a plan has demonstrated acceptable compliance with JCAHO standards.
- ◐ **Accreditation With Recommendations For Improvement** is granted when a plan receives at least one recommendation addressing insufficient or unsatisfactory compliance in a specific performance area.
- ⊗ **Not Accredited** indicates a plan has been denied accreditation because of significant noncompliance with JCAHO standards, or a plan's accreditation is withdrawn by JCAHO, or the plan voluntarily withdrew from the accreditation process.

## NOTE

*This Guide does not show an accreditation status for every plan. There may be various reasons why you won't find an accreditation symbol for a plan; check with the plan for specific information.*

*You may call a plan for more information about their accreditation status or call NCQA toll free at 888/275-7585 or JCAHO at 630/792-5800. You may also visit NCQA's web site at [www.ncqa.org](http://www.ncqa.org) or JCAHO's web site at [www.jcaho.org](http://www.jcaho.org). You can link to either site from OPM's Internet web site at <http://www.opm.gov/insure>.*

# Pre-Tax Payment of Premium Contributions

The Postal Service has established the pre-tax payment of health insurance premium contributions as a tax-saving benefit feature for its employees. This feature is sponsored by the Postal Service-it is not a provision of the FEHB Program. As a result, forms and handbooks published by OPM do not address how payment on a pre-tax basis prohibits Postal enrollees from reducing coverage at anytime. Read the “Reducing Coverage” section for details.

## Pre-tax Withholding

If you are a career USPS employee, your premium contributions will 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 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), 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 will not be affected.)

✓ Second, there are some restrictions on reducing your coverage outside FEHB Open Season that apply if you pay your premium contributions with pre-tax money. These are explained 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 to waive the pre-tax treatment. For more information, see the section, How to Waive Pre-Tax Payment on page 9.

## 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 family to self only coverage, only during an FEHB Open Season, unless one of the following qualified life status changes occurs:

### Qualified Life Status Changes

1. you marry, divorce, legally separate, or your marriage is annulled
2. you add a qualified dependent (for example, birth or adoption of a child)
3. you lose a qualified dependent (for example, death of your child or spouse)
4. you become subject to a court order, judgment or decree (resulting from a change in marital status or in legal custody) that requires you to begin or stop providing health benefits for your child
5. your spouse starts or ends employment or an unpaid leave of absence, or changes employment from full-time to part-time or the reverse
6. you, your spouse or your qualified dependent becomes eligible for Medicare or Medicaid
7. your qualified dependent has a change in eligibility for health benefits
8. you or your spouse has a change in eligibility for health benefits because you, your spouse, or your qualified dependent changes residence, workplace or work hours
9. you or your spouse has a significant change in health benefits because of your spouse’s employment
10. you complete a full pay period in non-pay status (for example, leave without pay)

Also, reducing your FEHB coverage outside of FEHB Open Season must be in keeping with your

# Pre-Tax Payment of Premium Contributions

qualified life status change. For example, if you have a new baby, you usually would not change from a self and family to a self only enrollment.

To reduce your FEHB coverage outside of FEHB Open Season, submit Standard Form (SF)2809, Health Benefits Registration Form, to your personnel services office no later than 60 days after a qualified life status change has occurred. You must provide any supporting documentation requested by your personnel services office. 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 SF 2809 is received. The effective date of a cancellation will be the last day of the pay period in which your SF 2809 is received.

If you are the only person left in your self and family enrollment as a result of a change in marital or family status (divorce, death of a child or spouse, child marries or reaches age 22), you must elect to reduce the enrollment (elect self only coverage, or cancel coverage) within 60 days of the qualified life status change. Otherwise, your self and family enrollment will continue until another event (that is, a qualified life status change or FEHB Open Season) occurs that allows you to elect to reduce coverage. The election cannot become effective retroactively, therefore there will be no retroactive premium adjustment.

Retirement is not a qualified life status change that allows cancellation prior to separation. If you wish to cancel an enrollment at retirement, the personnel services office will accept your completed SF2809 and forward it to OPM for processing after separation from the Postal Service.

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

## How to Waive Pre-tax Payments

If you wish to pay your premiums with after-tax money, you should contact your personnel services office and ask for Postal Service (PS) Form 8201, Pre-tax Health Insurance Premium Waiver/Restoration Form (November 1998). Complete the form and return it to your personnel services office by close of business **December 14, 1998**.

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 8201 to restore pre-tax payment of FEHB premiums.

If you have 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 PS 8201 to restore pre-tax payment of your premium contributions. The only time of year that you may change the method of payment from pre-tax to after-tax, or the reverse, is during the annual FEHB Open Season.

**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 qualified life status change.

## Your Right to More Information

This section of the FEHB Guide serves as your summary plan description of the USPS Plan for the Pretax 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 contacting the:

PRETAX PAYMENT OF HEALTH INSURANCE  
PREMIUMS  
PLAN ADMINISTRATOR  
475 L'ENFANT PLAZA SW-ROOM 9670  
WASHINGTON DC 20260-4210

# Patient Bill of Rights and Responsibilities

The Patient Bill of Rights and Responsibilities spells out recommendations made by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. These recommendations promote and ensure health care quality and protect health care consumers. The President signed an Executive memorandum directing the Office of Personnel Management to take steps to bring the FEHB Program into contractual compliance with these recommendations.

OPM is pleased to report that most FEHB plans already comply with the Commission's Patient Bill of Rights and Responsibilities. For 1999, you can expect all of the following from your FEHB plan:

- Direct access to women's health care providers for routine and preventative women's health care services.
- Coverage of emergency department services for screening and stabilizations without authorization if you have reason to believe your life is endangered or you would be seriously injured or disabled.
- Direct access to a qualified specialist within your network of providers if you have complex or seri-

ous medical conditions that need frequent specialty care. Authorizations, when required by a plan, will be for an adequate number of direct visits under an approved treatment plan.

- Extensive information about plan characteristics and performance, provider network characteristics, and care management.
- The elimination of "gag rules" in provider contracts that could limit communication about medically necessary treatment.

The health care system works best when enrollees take the time to become informed. As responsible consumers, you should:

- Read and understand your health benefits coverage, limitations, and exclusions, health plan processes, and procedures to follow when seeking care.
- Work with your physician in developing and carrying out a treatment plan.
- Practice healthy habits.

**Call the FEHB Fraud Hotline**

**202/418-3300**

**if a provider has billed you for services you did not receive**

# A Word About Medicare

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Most Postal and Federal employees aren't yet eligible for Medicare, but many of us have friends or relatives who are. The Balanced Budget Act of 1997 (P.L. 105-33) expanded Medicare's health plan options with the creation of Medicare+Choice. Beginning in 1999, Medicare beneficiaries can remain in the original Medicare plan or choose to get their Medicare benefits from an array of other Medicare+Choice options. These options include managed care plans such as HMOs and PPOs, as well as Private FFS plans and Medical Savings Accounts (MSAs).

Medicare beneficiaries will receive information about these new choices this fall, or can check Medicare's web site at [www.medicare.gov](http://www.medicare.gov). If a friend or relative asks you about these new choices, they need to know that they don't have to make any change. If they want to change and have an employer-sponsored health care policy, they should first talk with their former employing office. Former Postal and Federal employees should call their retirement system before making any change, especially if they are considering suspending their FEHB coverage.

# Your Links to 1999 FEHB Information

**OPM Internet Web Site – [www.opm.gov/insure](http://www.opm.gov/insure)**

**U.S. Postal Service Intranet Web Site –  
<http://blue.usps.gov/hrisp/comp>.**

You may obtain current and valuable information to help you choose a health plan by visiting OPM's Internet web site at <http://www.opm.gov/insure> and USPS's Intranet web site at <http://blue.usps.gov/hrisp/comp>.

You will find more information and new features on the sites for 1999. The new Health Plan Profiler (HPP) lets you view and print summary information about health plans. Enrollees in some states can use a new interactive decision tool to narrow the health plan search.

You can download and print plan brochures and other materials, access definitions by clicking hyperlinks, and use automated links to navigate to other sites. When you visit the sites you will see these choices and more:

- **1999 Plan Information** — gives you access to general information about plans, plan quality indicators (including detailed survey results which are not printed in this Guide), plan brochures, and information about how to choose a plan. You can link to other web sites with valuable information

about health plans, including those plans participating in the FEHB Program. You can also view, download and print the **Guides to Federal Employees Health Benefits Plans**.

- **Patient Bill of Rights** — gives you information about the three objectives of the Patient Bill of Rights and the eight principle areas of rights and responsibilities. You can also link to the full text of the Patient Bill of Rights and related background information.
- **Frequently Asked Questions** — gives you answers to questions about premiums, enrollment, family members, temporary continuation of coverage (TCC), switching plans, retirement and other topics of interest.

The Health Plan Profiler is an easy-to-use web tool that lets you create plan profiles and summaries. You also can link to FEHB plan web sites from the Health Plan Profiler. Plans that have a  in the column labeled "Web site" in this Guide have their own web site.

# Plan Report Cards

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## 1999 Plan Listing with Biweekly Premium Rates for USPS Employees

**Nationwide Managed Fee-for-Service Plans**  
(Pages 14 through 16)

**Plans Offering a Point of Service Product**  
(Pages 18 through 26)

**Health Maintenance Organization Plans**  
(Pages 28 through 55)

The USPS pays most of the cost of your health insurance. The amount you will pay will depend on the plan you select.

The premium listings in this booklet show the total biweekly premium costs and your share—that is, the amount that you must pay—which will be withheld from your salary biweekly during the 1999 plan year. The USPS pays the difference in what you pay and the total premium.

**Important:** Some FFS plans also offer a POS product.  
Check the POS section.

# Plan Report Cards

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## Plans Offering a Point of Service Product

(Pages 18 through 26)

**Important:** Some plans have been redesignated as HMOs.  
If you do not find your plan in this section,  
check the HMO section.

# Plan Report Cards

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## Health Maintenance Organization Plans

(Pages 28 through 55)

**Important:** Some plans have been redesignated as POS products.  
If you do not find your plan in this section,  
check the POS section.

# Notes

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Presorted  
First Class Mail  
Postage & Fees Paid  
USPS  
Permit No. G-10

***READ IMMEDIATELY:***  
HEALTH BENEFITS  
OPEN SEASON  
ENROLLMENT INFORMATION