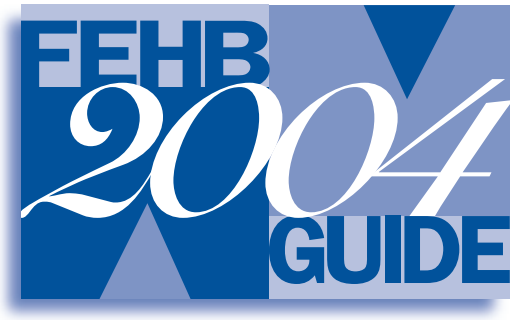


Guide to Federal Employees Health Benefits Plans

For United States Postal Service Employees

Belated open season elections accepted until 5:00 PM Central Time December 29, 2003.

Center for Retirement and Insurance Service

Visit OPM's web site at www.opm.gov/insure

RI 70-2
Revised November 2003

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

It is hard to believe that a year has passed and the Federal Employees Health Benefits (FEHB) Open Season is here again. This is your annual opportunity to evaluate your personal needs and, if necessary, change health plans. I am pleased to present the 2004 FEHB Guide to help you with your evaluation.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this Guide and our web-based resources make it easier than ever to get information about premiums, to compare benefits, to read customer service satisfaction ratings for the national and local plans that may be of interest, and to learn about quality information from the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and URAC.

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country. President Bush has chosen the FEHB as a model for modernizing and improving Medicare.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become a better educated consumer to meet your healthcare needs. Use this Guide, the health plan brochures, and the web resources at www.opm.gov/insure to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

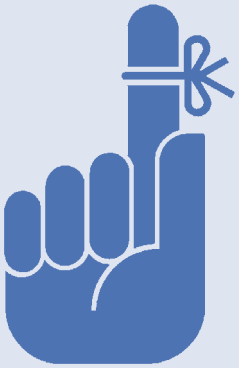
Sincerely,

Kay Coles James
Director

Table of Contents

Things to Remember

- ☑ The plan you choose can make a difference in your health.
- ☑ Be aware of benefit changes for 2004.
- ☑ Check the premium for 2004.



The information in this Guide gives you an overview of the FEHB Program and its participating plans. Read the plan brochures before you make any final decisions about health plans.

Federal Employees Health Benefits Open Season

November 10 to 5:00 PM Central Time December 9, 2003

Belated open season elections accepted until 5:00 PM Central Time December 29, 2003.

Because of a delay in mailing the *2004 Guide to Federal Employees Health Benefits Plans*, BELATED OPEN SEASON ELECTIONS WILL BE ACCEPTED UNTIL 5:00 PM CENTRAL TIME ON DECEMBER 29, 2003.

If you have any trouble using or do not wish to use the *PostalEASE* telephone, intranet or self-service kiosk, or if you are unable to use the telephone because you are deaf or hard of hearing, or if you cannot use the telephone, intranet or employee self-service kiosk for medical reasons, you may contact your local personnel office for assistance. Please complete the *PostalEASE health benefits worksheet first.*

You may still use the standard form (SF) 2809 *Health Benefits Election Form* instead of the *PostalEASE* health benefits worksheet. However, SF2809 has not been updated by the Office of Personnel Management to capture certain new data that is sent to health plans, which is why the *PostalEASE* health benefits worksheet is the better choice if you cannot use the telephone or employee web.

Open season and belated open season enrollment changes and new enrollments made by 5:00 PM Central Time on December 29, 2003, will be effective January 10, 2004 (Pay Period 03-04). New premium payments will be reflected in the paycheck dated January 30, 2004.

FEHB and *PostalEASE*

Beginning with the November 2003 open season, employees will make their Federal Employees Health Benefits (FEHB) program choices through the *PostalEASE* system. By using *PostalEASE* for health benefits, and by sending information to health insurance companies electronically instead of via paper forms as in past open seasons, the Postal Service expects that employees who make health benefits changes will get their new insurance cards more quickly. All the information you need for using *PostalEASE* is included in the FEHB *PostalEASE* Worksheet found on pages 20 to 23 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 2004 plan year, you may do so during the annual FEHB Open Season, which is from November 10 through December 9, 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 dependents. 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 Blue page or on a kiosk. Many Self and Family transactions can also be completed by telephone. If you are unable to enter your dependent information via the telephone, the *PostalEASE* system will refer you to the Web, a kiosk, or your local personnel office.

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.

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

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.

FEHB and You

Overview

The United States Postal Service (USPS) provides health benefits to its career employees by participating in the Federal Employees Health Benefits (FEHB) Program, which is administered by the U.S. Office of Personnel Management (OPM), Office of Retirement and Insurance Services. FEHB began operation in July 1960 and almost 8l5 million people are in the program, including 2.2 million federal and postal employees, 1.85 million retirees, and eligible family members. It is the largest employer-sponsored health insurance program in the world. OPM interprets health insurance laws and writes regulations for the FEHB Program. It gives advice and guidance to the USPS and other participating agencies to process your enrollment changes and to deduct your premiums. OPM also contracts with and monitors all of the plans participating in the FEHB Program.

The purpose of this 2004 Guide to Federal Employees Health Benefits (FEHB) Plans is to provide information about enrollment and premium features that USPS career employees must consider when selecting a health insurance plan under the FEHB Program. The Guide is a summary of FEHB plans – the plan brochures give specific benefit information. You can get individual plan brochures directly from the health plans, from your local personnel office, or from the OPM web site www.opm.gov/insure which also has a copy of this guide in addition to various health plan brochures and helpful information.

You may choose from among Fee-for-Service (FFS) plans regardless of where you live (see pages 25 through 34) and from Health Maintenance Organizations (HMO's) plans if you live (or sometimes if you work) within the area serviced by the plan (see pages 35 through 65). Some HMOs also offer a Point of Service (POS) product which allows you to use providers who are not part of the HMO network, but at an increased cost.

While FEHB eligibility, enrollment requirements and the plans available for 2004 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."

Coverage

New Employees – New employees have the opportunity to select a health plan with 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 16 through 19 of this Guide) **NOTE: These elections MUST be made within certain time limits as specified in the table.**

Your choice of plans and options includes Self Only coverage just for you, or Self and Family coverage for you, your spouse, and unmarried dependent children under age 22 (and in some cases, a disabled child 22 years or older who is incapable of self-support).

Eligible Family Members – Eligible family members for "self and family" health benefits registration purposes include an enrollee's:

- Spouse
- Unmarried dependent children under age 22, including legally adopted children and recognized natural (born out-of-wedlock) children.
- Unmarried dependent stepchildren and foster children, (including foster children who are also your grandchildren) under age 22 if they live with the enrollee in a regular parent-child relationship.
- Unmarried dependent children age 22 or over who are incapable of self-support because of physical or mental incapacity that existed before their 22nd birthday.

FEHB and You

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.

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 22
- Separation
- Retirement
- Divorce
- Death
- Relocation
- 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 an LWOP status, provided that you continue to pay the employee share of the premium. The Postal Service will invoice you for your share of the premium unless you complete and submit to your personnel office 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.

It is your responsibility to report life events that may cause you or your family member to lose eligibility. It is also your responsibility to complete and submit any required paperwork to change your enrollment and/or apply for any continuation of coverage, if eligible, within 60 days of loss of coverage. If you have questions, see your local personnel office.

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

FEHB Open Season

Each year you have the opportunity to enroll or change enrollment during an open season. The 2003 Open Season is from November 10 through December 9 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 plan to another
- 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 5 through 7 of this Guide)
- Cancel enrollment

If you decide to do any of the above actions, you MUST follow the instructions on the FEHB Worksheet contained in the center of this Guide and enter your election in *PostalEASE* via the Web, kiosk, or phone or submit to your local personnel office by 5:00 p.m. Central Time on December 9, 2003. It is critical that this be done timely.

FEHB and You

Your new enrollment or any changes that you make to your existing coverage will take effect on January 10, 2004 and the change in premium rate deductions will be seen in your January 30, 2004 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 2004. If your plane is not participating in 2004 you MUST choose another plan during open season or you will not have FEHB coverage. Ask your local personnel office for a list of the plans that will terminate at the end of the 2003 plan year.

If you decide to cancel your coverage during open season, you must cancel it using *PostalEASE* which includes a confirmation by you that you clearly accept the consequences of canceling. The cancellation will become effective on January 9, 2004.

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 qualified life status change and your election is in keeping with the change. See pages 5 through 7 of this Guide on Pre-tax Payment of Premium Contributions and the OPM table of permissible changes pages 16 through 19 of this Guide.

Note to those considering retirement: To be eligible to carry your FEHB enrollment into retirement, you must have been continuously covered, either as an enrollee or as an eligible family member under another FEHB enrollment, for the 5 years immediately preceding retirement, or if less than 5 years, for the entire period since your first opportunity to enroll. You, as an employee, are responsible for being informed about your health benefits. You should thoroughly read this Guide, the brochures of plans that interest you, and the bulletin board notices on health benefits topics. These include family member eligibility, the option to continue or terminate an enrollment during periods of non-pay status or insufficient pay, dual enrollment prohibition, coverage for former spouses, and discontinued health insurance plans. Be sure to read the section on the pre-tax payment of health insurance premium contributions, which specifies Internal Revenue Service (IRS) restrictions for reducing or canceling coverage (see pages 5 through 7 of this Guide).

After referring to these sources, if you still have questions regarding eligibility, enrollment criteria, and continued coverage after certain life events, or if you need assistance making your choice in *PostalEASE*, contact your local 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.

Pre-Tax Payment of Premium Contributions

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

Pre-Tax Withholding

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

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

Although you are automatically enrolled to pay premium contributions with pre-tax money, you do have an opportunity during FEHB Open Season, or if you have a qualified life status change, 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 your local personnel office to waive the pre-tax treatment. For more information, see the section "How to Waive or Restore Pre-Tax Payment" on page 7 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 qualified life status change. These are shown in the chart on pages 16 to 19 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

Pre-Tax Payment of Premium Contributions

"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 qualified life status change 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 your local personnel office within the time limit shown in the column labeled "Time Limits in Which Change May Be Permitted" in the chart on pages 16 to 19 of this Guide. 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.

Reducing your FEHB coverage outside of FEHB Open Season must be in keeping with, or on account of, your qualified life status change. 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.

A qualified life status change does not allow you the opportunity to change plans or options, only to reduce (from Self and Family to Self Only) or cancel your current plan within the time limit shown in the column labeled "Time Limits in Which Change May Be Permitted" in the chart on pages 16 to 19 of this Guide.

To reduce your FEHB coverage outside of FEHB Open Season, submit an FEHB *PostalEASE* Worksheet to your local personnel office within the time limits shown in the column labeled "Time Limits in Which Change May be Permitted" in the table on pages 16 to 19 of this Guide. You must provide any supporting documentation requested by your local personnel 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 Worksheet is received by your personnel office. The effective date of a cancellation will be the last day of the pay period in which your Worksheet is received by your personnel office, if received within the specified time limits.

It is your responsibility to timely notify and submit necessary forms to your local personnel office when you are the only person left on your enrollment.

Retirement is NOT a qualified life status change that allows cancellation prior to the date of your retirement. If you wish to cancel an enrollment at retirement, your personnel office will accept your completed SF 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 your local personnel office for more information about how termination during periods of non-pay status or insufficient pay affects FEHB enrollment.

Pre-Tax Payment of Premium Contributions

How to Waive or Restore Pre-Tax Payments

If you pay premiums with after-tax money, you will not be affected by the IRS guidelines described above that restrict reductions in coverage. You may reduce your level of FEHB coverage at any time of year without having a qualified life status change. 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 your local personnel office 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 your local personnel office by 5:00 p.m. Central Time, December 9, 2003. If this is your initial opportunity to enroll in FEHB, you have 60 days to submit your election to your local personnel office. You also may make such an election when you have a qualified life status change which is shown in the chart on pages 16 to 19 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 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 PS 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 qualified life status change 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 20260-4210

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.** Choose between Self Only or Self and Family.

- **A Choice of Plans and Options.** Select from Fee-For-Service (with the option of a Preferred Provider Organization), Health Maintenance Organization, Point of Service plans, or Consumer-Driven plans.

- **A Government Contribution.** The USPS pays 85 percent of the average premium toward the total cost of your premium, up to a maximum of 88.75 percent of the total premium for any plan.

- **Salary Deduction.** You pay your share of the premium through a payroll deduction and have the choice of doing so using pretax dollars. When your premium contributions are withheld on a pretax basis, certain Internal Revenue Service 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 a qualified life status change occurs. See your local personnel office for details.

- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enrollment. This year the Open Season runs from November 10, 2003, through December 8, 2003. Other events allow for certain types of changes throughout the year. See your local personnel office for details.

- **Continued Group Coverage.** Eligibility for you or your family members may continue following your retirement, divorce, death, or changes in employment status. See your local personnel office for more information.

- **Coverage after FEHB Ends.** You or your family members may be eligible for temporary continuation of FEHB coverage or for conversion to non-group (private) coverage when FEHB coverage ends. See your local personnel office for more information.

- **Consumer Protections.** Go to www.opm.gov/insure/health/consumers to see your appeal rights to OPM if you and your plan have a dispute over a claim; to read the Patients' Bill of Rights and the FEHB Program; and to learn about your privacy protections when it comes to your medical information.

FEHB
Federal Employees
Health Benefits Program

Picking a Health Plan

Step 1: 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. This is because Fee-for-Service (FFS) plans -- with and without a Preferred Provider Organization (PPO) – Health Maintenance Organizations (HMO), Point-of-Service (POS) plans, and Consumer-Driven plans all operate differently.

	Fee-for-Service w/PPO	Fee-for-Service w/o PPO	Health Maintenance Organization	Point-of-Service	Consumer-Driven Plans
Choice of doctors, hospitals, pharmacies, and other providers	You must use the plan's network for full benefits. Not using PPO providers means only some or none of your benefits will be paid.	You may use any doctor, hospital, etc. Benefits are not limited by where you get care.	You generally must use the network; no benefits outside of the network – you pay all costs.	You must use network for full benefits. You may go outside the network but it will cost you more.	You may use network and non-network providers. Not using the network will cost you more.
Specialty care	Referral not required to get full benefits.	Referral not required to get full benefits.	Referral generally required from primary care doctor to get benefits.	Referral required to get full benefits.	Referral not required to get full benefits.
Out-of-pocket costs	You pay fewer costs if you use a PPO provider than if you don't.	You pay regular plan out-of-pocket costs.	Your out-of-pocket costs are generally limited to copayments.	You pay less if you use a network provider than if you don't.	You pay less if you use a network provider than if you don't.
Paperwork	Some if you don't use network providers.	You have to file your own claims.	Little, if any.	Little if you use the network. You will have to file your own claims if you don't use the network.	Some if you don't use network providers.

See Definitions starting on page 7 for a more detailed description of each type of plan.

Picking a Health Plan

Step 2: What services are important to you and what health care do you expect to use? Refer to your medical and insurance records from last year as a guide to what services you might use this year. Add up the actual costs to you, including premiums. Estimate what you might spend on your health care for deductibles, coinsurance/copayments, and services that are not covered. Are there any annual limits for days or services covered and on the dollar amount the plan will spend on you? What is the maximum you will have to pay out-of-pocket each year?

Consult the health plans' brochures to find this benefit information. Copies of brochures as well as a tool to complete this sheet on-line are on our web site at www.opm.gov/insure/health.

	Health Plan _____	**Health Plan _____**	**Health Plan _____**
Annual premium			
Office visit to primary care doctor			
Office visit to specialist			
Hospital inpatient deductible/copay/ coinsurance			
Hospital room & board charges			
Generic drug (local pharmacy)			
Brand name drug (local pharmacy)			
Catastrophic protection limit			
Mental health care visits			
Home health care visits			
Durable medical equipment			
Maternity care			
Well-child care			
Routine physicals			
Accreditation			
The following information can be found in the Member Survey Results section in the benefit charts.			
Overall member satisfaction with plan			
Getting needed care			
Getting care quickly			
How well doctors communicate			
Customer service			
Claims processing			

Picking a Health Plan

Step 3: Consider quality. Quality is how well health plans keep their members healthy or treat them when they are sick. Good quality doesn't always mean receiving more care. Good quality health care means doing the right thing at the right time, in the right way, for the right person to achieve the best possible results. We provide two types of quality information in the plan benefit charts: independent evaluations (accreditation) from private organizations and evaluations by enrollees (member survey).

Accreditation evaluations shown in this Guide are performed by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and URAC.

Compare the accreditation status of different health plans with the following key (a lower number means a better accredited plan).

NCQA (www.ncqa.org):

1 = Excellent (HMO) or Full (PPO)

2 =Commendable (HMO only)

3 = Accredited (HMO) or One-Year (PPO)

4 = Provisional (HMO and PPO)

6 = New Health Plan

JCAHO (www.jcaho.org):

1 = Accreditation with Full Compliance

2 = Accreditation with Requirements for Improvement

3 = Provisional

4 = Conditional

URAC (www.urac.org):

1 = Full Accreditation

2 = Conditional Accreditation

3 = Provisional Accreditation

Member Survey results, shown in the plan comparison sections, are collected, scored, and reported by an independent organization – not by the health plans. Here is a brief explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• Were you satisfied with the choices your health plan gave you to select a personal doctor? • Were you satisfied with the time it takes to get a referral to a specialist?
Getting Care Quickly	• Did you get the advice or help you needed when you called your doctor during regular office hours? • Could you get an appointment for regular or routine care when you wanted?
How Well Doctors Communicate	• Did your doctor listen carefully to you and explain things in a way you could understand? • Did your doctor spend enough time with you?
Customer Service	• Was your plan helpful when you called its customer service department? • Did you have paperwork problems? • Were the plan's written materials understandable?
Claims Processing	• Did your plan pay your claims correctly and in a reasonable time?

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery?
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

FEHB Web Resources

Use the FEHB web site for additional help in choosing the health plan that is right for you.

The FEHB web site at www.opm.gov/insure/health can help you to choose your health plan. In addition to the information found in this Guide you will find:

- An interactive tool that will allow you to find the health plans that service your area and will allow you to make side-by-side comparisons of the costs, benefits, and quality indicators of the plans that interest you.
- Electronic versions of all health plan brochures.
- An evaluation of how your plan compares to other plans and the FEHB average in important medical areas under the Health Plan Employer Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures that allows users to reliably compare managed care health plan performance across specific clinical areas. The performance measures are related to many significant public health issues such as cancer, heart disease, asthma, and diabetes. Compare plan results at www.opm.gov/insure/health/hedis2002.
- Information on enrolling, with the ability to enroll online for annuitants and employees of selected agencies.
- Information on how plans in the FEHB Program coordinate benefit payments with Medicare.
- A comprehensive set of Frequently Asked Questions and answers on all aspects of the Program.
- An online version of the FEHB Handbook for detailed guidance on FEHB policies and procedures.

You can also look at and download:

- All of the FEHB Guides including the guide for USPS Employees, the FEHB Guide for United States Postal Service Inspectors and Office of Inspector General Employees, the FEHB Guide for Certain Temporary (Non-career) USPS Empoyees, and the FEHB Guide for TCC and Former Spouse Enrollees.
- Plan brochures that include benefits, cost, and other major features of each health plan.

Stop Health Care Fraud

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program (FEHBP) premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHBP regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your health plan identification number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid health care providers who say that an item or service is not usually covered, but they know how to bill your health plan to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from your health plan.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get your health plan to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call your health plan and explain the situation.
    - If they do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member under your FEHB coverage:
    - your former spouse after a divorce decree or annulment is final (even if a court orders it); or
    - your child over age 22 unless he/she is incapable of self support.
- If you have any questions about the eligibility of a dependent, check with your local personnel office.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHBP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

USPS Employees:

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

The chart[1] below combines and replaces the OPM chart titled "Table of Permissible Changes in Enrollment for SF2809," previously published in the SF2809 *Health Benefits Election Form*, and the list of qualified life status changes published in previous editions of RI 70-2, *Guide to Federal Employees Health Benefits Plans For United States Postal Service Employees*, and the FEHB guides for USPS law enforcement and noncareer employees. (Since USPS is using *PostalEASE* for Federal Employees Health Benefits (FEHB) elections, SF2809 is no longer used.) This chart uses the term "qualifying life event," while in *PostalEASE* and other USPS information sources:

1. the term "permitting event" is used to describe events that allow an FEHB enrollment change—refer to the column in the Table labeled "FEHB Enrollment Change that May Be Permitted" and the headers "From Enrolled to Not Enrolled," "From Self Only to Self and Family," and "From One Plan or Option to Another;"

2. the term "qualified life status change" is used to describe events that allow employees who are paying premiums on a pre-tax basis to cancel coverage, or to reduce coverage from Self and Family to Self Only—refer to the column in the Table labeled "FEHB Enrollment Change that May Be Permitted" and the header "Cancel or Change to Self Only;"

3. the term "qualified life status change" is used to describe events that allow employees to waive (end) or participate (begin) pre-tax payment of health insurance premiums—refer to the column in the Table labeled "Premium Conversion Election Change that May Be Permitted."

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 change described in the table. For example, if you have a new baby, you would usually not cancel coverage. This restriction does not apply to open season changes, or to the initial opportunity to enroll. USPS career employees are automatically enrolled for pre-tax payment of health insurance premiums; noncareer employees must elect it. 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.

[1] This chart does not apply to Federal employees, only USPS employees.

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

See explanatory note on first page of this chart.

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1A	Initial Opportunity to Enroll, for example: • New employee • Change from excluded position • Temporary (Non-career) employee who completes 1 year of service and is eligible to enroll under 5 USC 8906a	Yes	N/A	N/A	N/A	Automatic unless waived *(except for temporary employees)*	Yes *(Automatic for temporary employees)*	Within 60 days after becoming eligible
1B	Open Season	Yes	Yes	Yes	Yes	Yes	Yes	As announced by OPM
1C	Change in family status that results in increase or decrease in number of eligible family members, for example: • Marriage, divorce, annulment, legal separation • Birth, adoption, acquiring foster child or stepchild, issuance of court order requiring employee to provide coverage for child • Last dependent child loses coverage, for example child reaches age 22 or marries, stepchild moves out of employee's home, disabled child becomes capable of self-support, child acquires other coverage by court order • Death of spouse or dependent	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after change in family status
		Employees may enroll or change beginning 31 days before the event						
1D	Any change in employee's employment status that could result to entitlement to coverage, for example: • Reemployment after a break in service of more than 3 days • Return to pay status from nonpay status, or return to receiving pay sufficient to cover premium withholdings, if coverage terminated *(If coverage did not terminate, see 1G)*	Yes	N/A	N/A	N/A	Automatic unless waived	Yes	Within 60 days after employment status change
1E	Any change in employee's employment status that could affect the cost of insurance, including: • Change from temporary appointment with eligibility for coverage under 5 USC 8906a to appointment that permits receipt of government contribution • Change from full time to part time career or the reverse	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after employment status change

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

See explanatory note on first page of this chart.

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only** [2]	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1F	Employee restored to civilian position after serving in uniformed service [3]	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 [4] 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. [5]	N/A	Yes	Yes	N/A *(see M1)*	No *(see M1)*	No *(see M1)*	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. [6]	No	No	Yes *(Change may be made only once)*	N/A *(see M1)*	No *(see M1)*	No *(see M1)*	Any time beginning on the 30th day before becoming eligible for Medicare

[2] 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 if Open Season only if **the QLE caused** the enrollee and all the eligible family members to acquire other health insurance coverage.

[3] 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 will be forthcoming.

[4] 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.

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

See explanatory note on first page of this chart.

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1M	Employees or eligible family member **loses** coverage under FEHB or another group insurance plan including the following: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to self-only of the covering enrollment • Loss of coverage due to termination of membership in employee organization sponsoring the FEHB plan [7] • 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

[5] 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.

[6] 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.

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

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

See explanatory note on first page of this chart.

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1O	Employee or eligible family member loses coverage due to discontinuation in whole or part of FEHB plan [8]	Yes	Yes	Yes	Yes	Yes	Yes	During open season, unless OPM sets a different time
1P	Employee or eligible family member **gains** coverage under FEHB or another group insurance plan, including the following: • Medicare *(Employees who become eligible for Medicare and want to change plans or options, see 1I)* • TRICARE for Life, due to enrollment in Medicare • TRICARE due to change in employment status, including: (1) entry into active military service, (2) retirement from reserve military service under chapter 67, title 10 • Medicaid or similar state sponsored program of medical assistance for the needy • Health insurance acquired due to change of worksite or residence that affects eligibility for coverage • Health insurance acquired due to spouse's or dependent's change in employment status (including state, local or foreign government or private sector employment) [9]	No	No	No	Yes	Yes	Yes	Within 60 days after QLE
1Q	Change in spouse's or dependent's coverage options under a non-Federal health plan, for example: • Employer starts or stops offering a different type of coverage *(If no other coverage is available, also see 1M)* • Change in cost of coverage • HMO adds a geographic service area that now makes spouse eligible to enroll in that HMO • HMO removes a geographic area that makes spouse ineligible for coverage under that HMO, but other plans or options are available *(If no other coverage is available, see 1M)*	No	No	No	Yes	Yes	Yes	Within 60 days after QLE

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

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

How to Use *PostalEASE*

Manage Your Federal Employees Health Benefits (FEHB) Enrollment

The *PostalEASE* telephone system and web site 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 Intranet (from the blue page) or at an Employee Self-Service Kiosk (available in some facilities), 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 10, 2003 – December 9, 2003, 5 PM Central Time).
- Make an election as a new employee within 60 days of your date of hire.
- Enter your dependents' information, confirming any names already listed and adding any new names. **Note** that as some insurance carriers have provided dependent names on a one-time basis, the names may appear in *PostalEASE*, but they may not be up to date. **Be sure to confirm your dependent list. Note also** that *PostalEASE* will **not** transmit dependent change information to the insurance carrier if an enrollment transaction has not occurred. **If you are not making a change in your enrollment at the same time, contact your health plan carrier directly** with information on dependents.

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 qualified life status change. You must contact your local personnel office 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 the other side of this page.
2. **Read and understand the RI 70-2**, *Guide to the FEHB Plans*, which is mailed to you each FEHB Open Season.
3. **Make sure you have the following information** ready before using *PostalEASE*.
   a. Your USPS personal identification number (**PIN**) If you don't know your PIN, just call *PostalEASE*. 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 Intranet (from the blue page) or at an employee Self-Service Kiosk (available in some facilities).
   b. Your Social Security Number (**SSN**).
   c. Your daytime **phone number.**
   d. The name of the **health benefits plan** in which you are enrolling.
   e. The **code** of the health benefits plan in which you are **enrolling**. For the name and code, refer to the list of codes in RI 70-2, *Guide to FEHB Plans*, or to the health plan brochure.
   f. The names, SSNs (optional), addresses, and dates of birth for all eligible family members that will be covered under your health benefits enrollment. For more information on family member eligibility, see RI 70-2, *Guide to FEHB Plans.*
   g. The insurance company 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 cancelling coverage, the **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 code for your current plan is found on your biweekly earnings statement. It is the three-character code that follows the letters "HP or "HB." For example, the Blue Cross Self and Family Standard plan will be shown as HP105 or HB105, and you will enter the code 105 in *PostalEASE*. You may also refer to the list of codes in RI 70-2, *Guide to FEHB Plans.*
4. **Complete the worksheet** that follows, using the information you prepared above.

PostalEASE FEHB Worksheet

This worksheet will help you prepare to call *PostalEASE*, or use *PostalEASE* on the Intranet (from the blue page), or on an Employee Self-Service Kiosk (now available in some facilities). You may also prepare this worksheet and contact your local personnel office if you cannot enroll or make a change because *PostalEASE* does not accept the required documentation.

Note: If you have any trouble using *PostalEASE*, or if you are unable to use the telephone because you are deaf or hard of hearing, or you cannot use the telephone, Intranet, or Employee Self-Service Kiosk for medical reasons, you may contact your local personnel office for assistance. **If you contact your local personnel office, be sure to complete this worksheet first.**

Part 1 – Employee Information

Your Name (Last, First, Middle Initial)	Social Security Number

Type Of Action You Are Requesting

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

New Hire: ❑ New Enrollment ❑ Waive Enrollment

Special Enrollment (if you are notified that your current plan is being discontinued or your service are is reduced):

❑ Change Current Enrollment ❑ Cancel Enrollment

New Plan Enrollment Code _____ **New Plan Name** _____

Old Plan Enrollment Code (if you are changing plans or cancelling your current plan) _____

Please note:

Changes due to a permitting event or a qualified life status change (QLSC) cannot be made via *PostalEASE*.

If you wish to make any change that is not listed under "Type of Action You Are Requesting" above, you must contact your local personnel office. You will need to present documentation showing that your election is due to a permitting event or QLSC and that you are contacting personnel within the required timeframe.

For more information on permitting events and QLSCs, please refer to the RI 70-2, *Guide to FEHB Plans*, which is mailed to you each FEHB Open Season.

Your Other Group Insurance (Not used for cancelling enrollment or waiving enrollment as a new employee)

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

❑ Yes ❑ No

Identify Type of Other Insurance Coverage

❑ Medicare Part A ❑ Medicare Part B

❑ Tricare or Champus Policy No. (if known) _____

Other Group Insurance Co. Name

_____

Policy No. (if known) _____

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

PostalEASE FEHB Worksheet

Part 2 – Dependent Information (for Self and Family coverage only)

A complete mailing address (if different from yours) 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 Intranet (blue page) or at an Employee Self-Service Kiosk (available in some facilities) or visit your local personnel office to make or change your FEHB enrollment.

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

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

* Relationship Codes:
01 = Spouse
02 = Spouse from a common law marriage (requires certification to be filed with local personnel office)
19 = Child
09 = Adopted child
10 = Foster child (requires certification to be filed with local personnel office)
17 = Stepson or stepdaughter (if living with you in a parent-child relationship)
99 = Unmarried child over age 22 incapable of self-support (requires certification to be filed with local personnel office)

Employee Signature _____ **Confirmation Number You Receive From *PostalEASE*** _____

For Personnel Office Use Only

Remarks: Specific information on type pf permitting event or QLSC, reason for correction, type of certification, supporting documentation, reason for verification, etc., should be provided here.

_____

_____

_____

_____

Personnel Office _____ Date Received in Personnel Office (employee election date) _____

Address _____

Contact Name _____

Telephone Number _____ Date of Event/QLSC/Birth _____

File copy in OPF for any FEHB transaction processed by HR and ASC

How to Use *PostalEASE*

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

- If you have access to the *PostalEASE* Employee Web on the Intranet (from the blue page) or to an employee Self-Service Kiosk (available in some facilities), using either may be simpler than using the telephone. Just follow the instructions.
- Otherwise, call *PostalEASE* toll-free at 1-800-4PS-EASE (1-877-477-3273)
- When prompted, select Federal Employees Health Benefits.
- Follow the script and prompts to enter your SSN, your USPS PIN, and other required information. (Having your completed *PostalEASE* FEHB Worksheet on hand will help you complete your transaction.
- If you currently have an FEHB enrollment and you do not want to make any changes… ***do nothing.***

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

PRIVACY ACT STATEMENT: The collection of this information is authorized by 39 USC 401, 1001,1003,1005; 5 usc 8339; 42 USC 2000e-1 6, and Executive Orders 11478 arid 11590. This information will be used to process your enrollment in the Federal Employees Health Benefit system and to manage your claim under that plan. As a routine use, the information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes; where pertinent, in a legal proceeding to which the USPS is a party or has an interest; to a government agency in order to obtain information relevant to a USPS decision concerning employment, security clearances, contracts, licenses, grants, permits or other benefits; to a government agency upon its request when relevant to its decision concerning employment, security clearances, security or suitability investigations, contracts, licenses, grants or other benefits; to a congressional office at your request; to an expert, consultant, or other person under contract with the USPS to fulfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review of private relief legislation; to an independent certified public accountant during an official audit of USPS finances; to an investigator, administrative judge or complaints examiner appointed by the Equal Employment Opportunity Commission for investigation of a formal EEO complaint under 29 CFR 1614; to the Merit Systems Protection Board or Office of Special Counsel for proceedings or investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to agencies having taxing authority for taxing purposes; to financial organizations receiving allotments; to State Employment Security Agencies to process unemployment compensation claims; to a Federal or state agency providing parent locator service or to other authorized persons as defined by Pub. L. 93-647; to the National Association of Postal Supervisors that relates to postal supervisors; to a prospective employer for consideration of employment; to management for compilation of a local seniority list for posting; to the EEOC for enforcement of Federal EEO regulations; to the appropriate finance center as required under the provisions of the Dual Compensation Act; to the Office of Personnel Management, Social Security Administration, Veterans Administration, Office of Workers' Compensation Programs; health insurance carriers, or plans, or other program management agencies or retirement systems for use in determining a claim for benefits; and to OPM for its active employee/annuitant data systems used to analyze Federal retirement and insurance costs. Providing the information is voluntary; however, if this information is not provided, we may not be able to process your enrollment. We also request that you provide your social security number so that it may be used as your individual identifier in the Federal Employee Health Benefits system. Executive order 9397 dated 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. Computer Matching: Limited information may be disclosed to a Federal, state, or local government administering benefits or other programs pursuant to statute for purpose of conducting computer matching programs under the Act. These programs include, but are not limited to, matches performed to verify an individual's initial or continuing eligibility for, indebtedness to, or compliance with requirements of a benefit program.

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Plan Comparisons

Nationwide Fee-For-Service Plans Open to All

(Pages 26 through 29)

Fee-For-Service (FFS) Plans with a Preferred Provider Organization (PPO) — An FFS plan that allows you to see medical providers who reduce their charges to the plan; you pay less money out-of-pocket when you use a PPO provider. When you visit a PPO you usually won't have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. For instance, lab work and radiology services from independent practitioners within the hospital are frequently not covered by the PPO agreement.

Fee-For-Service (FFS) Plans (non-PPO) — An FFS plan that either pays the medical provider directly or reimburses you for covered medical expenses. When you need medical attention, you visit the doctor or hospital of your choice.

In **PPO-only** options, you must use PPO providers to receive benefits.

Consumer-Driven Plans — Describes a wide range of approaches to give you more incentive to control the cost of either your health benefits or health care. You have greater freedom in spending health care dollars up to a designated amount, and you receive full coverage for in-network preventive care. In return, you assume significantly higher cost sharing expenses after you have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

Nationwide Fee-for-Service Plans Open to All

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.

The **Generic** drug figure is the copayment or coinsurance most commonly paid by members of this health plan for a Generic formulary drug.

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
APWU Health Plan-High (APWU)	800/222-2798	471	472	$35	$64
APWU Health Plan-Consumer driven (APWU)	800/222-2798	474	475	$17.53	$40.81
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	$26.98	$62.85
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	Local phone #	111	112	$17.10	$40.05
GEHA Benefit Plan-High (GEHA)	800/821-6136	311	312	$54.32	$103.02
GEHA Benefit Plan-Std (GEHA)	800/821-6136	314	315	$13.61	$30.94
Mail Handlers-High (MH)	800/410-7778	451	452	$73.67	$130.58
Mail Handlers-Std (MH)	800/410-7778	454	455	$14.47	$31.42
NALC	888/636-6252	321	322	$29.76	$42.75
PBP Health Plan-High (PBP)	800-544-7111	361	362	$161.14	$329.75
PBP Health Plan-Std (PBP)	800-544-7111	364	365	$45.98	$101.67

Brand Name/Non-formulary is what you pay for a manufacturer's Brand name drug on this health plan's formulary. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in this column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a Non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

The prescription drug copayments or coinsurances described in this chart do not represent the complete range of cost-sharing under these plans. Many plans have variations in their prescription drug benefits (e.g., you pay the greater of a dollar amount or a percentage, or you pay one amount for your first prescription and then a different amount for refills). The prescription drug figures in this chart show what most plan members pay for their medications under each plan. **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	Prescription Drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services	R&B	Generic	Brand Name / Non-formulary	Mail Order Discounts
APWU-High	PPO Non-PPO	$275 $500	None None	None $300	$18 30%	10% 30%	10% 30%	$8 50%	25% 50%	Yes No
APWU	PPO Non-PPO	$600 * $600 *	None None	None None	15% 40%	15% 40%	15% 40%	25% N/A	25%/25% N/A	No No
BCBS -Std	PPO Non-PPO	$250 $250	None None	$100 $300	$15 25%	10% 25%	Nothing 30%	25% 45%+	25% 45%+	Yes No
BCBS -Basic	PPO	None	None	$100/day x 5	$20/$30	$100	Nothing	$10	$25/$35 or 50%	No
GEHA -High	PPO Non-PPO	$350 $350	None None	$100 $300	$20 25%	10% 25%	Nothing Nothing	$5 $5	$25 $25	Yes Yes
GEHA -Std	PPO Non-PPO	$450 $450	None None	None None	$10 35%	15% 35%	15% 35%	$5 $5	50% 50%	Yes Yes
MH -High	PPO Non-PPO	$250 $300	$200 $200	$100 $300	$20/$10 30%	10% 30%	Nothing 30%	$10 50%	$25/$40 50%	Yes Yes
MH -Std	PPO Non-PPO	$300 $350	$400 $400	$200 $400	$20/$10 30%	10% 30%	Nothing 30%	$10 50%	$30/$45 50%	Yes Yes
NALC	PPO Non-PPO	$250 $300	None $25	None $100	$20 30%	10% 30%	10% 30%	25% 50%	25% 50%+	Yes Yes
PBP -High	PPO Non-PPO	$200 $500	$90 $90	None $150	10% 20%	10% 25%	10% 25%	$3 20%+	$25 or 20%/$40 or 20% 20%+	Yes Yes
PBP -Std	PPO Non-PPO	$250 $600	$90 $90	None $250	$8 30%	9% 30%	9% 30%	$4 30%+	$30 or 20%/$40 or 20% 30%+	Yes Yes

**Rollover from previous year may reduce your deductible.*

Nationwide Fee-for-Service Plans Open to All

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. Here is a brief explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• Were you satisfied with the choices your health plan gave you to select a personal doctor? • Were you satisfied with the time it takes to get a referral to a specialist?
Getting Care Quickly	• Did you get the advice or help you needed when you called your doctor during regular office hours? • Could you get an appointment for regular or routine care when you wanted?
How Well Doctors Communicate	• Did your doctor listen carefully to you and explain things in a way you could understand? • Did your doctor spend enough time with you?
Customer Service	• Was your plan helpful when you called its customer service department? • Did you have paperwork problems? • Were the plan's written materials understandable?
Claims Processing	• Did your plan pay your claims correctly and in a reasonable time?

		Member Survey Results ● above average, ◒ average, ○ below average					
Plan Name	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
APWU Health Plan-High	47	●	◒	●	●	●	●
APWU Health Plan-Consumer driven	47	●	◒	●	●	●	●
Blue Cross and Blue Shield Service Benefit Plan-Std	10	◒	◒	◒	◒	○	◒
Blue Cross and Blue Shield Service Benefit Plan-Basic	11	○	○	○	○	○	○
GEHA Benefit Plan-High	31	●	◒	◒	◒	●	●
GEHA Benefit Plan-Std	31	●	◒	◒	◒	●	●
Mail Handlers-High	45	○	◒	○	◒	◒	◒
Mail Handlers-Std	45	○	◒	○	◒	◒	◒
NALC	32	●	●	●	●	●	●
PBP Health Plan-High	36	◒	◒	●	●	○	○
PBP Health Plan-Std	36	◒	◒	●	●	○	○

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

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. In the past, BCBS has conducted a single survey representing all of its members *nation-wide*. This year, however, we are able to provide local member satisfaction results for both the Standard Option plan and the Basic Option plan.

In the future, we expect to increase the number of plans conducting local or regional Member Satisfaction surveys. We look forward to making those results available to help you select quality health plans.

Below are Member Survey ratings for local BCBS plans by location:

Plan Name		Location	Plan Code	Member Survey Results ● above average, ◒ average, ○ below average: Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Arizona	10	●	○	○	○	◒	●
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	California	10	●	○	◒	◒	◒	●
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	District of Columbia	10	◒	◒	○	◒	◒	◒
	- Basic		11	○	○	○	○	○	◒
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Florida	10	●	◒	○	○	◒	●
	- Basic		11	○	○	○	○	○	◒
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Illinois	10	◒	●	◒	◒	◒	◒
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Maryland	10	◒	◒	◒	◒	○	◒
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Texas	10	●	◒	◒	◒	◒	◒
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Virginia	10	●	◒	◒	◒	●	●
	- Basic		11	○	○	○	○	◒	●

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Plan Comparisons

Nationwide Fee-For-Service Plans Open Only to Specific Groups

(Pages 32 through 34)

Fee-For-Service (FFS) Plans with a Preferred Provider Organization (PPO) — An FFS plan that allows you to see medical providers who reduce their charges to the plan; you pay less money out-of-pocket when you use a PPO provider. When you visit a PPO you usually won't have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. For instance, lab work and radiology services from independent practitioners within the hospital are frequently not covered by the PPO agreement.

Fee-For-Service (FFS) Plans (non-PPO) — An FFS plan that either pays the medical provider directly or reimburses you for covered medical expenses. When you need medical attention, you visit the doctor or hospital of your choice.

Nationwide Fee-for-Service Plans Open Only to Specific Groups

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.

The **Generic** drug figure is the copayment or coinsurance most commonly paid by members of this health plan for a Generic formulary drug.

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Association Benefit Plan (ABP)	800/634-0069	421	422	$36.84	$87.89
Foreign Service Benefit Plan (FS)	202/833-4910	401	402	$19.36	$66.88
Panama Canal Area Benefit Plan (PCA)	800/548-8969	431	432	$17.12	$35.74
Rural Carrier Benefit Plan (Rural)	800/638-8432	381	382	$56.62	$79.70
SAMBA	800/638-6589	441	442	$48.79	$125.30
Secret Service Employees Health Association (SSEHA)	800/296-0724	Y71	Y72	$32.42	$89.38

Brand Name/Non-formulary is what you pay for a manufacturer's Brand name drug on this health plan's formulary. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in this column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a Non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

The prescription drug copayments or coinsurances described in this chart do not represent the complete range of cost-sharing under these plans. Many plans have variations in their prescription drug benefits (e.g., you pay the greater of a dollar amount or a percentage, or you pay one amount for your first prescription and then a different amount for refills). The prescription drug figures in this chart show what most plan members pay for their medications under each plan. **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	Prescription Drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services	R&B	Generic	Brand Name / Non-formulary	Mail Order Discounts
ABP	PPO Non-PPO	$300 $300	None None	$100 $300	$10 30%	10% 30%	Nothing 30%	$5 $5	$25/$40 $25/$40	Yes Yes
FS	PPO Non-PPO	$300 $300	None None	Nothing $200	10% 30%	10% 30%	Nothing 20%	$10/25% $10/25%	$20/25%/N/A $20/25%/N/A	Yes Yes
PCA	POS FFS	None None	$400 $400	$50 $125	$10 50%	Nothing 50%	Nothing 50%	50% 50%	50% 50%	No
Rural	PPO Non-PPO	$350 $400	$200 $200	$100 $300	$20 25%	10% 20%	Nothing 20%	30% 30%	30% 30%	Yes Yes
SAMBA	PPO Non-PPO	$350 $350	None None	$200 $300	$20 30%	10% 30%	Nothing 30%	$10 $10	$25/$40 $25/$40	Yes Yes
SSEHA	Par Non-Par	$200 $200	None None	$100 $100+any diff.	20% 20%+diff.	20% 20%+diff.	Nothing 20%+diff.	$10 All chgs.	$20 All chgs	Yes No

Nationwide Fee-for-Service Plans Open Only to Specific Groups

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. Here is a brief explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• Were you satisfied with the choices your health plan gave you to select a personal doctor? • Were you satisfied with the time it takes to get a referral to a specialist?
Getting Care Quickly	• Did you get the advice or help you needed when you called your doctor during regular office hours? • Could you get an appointment for regular or routine care when you wanted?
How Well Doctors Communicate	• Did your doctor listen carefully to you and explain things in a way you could understand? • Did your doctor spend enough time with you?
Customer Service	• Was your plan helpful when you called its customer service department? • Did you have paperwork problems? • Were the plan's written materials understandable?
Claims Processing	• Did your plan pay your claims correctly and in a reasonable time?

		Member Survey Results ● above average, ◒ average, ○ below average					
Plan Name	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Association Benefit Plan	42	●	◒	●	◒	●	●
Foreign Service Benefit Plan	40	◒	○	○	○	○	○
Panama Canal Area Benefit Plan	43	○	●	◒	●	●	○
Rural Carrier Benefit Plan	38	●	●	●	◒	●	●
SAMBA	44	●	○	◒	◒	◒	●
Secret Service Employees Health Association	Y7	○	◒	○	○	○	○

Plan Comparisons

Health Maintenance Organization Plans, Plans Offering a Point of Service Product, and Local Consumer-Driven Plans

(Pages 36 through 65)

Health Maintenance Organization (HMO) — A health plan that 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. Some HMOs are affiliated with or have arrangements with HMOs in other service areas for non-emergency care if you travel or are away from home for extended periods (reciprocity). Plans that offer reciprocity discuss it in their brochure.

- 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 generally no coinsurance for inhospital care.
- Most HMOs ask you to choose a doctor or medical group to be 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 most appropriate to your condition.
- Care is not covered from a provider not in the plan's network unless it's emergency care or your plan has an arrangement with another plan.

Plans Offering a Point of Service (POS) Product — A product similar to an HMO and FFS plan.

The POS product lets you use providers who are not part of the HMO network for some services. However, you pay more for using these non-network providers. You usually pay higher deductibles and coinsurances than you pay with 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.

The POS plans have two rows for "In Network" and "Out of Network" benefits. In Network shows what you pay if you go to the plan's providers; Out of Network shows what you pay if you decide not to go to the plan's providers.

Consumer-Driven Plans — Describes a wide range of approaches to give you more incentive to control the cost of either your health benefits or health care. You have greater freedom in spending health care dollars up to a designated amount, and you receive full coverage for in-network preventive care. In return, you assume significantly higher cost sharing expenses after you have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

Health Maintenance Organization (HMO) and Point of Service (POS) 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.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Alabama						
HealthSpring of Alabama, Inc. - Birmingham/Other areas	800/947-5093	DF1	DF2	$29.35	$114.91	
Arizona						
Aetna Health Inc. - Phoenix/Tucson Areas	800/537-9384	WQ1	WQ2	$12.99	$35.69	NCQA 2
Health Net of Arizona, Inc. - Maricopa/Pima/Other AZ counties	800/289-2818	A71	A72	$15.93	$40.37	NCQA 2
Humana CoverageFirst (Consumer Driven Plan) - Phoenix	888/393-6765	DB1	DB2	$10.27	$23.61	
PacifiCare Desert Region (AZ) - Maricopa, Pima County & Apache Junction	800-531-3341	A31	A32	$14.44	$35.96	NCQA 1
California						
Aetna Health Inc. - Los Angeles and San Diego Areas	800/537-9384	2X1	2X2	$12.18	$29.70	NCQA 2
Aetna HealthFund (Consumer Driven Plan) - Northern/Central Valley/Southern CA	888/238-6240	221	222	$14.56	$33.49	
Blue Cross- HMO - Most of California	800/235-8631	M51	M52	$17.38	$54.00	NCQA 1
Blue Shield of CA Access+ - Most of California	800/880-8086	SJ1	SJ2	$15.17	$37.64	NCQA 1
Health Net of California - Most of California	800/522-0088	LB1	LB2	$16.08	$38.07	NCQA 1
Kaiser Permanente - Northern California	800/464-4000	591	592	$17.77	$49.95	NCQA 1
Kaiser Permanente - Southern California	800/464-4000	621	622	$16.67	$38.54	NCQA 1
PacifiCare of California - Most of California	800-531-3341	CY1	CY2	$13.49	$31.31	NCQA 1
UHP Healthcare - LA/Orange/San Bernardino Counties	800/544-0088	C41	C42	$12.11	$25.79	JCAHO 1
Universal Care - Southern California	800/635-6668	6Q1	6Q2	$12.39	$32.71	NCQA 2
Colorado						
Kaiser Permanente - Denver/Colorado Springs areas	800/632-9700	651	652	$16.09	$41.88	NCQA 1
PacifiCare of Colorado - Denver/Colorado Springs/Ft.Collins	800/877-9777	D61	D62	$17.55	$45.71	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 3 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Alabama											
HealthSpring of Alabama, Inc.	$20/$25	$100/day x 5	$10	$25/$50	Yes	●	●	●	●	◒	◒
Arizona											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	○	○	○	○	○	○
Health Net of Arizona, Inc.	$15/$15	$100/day x 5	$10	$30/$45	Yes	○	○	○	○	○	◒
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
PacifiCare Desert Region (AZ & NV)	$15/$30	$200/ day x 5	$15	$35/$50	Yes	◒	○	◒	◒	◒	●
California											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	○	○	○	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
Blue Cross- HMO	$10/$10	None	$5	$10/50%	Yes	◒	○	○	◒	◒	◒
Blue Shield of CA Access+	$10/$10	None	$5	$10/$25	Yes	◒	○	◒	◒	◒	◒
Health Net of California	$10/$10	$100	$10	$20/$35	Yes	◒	○	○	◒	○	◒
Kaiser Permanente	$15/$15	None	$10	$25	No	●	○	○	○	◒	●
Kaiser Permanente	$10/$10	None	$10	$25	No	●	○	○	○	●	◒
PacifiCare of California	$15/$30	$100/day x 3	$15	$35/$50	Yes	●	◒	◒	◒	◒	◒
UHP Healthcare	$10/$10	$300	$10	$30/$50	No						
Universal Care	$10/$10	$300	$10	$20/$30	Yes	◒	○	○	◒	◒	◒
Colorado											
Kaiser Permanente	$15/$25	$250	$10	$20	No	◒	◒	◒	○	◒	◒
PacifiCare of Colorado	$10/$40	$150/day x 5	$10	$35/$50	Yes	○	◒	●	◒	○	◒

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) 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.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Connecticut						
Aetna HealthFund (Consumer Driven Plan) - All of Connecticut	888/238-6240	221	222	$14.56	$33.49	
ConnectiCare - All of Connecticut	800/251-7722	TE1	TE2	$17.14	$71.90	NCQA 1
District of Columbia						
Aetna Health Inc.-High- Washington, DC Area	800/537-9384	JN1	JN2	$18.11	$40.78	NCQA 1
Aetna Health Inc.-Std -Washington, DC Area	800/537-9384	JN4	JN5	$11.90	$27.84	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - All of Washington D.C.	888/238-6240	221	222	$14.56	$33.49	
CareFirst BlueChoice - Washington, D.C. Metro Area	866/520-6099	2G1	2G2	$38.32	$81.51	NCQA 2
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	$16.42	$39.09	NCQA 2
M.D. IPA - Washington, DC area	800/251-0956	JP1	JP2	$16.52	$39.64	NCQA 1
Florida						
Av-Med Health Plan - Broward, Dade and Palm Beach	800/882-8633	ML1	ML2	$16.52	$76.56	NCQA 2
Capital Health Plan - Tallahassee area	850/383-3311	EA1	EA2	$16.71	$66.49	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Tampa	888/393-6765	MJ1	MJ2	$11.35	$26.10	
Humana CoverageFirst (Consumer Driven Plan) - Jacksonville	888/393-6765	MQ1	MQ2	$11.89	$27.34	
Humana CoverageFirst (Consumer Driven Plan) - South Florida	888/393-6765	QP1	QP2	$10.81	$24.86	
Humana Medical Plan - South Florida	888/393-6765	EE1	EE2	$16.94	$38.97	URAC 1
JMH Health Plan - Broward-Dade counties	800/721-2993	J81	J82	$14.92	$36.93	
Total Health Choice - Broward/Dade/Palm Beach Counties	800/213-1133	4A1	4A2	$13.14	$32.74	
Vista Healthplan - South Florida	866/847-8235	3N1	3N2	$18.97	$119.06	
Vista Healthplan - Pensacola area	866/847-8235	RK1	RK2	$17.85	$96.49	
Vista Healthplan - Gainesville	866/847-8235	UL1	UL2	$14.23	$37.98	
Vista Healthplan - Tallahassee	866/847-8235	Y91	Y92	$13.40	$35.79	
Vista Healthplan of South Florida - Southern Florida	800/441-5501	5E1	5E2	$12.66	$34.81	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

Member Survey Results — See page 3 for a description.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 3 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Connecticut											
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
- Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
ConnectiCare	$10/$10	None	$10	$20/$35	Yes	●	●	●	●	●	●
District of Columbia											
Aetna Health Inc.-Std	$20/$25	$250/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna Health Inc.-High	$15/$20	$150/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
- Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
CareFirst BlueChoice	$20/$30	$100/day x 5	$10	$25/$40	Yes	○	○	○	◒	○	○
Kaiser Permanente	$10/$20	$100	$10/$20Net	$20/$40	Yes	◒	○	○	○	◒	◒
M.D. IPA	$10/$20	$100	$8	$20/$35	No	◒	◒	◒	◒	●	●
Florida											
Av-Med Health Plan	$15/$25	$100/dayx5	$15	$30/$50	No	◒	○	○	○	◒	◒
Capital Health Plan	$10/$10	$100	$8	$25/$40	No	●	●	◒	◒	●	●
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
- Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
- Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
- Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Medical Plan	$10/$20	$100/day x 3	$5/$20	$20/$40	No	○	○	○	○	◒	○
JMH Health Plan	$10/$10	None	$5	50%	No						
Total Health Choice	$10/$10	$100	$5	$15	No						
Vista Healthplan	$10/$20	$100/day x 3	$10	$20/$40	Yes	○	○	○	○	○	○
Vista Healthplan	$10/$20	$100/day x 3	$10	$20/$40	Yes						
Vista Healthplan	$10/$20	$100/day x 3	$10	$20/$40	Yes						
Vista Healthplan	$10/$20	$100/day x 3	$10	$20/$40	Yes						
Vista Healthplan of South Florida	$10/$20	$100 x 3 days	$10	$20/$40	Yes	○	○	○	○	○	○

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Health Maintenance Organization (HMO) and Point of Service (POS) 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.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Georgia						
Aetna Health Inc. - Atlanta and Athens Areas	800/537-9384	2U1	2U2	$15.03	$36.26	NCQA 2
Aetna HealthFund (Consumer Driven Plan) - Atlanta Area	888/238-6240	221	222	$14.56	$33.49	
Kaiser Permanente - Atlanta area	800/611-1811	F81	F82	$14.46	$36.71	NCQA 1
Guam						
PacifiCare Asia Pacific-High -Guam/N.Mariana Islands/Belau	671/647-3526	JK1	JK2	$16.27	$52.80	
PacifiCare Asia Pacific-Std - Guam/N.Mariana Islands/Belau	671/647-3526	JK4	JK5	$12.82	$33.86	
Hawaii						
HMSA - All of Hawaii	808/948-6499	871	872	$15.18	$33.79	NCQA 1
Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu/Kauai	808/432-5955	631	632	$18.13	$38.97	NCQA 1
Kaiser Permanente-Std - Islands of Hawaii/Maui/Oahu/Kauai	808/432-5955	634	635	$14.57	$31.33	NCQA 1
Idaho						
Group Health Cooperative-High -Kootenai and Latah	888/901-4636	VR1	VR2	$17.91	$61.10	NCQA 1
Group Health Cooperative-Std - Kootenai and Latah	888/901-4636	VR4	VR5	$15.52	$35.71	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

Member Survey Results — See page 3 for a description.
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Plan Name		Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
				Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Georgia												
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes	○	◒	○	○	◒	○
Aetna HealthFund	- In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
	- Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
Kaiser Permanente		$15/$15	$250	$10/$16 Com	$10/$16	No	●	◒	◒	◒	●	●
Guam												
PacifiCare Asia Pacific-High		$10/$10	None	$5	$5/$20	No	●	○	◒	◒	◒	◒
PacifiCare Asia Pacific-Std		$15/$15	$150	$5	$5/$20	No	●	○	◒	◒	◒	◒
Hawaii												
HMSA	- In-Network	$15/$15	None	$5	$20/50%	Yes	●	●	●	●	●	●
	- Out-of-Network	30% sch +/30% sch +	None	$5+20%+	$20+20%+/50%+	No						
Kaiser Permanente-High		$10/$10	None	$10	$10	Yes	●	◒	◒	◒	◒	◒
Kaiser Permanente-Std		$15/$15	None	$10	$10	Yes	●	◒	◒	◒	◒	◒
Idaho												
Group Health Cooperative-High		$15/$15	$200/day x 3	$15	$25/$50	Yes	◒	◒	●	◒	◒	◒
Group Health Cooperative-Std		$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes	◒	◒	●	◒	◒	◒

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Health Maintenance Organization (HMO) and Point of Service (POS) 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.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Illinois						
Aetna HealthFund (Consumer Driven Plan) - Chicago Area	888/238-6240	221	222	$14.56	$33.49	
BlueCHOICE - Madison and St. Clair counties	800/634-4395	9G1	9G2	$17.29	$37.43	NCQA 1
Group Health Plan - Southern/Metro East/Central	800/755-3901	MM1	MM2	$54.20	$99.51	URAC 1
Health Alliance HMO - Central/E.Central/N.West/South/West IL	800/851-3379	FX1	FX2	$26.08	$68.25	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Chicago	888/393-6765	MW1	MW2	$8.65	$19.89	
Humana Health Plan Inc.-High -Chicago area	888/393-6765	751	752	$17.55	$40.36	
Humana Health Plan Inc.-Std - Chicago area	888/393-6765	754	755	$13.45	$30.94	
John Deere Health Plan - Bloomingtn/Moline/Peoria/RockIsld	800/247-9110	YH1	YH2	$16.00	$39.20	NCQA 1
Mercy Health Plans/Premier Health Plans - Southwest Illinois	800/327-0763	7M1	7M2	$50.22	$90.94	
OSF HealthPlans - Central/Central-Northwestern Illinois	800/673-5222	9F1	9F2	$14.71	$38.69	NCQA 1
PersonalCare's HMO - Central Illinois	800/431-1211	GE1	GE2	$15.49	$39.84	NCQA 1
Unicare HMO - Chicagoland Area	888/234-8855	171	172	$16.46	$71.04	NCQA 1
Union Health Service - Chicago area	312/829-4224	761	762	$13.92	$34.51	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

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Plan Name		Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
				Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Illinois												
Aetna HealthFund	- In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
	- Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
BlueCHOICE		$10/$10	None	$7	$12/$25	Yes	◒	●	●	◒	◒	◒
Group Health Plan		$10/$20	$100	$10	$20/$35	Yes	◒	◒	◒	◒	◒	◒
Health Alliance HMO		$15/$15	$100	$10	$20/$40	No	●	◒	●	◒	◒	●
Humana CoverageFirst	- In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
	- Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan Inc.-High		$10/$20	$100/day x 3	$5/$15	$15/$35	No	◒	○	◒	◒	○	○
Humana Health Plan Inc.-Std		$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	○	◒	◒	○	○
John Deere Health Plan		$15/$15	$100/day x 5	$10	$20/$35	Yes	●	●	●	◒	●	●
Mercy Health Plans/Premier	- In-Network	$10/$20	None	$10	$20/$35	Yes	◒	●	◒	◒	◒	◒
	- Out-of-Network	30%/30%	None	N/A	N/A	No						
OSF HealthPlans		$20/$20	$500	$10	$20/$40	No	●	◒	●	●	◒	●
PersonalCare's HMO		$20/$20	$100/day x 5	$10	$20/$50	No	◒	●	●	◒	◒	◒
Unicare HMO		$15/$15	None	$5	$15/$25	No	◒	◒	○	◒	◒	○
Union Health Service		$10/$10	None	$15	$15/$15	No						

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

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Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Indiana						
Advantage Health Plan, Inc. - Most of Indiana	800/553-8933	6Y1	6Y2	$25.70	$69.73	NCQA 6
Aetna Health Inc. - Southeastern Indiana	800/537-9384	RD1	RD2	$16.99	$43.96	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - Lake and Porter Counties	888/238-6240	221	222	$14.56	$33.49	
Arnett HMO - Lafayette area	765/448-7440	G21	G22	$14.40	$37.43	NCQA 1
Health Alliance HMO - Fountain/Vermillion/Warren Counties	800/851-3379	FX1	FX2	$26.08	$68.25	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Southern Indiana	888/393-6765	BM1	BM2	$12.97	$29.83	
Humana CoverageFirst (Consumer Driven Plan) - Lake/Porter/LaPorte Counties	888/393-6765	MW1	MW2	$8.65	$19.89	
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	$34.75	$82.41	NCQA 2
Humana Health Plan Inc.-High -Lake/Porter/LaPorte Counties	888/393-6765	751	752	$17.55	$40.36	
Humana Health Plan Inc.-Std - Lake/Porter/LaPorte Counties	888/393-6765	754	755	$13.45	$30.94	
M*Plan - Indiana Metropolitan areas	317/571-5320	IN1	IN2	$44.93	$104.92	NCQA 1
Physicians Health Plan of Northern Indiana - Northeast Indiana	260/432-6690	DQ1	DQ2	$17.41	$39.09	
Unicare HMO - Lake/Porter Counties	888/234-8855	171	172	$16.46	$71.04	NCQA 1
Iowa						
Avera Health Plans - Northwestern Iowa	888/322-2115	AV1	AV2	$16.29	$38.03	
Coventry Health Care of Iowa - Central Iowa/Cedar Rapids/Sioux City	800/257-4692	SV1	SV2	$15.09	$40.75	NCQA 1
Health Alliance HMO - Central and Eastern Iowa	800/851-3379	FX1	FX2	$26.08	$68.25	NCQA 1
John Deere Health Plan - Central/Eastern Iowa	800/247-9110	YH1	YH2	$16.00	$39.20	NCQA 1
Sioux Valley Health Plan-High -Northwestern Iowa	800/752-5863	AU1	AU2	$70.34	$164.13	
Sioux Valley Health Plan-Std - Northwestern Iowa	800/752-5863	AU4	AU5	$38.00	$89.71	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs: Generic	Prescription Drugs: Brand name/ Non-formulary	Prescription Drugs: Mail order discount	Member Survey Results (● above average, ◒ average, ○ below average): Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Indiana											
Advantage Health Plan, Inc.	$15/$30	$400x2/Yr	$10	$30/$50	Yes	○	◒	◒	●	◒	◒
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	●	◒	◒	○
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
Arnett HMO	$10/$10	None	$10	$20/$40	No	●	●	●	◒	●	●
Health Alliance HMO	$15/$15	$100	$10	$20/$40	No	●	◒	●	◒	◒	●
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	◒	◒	◒	◒	◒
Humana Health Plan Inc.-High	$10/$20	$100/day x 3	$5/$15	$15/$35	No	◒	○	◒	◒	○	○
Humana Health Plan Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	○	◒	◒	○	○
M*Plan	$15/$30	$250	$10/$20	$30/$50	Yes	◒	◒	◒	◒	○	◒
Physicians Health Plan of Northern Indiana	$15/$15	20%	$10	$20/$40	No	●	●	●	●	●	●
Unicare HMO	$15/$15	None	$5	$15/$25	No	◒	○	○	◒	○	○
Iowa											
Avera Health Plans	$10/$15	$100/dayx3	$10	$20	No						
Coventry Health Care of Iowa	$10/$10	None	$5	$15/$30	No	○	●	●	◒	○	○
Health Alliance HMO	$15/$15	$100	$10	$20/$40	No	●	◒	●	◒	◒	●
John Deere Health Plan	$15/$15	$100/day x 5	$10	$20/$35	Yes	●	●	●	◒	●	●
Sioux Valley Health Plan - In-Network	$20/$30	$100/day x 5	$15	$30/$50	No						
Sioux Valley Health Plan - Out-of-Network	40%/40%	40%	N/A	N/A	No						
Sioux Valley Health Plan - In-Network	$25/$25	$100/day x 5	$15	$30/$50	No						
Sioux Valley Health Plan - Out-of-Network	40%/40%	40%	N/A	N/A	No						

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Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Kansas						
Coventry Health Care of Kansas - Kansas City - Kansas City area	800/969-3343	HA1	HA2	$16.98	$57.72	
Coventry Health Care of Kansas - Wichita/Salina areas	800/664-9251	7W1	7W2	$14.89	$38.42	
Humana CoverageFirst (Consumer Driven Plan) - Kansas City	888/393-6765	PH1	PH2	$8.65	$19.89	
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	$27.39	$65.52	URAC 1
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	$13.83	$31.80	URAC 1
Preferred Plus of Kansas - S. Central Area	800/660-8114	VA1	VA2	$68.95	$237.52	JCAHO 1
Kentucky						
Humana CoverageFirst (Consumer Driven Plan) - Louisville	888/393-6765	BM1	BM2	$12.97	$29.83	
Humana Health Plan - Louisville area	888/393-6765	D21	D22	$34.75	$82.41	NCQA 2
United Healthcare of Ohio, Inc. - Northern Kentucky	800/231-2918	3U1	3U2	$54.17	$127.11	NCQA 1
Louisiana						
Coventry Healthcare Louisiana - New Orleans area	800/341-6613	BJ1	BJ2	$13.76	$31.96	
Coventry Healthcare Louisiana - Baton Rouge area	800/341-6613	JA1	JA2	$27.17	$68.83	
Vantage Health Plan - Monroe/Shreveport/Alexandria Areas	888/823-1910	MV1	MV2	$34.71	$135.75	
Maryland						
Aetna Health Inc.-High -Northern/Central/Southern Maryland	800/537-9384	JN1	JN2	$18.11	$40.78	NCQA 1
Aetna Health Inc.-Std - Northern/Central/Southern Maryland	800/537-9384	JN4	JN5	$11.90	$27.84	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - All of Maryland	888/238-6240	221	222	$14.56	$33.49	
CareFirst BlueChoice - All of Maryland	866/520-6099	2G1	2G2	$38.32	$81.51	NCQA 2
Kaiser Permanente - Baltimore/Washington, DC areas	301/468-6000	E31	E32	$16.42	$39.09	NCQA 2
M.D. IPA - All of Maryland	800/251-0956	JP1	JP2	$16.52	$39.64	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 3 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs: Generic	Prescription Drugs: Brand name/ Non-formulary	Prescription Drugs: Mail order discount	Member Survey Results (● above average, ◒ average, ○ below average): Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Kansas											
Coventry Health Care of Kansas - Kansas City	$15/$15	$100/day x 3	$10	$20/$50	Yes	○	◒	◒	●	○	◒
Coventry Health Care of Kansas	$15/$15	$100/day x 3	$5	$15/$45	Yes	○	◒	◒	●	○	◒
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan, Inc.-High	$10/$20	$100/day x 3	$5/$20	$20/$40	No	○	◒	◒	○	◒	○
Humana Health Plan, Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	○	◒	◒	○	◒	○
Preferred Plus of Kansas	$10/$10	$50/day x 10	$5	$15	Yes						
Kentucky											
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	◒	◒	◒	◒	◒
United Healthcare of Ohio, Inc.	$15/$15	$250	$10	$15/$30	Yes	◒	●	◒	●	◒	◒
Louisiana											
Coventry Healthcare Louisiana	$15/$15	$100/day x 3	$10	$20/$45	Yes	○	◒	◒	●	◒	◒
Coventry Healthcare Louisiana	$15/$15	$100/day x 3	$10	$20/$45	Yes	○	◒	◒	●	◒	◒
Vantage Health Plan	$15/$15	$250	$10	$20/$35	Yes						
Maryland											
Aetna Health Inc.-High	$15/$20	$150/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna Health Inc.-Std	$20/$25	$250/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
CareFirst BlueChoice	$20/$30	$100/day x 5	$10	$25/$40	Yes	○	○	○	◒	○	○
Kaiser Permanente	$10/$20	$100	$10/$20Net	$20/$40	Yes	◒	○	○	○	◒	◒
M.D. IPA	$10/$20	$100	$8	$20/$35	No	◒	◒	◒	◒	●	●

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) 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.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Massachusetts						
Blue Chip, Coord Hlth Partners - Southeastern Massachusetts	401/459-5500	DA1	DA2	$39.52	$141.05	NCQA 1
ConnectiCare - Counties Hampden, Hampshire, Franklin	800/251-7722	TE1	TE2	$17.14	$71.90	NCQA 1
Fallon Community Health Plan - Central/Eastern Massachusetts	800/868-5200	JV1	JV2	$35.34	$107.11	NCQA 1
Michigan						
Bluecare Network of MI - Midland County Area	800/662-6667	K51	K52	$17.83	$116.47	NCQA 1
Bluecare Network of MI - Kalamazoo County Area	800/662-6667	KF1	KF2	$56.00	$230.60	NCQA 1
Bluecare Network of MI - Genesee County Area	800/662-6667	KN1	KN2	$25.19	$143.97	NCQA 1
Bluecare Network of MI - Kent County Area	800/662-6667	KR1	KR2	$49.54	$230.00	NCQA 1
Bluecare Network of MI - Mid Michigan	800/662-6667	LN1	LN2	$66.21	$177.44	NCQA 1
Bluecare Network of MI - Southeast MI	800/662-6667	LX1	LX2	$13.45	$40.23	NCQA 1
Grand Valley Health Plan - Grand Rapids area	616/949-2410	RL1	RL2	$16.85	$93.42	NCQA 1
Health Alliance Plan - Southeastern Michigan/Flint area	800/422-4641	521	522	$15.13	$40.09	NCQA 1
HealthPlus MI - Flint/Saginaw areas	800/332-9161	X51	X52	$33.57	$76.84	NCQA 1
M-Care - Southeastern Michigan and Flint area	800/658-8878	EG1	EG2	14.25	$37.76	NCQA 1
OmniCare - Southeastern Michigan	800/477-6664	KA1	KA2	14.23	$35.02	NCQA 3
Total Health Care - Greater Detroit/Flint areas	800/826-2862	N21	N22	13.02	$31.97	
Minnesota						
Avera Health Plans - Southwestern Minnesota	888/322-2115	AV1	AV2	$16.29	$38.03	
HealthPartners Classic-High -Minneapolis/St. Paul/St.Cloud	952-883-5000	531	532	$50.11	$137.10	NCQA 1
HealthPartners Open Access-Basic - Minneapolis/St. Paul/St.Cloud	952-883-5000	534	535	$20.64	$66.36	NCQA 1
HealthPartners Primary Clinic Plan - Minneapolis/St. Paul/St. Cloud	952-883-5000	HQ1	HQ2	$96.57	$248.60	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Massachusetts											
Blue Chip, Coord Hlth Partners - In-Network	$15/$25	$500	$7	$25/$40	Yes	○	●	●	●	◒	◒
- Out-of-Network	30%/30%	None	$40+20%	$40+20%/$40+20%	No						
ConnectiCare	$10/$10	None	$10	$20/$35	Yes	●	●	●	●	●	●
Fallon Community Health Plan	$10/$10	$100	$5	$20/$40	Yes	◒	◒	●	◒	◒	◒
Michigan											
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20	Yes	◒	○	◒	○	○	◒
Grand Valley Health Plan	$10/$10	None	$5	$5	No	●	◒	●	◒	●	●
Health Alliance Plan	$10/$10	None	$10	$20	Yes	◒	◒	○	◒	○	◒
HealthPlus MI	$10/$10	None	$10	$20	Yes	●	●	●	●	●	●
M-Care	$10/$10	None	$10	$20/$30	No	◒	◒	◒	◒	◒	◒
OmniCare	$10/$10	None	$5	$10/$25	Yes	○	○	○	○	◒	◒
Total Health Care	$10/$10	None	Nothing	Nothing	No	○	○	○	◒	◒	○
Minnesota											
Avera Health Plans	$10/$15	$100/dayx3	$10	$20	Yes						
HealthPartners Classic-High	$15/$15	$100	$12	$12/$24	No	○	◒	◒	◒	○	◒
HealthPartners Open Access-Basic	$15/$15	$100	$10	$10/$35	No	○	◒	◒	◒	○	◒
HealthPartners Primary Clinic Plan	$20/$20	$200	$12	$12/$24	No	○	◒	◒	◒	○	◒

Health Maintenance Organization (HMO) and Point of Service (POS) 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.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Missouri						
BlueCHOICE - St Louis/Central/SW areas	800/634-4395	9G1	9G2	$17.29	$37.43	NCQA 1
Coventry Health Care of Kansas - Kansas City - Kansas City area	800-969-3343	HA1	HA2	$14.89	$38.42	
Group Health Plan - St. Louis area	800/755-3901	MM1	MM2	$54.20	$99.51	URAC 1
Humana CoverageFirst (Consumer Driven Plan) - Kansas City	888/393-6765	PH1	PH2	$8.65	$19.89	
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	$27.39	$65.52	URAC 1
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	$13.83	$31.80	URAC 1
Mercy Health Plans/Premier Health Plans - East/Central/Southwest Missouri	800/327-0763	7M1	7M2	$50.22	$90.94	
Montana						
New West Health Services - Most of Montana	800/290-3657	NV1	NV2	$17.24	$38.36	
Nevada						
Aetna Health Inc. - Las Vegas Area	800/537-9384	Y11	Y12	$15.13	$37.68	
Health Plan of Nevada - Las Vegas area	800/777-1840	NM1	NM2	$10.35	$26.49	NCQA 2
PacifiCare Desert Region (NV) - Las Vegas/Clark County	800-531-3341	K91	K92	$14.07	$31.95	NCQA 2
New Jersey						
Aetna Health Inc. - All of New Jersey	800/537-9384	P31	P32	$17.88	$56.31	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - All of New Jersey	888/238-6240	221	222	$14.56	$33.49	
AmeriHealth HMO - All of New Jersey	800/454-7651	FK1	FK2	$17.01	$40.62	NCQA 1
GHI Health Plan-High -Northern New Jersey	212/501-4444	801	802	$41.85	$135.80	URAC 1
New Mexico						
Cimarron Health Plan - All of New Mexico	800/473-0391	PX1	PX2	$18.03	$93.71	NCQA 2
Lovelace Health Plan - All of New Mexico	800/244-6224	Q11	Q12	$17.31	$50.57	NCQA 1
Presbyterian Health Plan - All NM counties except Otero & S. Eddy	800/356-2219	P21	P22	$16.24	$49.33	NCQA 2

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs: Generic	Prescription Drugs: Brand name/ Non-formulary	Prescription Drugs: Mail order discount	Member Survey Results (● above average, ◒ average, ○ below average): Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Missouri											
BlueCHOICE	$10/$10	None	$7	$12/$25	Yes	◒	●	●	◒	◒	◒
Coventry Health Care of Kansas - Kansas City	$15/$15	$100/day x 3	$10	$20/$50	Yes	○	◒	◒	●	○	◒
Group Health Plan	$10/$20	$100	$10	$20/$35	Yes	◒	◒	◒	◒	◒	◒
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Humana Health Plan, Inc.-High	$10/$20	$100/day x 3	$5/$20	$20/$40	No	○	◒	◒	○	◒	○
Humana Health Plan, Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	○	◒	◒	○	◒	○
Mercy Health Plans/Premier - In-Network	$10/$20	None	$10	$20/$35	Yes	◒	●	●	●	●	●
Mercy Health Plans/Premier - Out-of-Network	30%/30%	None	N/A	N/A	No						
Montana											
New West Health Plan	$15/$15	$100	$10	$20/$40	Yes						
Nevada											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes						
Health Plan of Nevada	$10/$10	$100	$5	$20/$35	Yes	○	○	○	○	○	○
PacifiCare Desert Region (AZ & NV)	$15/$30	$200/ day x 5	$15	$35/$50	Yes	◒	○	○	○	◒	◒
New Jersey											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	◒	◒	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
AmeriHealth HMO	$30/$35	$200/day x 3	$15	$40/50%	Yes	○	◒	◒	◒	◒	○
GHI Health Plan - In-Network	$15/$15	None	$10	$20/$50	Yes	◒	◒	◒	◒	○	◒
GHI Health Plan - Out-of-Network	50% of sch./50% of sch.	None	N/A	N/A	No						
New Mexico											
Cimarron Health Plan	$10/$10	$100	$5	$15/$30	Yes	○	○	○	○	○	○
Lovelace Health Plan	$15/$25	$250	$7	$15/$35	Yes	◒	○	○	◒	◒	◒
Presbyterian Health Plan	$10/$10	None	$7	$17/$34	Yes	◒	○	○	◒	◒	◒

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Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
New York						
Aetna Health Inc. - NYC Area and Dutchess/Sullivan/Ulster	800/537-9384	JC1	JC2	$18.18	$70.43	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - New York City Area	888/238-6240	221	222	$14.56	$33.49	
Blue Choice - Rochester area	800/462-0108	MK1	MK2	$13.51	$33.86	NCQA 2
Capital District Physicians' Health Plan - North /Central New York	518/641-3700	PW1	PW2	$17.65	$74.43	NCQA 1
Capital District Physicians' Health Plan - Hudson Valley area	518/641-3700	QB1	QB2	$17.13	$63.04	NCQA 1
Capital District Physicians' Health Plan - Capital District area	518/641-3700	SG1	SG2	$16.61	$50.91	NCQA 1
GHI Health Plan-High -All of New York	212/501-4444	801	802	$41.85	$135.80	URAC 1
GHI Health Plan-Std - NYC/Brnx/Kings/Queen/Rich/Nass/Suff/Rock/Westche	212/501-4444	804	805	$17.87	$70.08	URAC 1
GHI HMO Select - Brnx/Brklyn/Manhat/Queen/Richmon/Westche	877/244-4466	6V1	6V2	$32.98	$110.89	NCQA 3
GHI HMO Select - Capital/Hudson Valley Regions	877/244-4466	X41	X42	$21.62	$96.47	NCQA 3
HIP of Greater New York-High -New York City area	800/HIP-TALK	511	512	$16.44	$81.91	NCQA 2
HIP of Greater New York-Std - New York City area	800/HIP-TALK	514	515	$13.16	$36.84	NCQA 2
HMO Blue - Utica/Rome/Central New York areas	800/722-7884	AH1	AH2	$67.71	$211.76	NCQA 1
HMOBlue-CNY - Syracuse/Binghamton/Elmira areas	800/828-2887	EB1	EB2	$40.15	$97.34	NCQA 1
Independent Health Assoc - Western New York	800/453-1910	QA1	QA2	$11.82	$33.09	NCQA 1
MVP Health Care - Eastern Region	888/687-6277	GA1	GA2	$13.92	$35.94	NCQA 1
MVP Health Care - Central Region	888/687-6277	M91	M92	$15.78	$40.75	NCQA 1
MVP Health Care - Mid-Hudson Region	888/687-6277	MX1	MX2	$16.21	$44.97	NCQA 1
Preferred Care - Rochester area	800/950-3224	GV1	GV2	$13.45	$35.91	NCQA 1
Univera Healthcare - Western New York (Southern Counties)	716/847-0881	KQ1	KQ2	$16.28	$56.15	NCQA 1
Univera Healthcare - Western New York (Northern Counties)	716/847-0881	Q81	Q82	$12.84	$36.41	NCQA 1
Vytra Health Plans - Queens/Nassau/Suffolk Counties	800/406-0806	J61	J62	$32.21	$133.20	

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
New York											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	○	◒	○	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
Blue Choice	$15/$15	None	$5	$20/$35	No	●	●	●	●	◒	●
Capital District Physicians' Health Plan	$15/$15	$240	$10	$20/$35	Yes	●	●	●	●	●	●
Capital District Physicians' Health Plan	$15/$15	$240	$10	$20/$35	Yes	●	●	●	●	●	●
Capital District Physicians' Health Plan	$15/$15	$240	$10	$20/$35	Yes	●	●	●	●	●	●
GHI Health Plan - In-Network	$15/$15	None	$10	$20/$50	Yes	◒	◒	◒	◒	○	◒
GHI Health Plan - Out-of-Network	50% of sch./50% of sch.	None	N/A	N/A	No						
GHI Health Plan-Std	$25/$25	$250/day x 3	$10	$25/$50	Yes	◒	◒	◒	◒	○	◒
GHI HMO Select	$10/$10	None	$10	$20/$30	Yes	○	○	◒	◒	○	○
GHI HMO Select	$10/$10	None	$10	$20/$30	Yes	○	○	◒	◒	○	○
HIP of Greater New York-High	$10/$10	None	$10	$15/$40	Yes	◒	◒	○	○	◒	○
HIP of Greater New York-Std	$10/$20	$500	$10	$20/$40	Yes	◒	◒	○	○	◒	○
HMO Blue	$15/$15	$240	$10	$25/$40	No	◒	●	●	●	○	◒
HMOBlue-CNY	$15/$15	$100	$10	$25/$40	No	◒	●	●	●	○	◒
Independent Health Assoc	$15/$15	None	$10	$20/$35	No	◒	●	●	●	●	●
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	●	●	◒
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	●	●	◒
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	●	●	◒
Preferred Care	$15/$15	None	$10	$20/$35	Yes	●	●	●	●	●	●
Univera Healthcare	$15/$15	$250	$10	$20/$45	No	◒	●	●	◒	◒	●
Univera Healthcare	$15/$15	$250	$10	$20/$45	No	◒	●	●	◒	◒	●
Vytra Health Plans	$10/$10	None	$5	$10	Yes	◒	●	◒	◒	●	◒

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Health Maintenance Organization (HMO) and Point of Service (POS) 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.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
North Dakota						
Heart of America HMO - Northcentral North Dakota	800-525-5661	RU1	RU2	$13.32	$34.24	
Ohio						
Aetna Health Inc. - Cleveland Area	800/537-9384	7D1	7D2	$15.87	$38.23	NCQA 1
Aetna Health Inc. - Greater Cincinnati Area	800/537-9384	RD1	RD2	$16.99	$43.96	NCQA 1
AultCare HMO - Stark/Carroll/Holmes/Tuscarawas/Wayne Co	330/363-6360	3A1	3A2	$16.41	$40.29	
Blue HMO - Most of Ohio	800/228-4375	R51	R52	$30.39	$104.31	NCQA 1
HMO Health Ohio - Northeast Ohio	800/522-2066	L41	L42	$17.00	$59.53	NCQA 1
HOMETOWN HEALTH PLAN - Massillon	800-426-9013	MZ1	MZ2	$14.59	$36.47	
Humana CoverageFirst (Consumer Driven Plan) - Cincinnati	888/393-6765	L81	L82	$10.81	$24.86	
Kaiser Permanente - Cleveland/Akron areas	800/686-7100	641	642	$17.08	$45.35	
Paramount Health Care - Northwest/North Central Ohio	800/462-3589	U21	U22	$17.39	$82.11	NCQA 1
SummaCare Health Plan - Cleveland, Akron areas	330/996-8700	5W1	5W2	$16.36	$72.80	NCQA 1
SuperMed HMO - Northeast Ohio	800/522-2066	5M1	5M2	$24.74	$102.77	NCQA 1
The Health Plan of the Upper Ohio Valley - Eastern Ohio	800/624-6961	U41	U42	$17.38	$39.96	NCQA 1
United Healthcare of Ohio, Inc. - Cincinnati/Dayton/Springfield areas	800/231-2918	3U1	3U2	$54.17	$127.11	NCQA 1
Oklahoma						
Aetna Health Inc. - Oklahoma City/Tulsa Areas	800/537-9384	SL1	SL2	$17.67	$55.96	NCQA 1
PacifiCare Southwest Region (OK) - Central/Northeastern Oklahoma	800-531-3341	2N1	2N2	$18.82	$63.67	NCQA 1
Oregon						
Kaiser Permanente-High -Portland/Salem areas	800/813-2000	571	572	$27.30	$64.45	NCQA 1
Kaiser Permanente-Std - Portland/Salem areas	800/813-2000	574	575	$16.84	$38.64	NCQA 1
PacifiCare of Oregon - Metro Portland/Salem/Corvalis/Eugene	800-531-3341	7Z1	7Z2	$23.83	$48.98	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 3 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
North Dakota											
Heart of America HMO	$10/Nothing	None	50%	50%	No						
Ohio											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	●	◒	◒	○
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	●	◒	◒	○
AultCare HMO	$10/$10	None	$10	$20/$35	No	●	●	●	◒	●	●
Blue HMO	$10/$10	None	$10	$20/$30	Yes	◒	●	●	●	○	◒
HMO Health Ohio	$10/$10	None	$10	$20/$30	Yes	◒	◒	◒	◒	◒	○
HOMETOWN HEALTH PLAN	$15/$20	$250	$15	$25/$40	No						
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Kaiser Permanente	$10/$10	$100	$10	$25	No	●	◒	◒	◒	◒	◒
Paramount Health Care	$10/$20	$300	$5	$15/$25	No	●	●	◒	◒	●	●
SummaCare Health Plan	$10/$10	None	$10	$20/$40	Yes	◒	●	●	●	◒	●
SuperMed HMO	$10/$10	None	$10	$20	Yes	◒	◒	◒	◒	◒	○
The Health Plan of the Upper Ohio Valley	$10/$20	$250	$15	$30/$50	Yes	◒	●	●	●	●	●
United Healthcare of Ohio, Inc.	$15/$15	$250	$10	$15/$30	Yes	◒	●	◒	●	◒	◒
Oklahoma											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes						
PacifiCare Southwest Region (OK & TX)	$20/$40	$400/day x 5	$20	$40/$50	Yes	◒	○	◒	◒	◒	◒
Oregon											
Kaiser Permanente-High	$10/$10	None	$10	$20	Yes	◒	◒	○	○	●	◒
Kaiser Permanente-Std	$15/$15	None	$15	$30	Yes	◒	◒	○	○	●	◒
PacifiCare of Oregon	$20/$45	$400/day x 5	$20	$40/$50	Yes	◒	◒	●	●	◒	◒

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Health Maintenance Organization (HMO) and Point of Service (POS) 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.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Pennsylvania						
Aetna Health Inc. - Philadelphia and Southeastern PA	800/537-9384	P31	P32	$17.88	$56.31	NCQA 1
Aetna Health Inc. - Pittsburgh Area	800/537-9384	YE1	YE2	$13.95	$38.47	
Aetna HealthFund (Consumer Driven Plan) - Philadelphia and Southeastern PA	888/238-6240	221	222	$14.56	$33.49	
HealthAmerica Pennsylvania-High -Greater Pittsburgh area	866/351-5946	261	262	$20.91	$91.67	NCQA 1
HealthAmerica Pennsylvania-Std - Greater Pittsburgh area	866/351-5946	264	265	$16.64	$50.10	NCQA 1
HealthAmerica Pennsylvania-High -Northeast Pennsylvania	866/351-5946	4N1	4N2	$35.82	$117.14	
HealthAmerica Pennsylvania-Std - Northeast Pennsylvania	866/351-5946	4N4	4N5	$18.18	$73.40	
HealthAmerica Pennsylvania-High -Central Pennsylvania	866/351-5946	SW1	SW2	$33.88	$102.05	NCQA 1
HealthAmerica Pennsylvania-Std - Central Pennsylvania	866/351-5946	SW4	SW5	$17.91	$58.39	NCQA 1
HealthAmerica Pennsylvania-High -Northwestern Pennsylvania	866/351-5946	VJ1	VJ2	$16.82	$54.22	
HealthAmerica Pennsylvania-Std - Northwestern Pennsylvania	866/351-5946	VJ4	VJ5	$15.40	$39.27	
Keystone Health Plan Central - Harrisburg/Northern Region/Lehigh Valley	800/622-2843	S41	S42	$30.89	$91.05	NCQA 1
Keystone Health Plan East - Philadelphia area	800/227-3115	ED1	ED2	$18.08	$96.74	NCQA 1
UPMC Health Plan - Western Pennsylvania area	888/876-2756	8W1	8W2	$17.56	$71.09	
Puerto Rico						
Humana Health Plans of Puerto Rico - Puerto Rico	800/314-3121	ZJ1	ZJ2	$9.39	$21.61	
Triple-S - All of Puerto Rico	787/749-4777	891	892	$12.70	$27.29	
Rhode Island						
Blue Chip, Coord Hlth Partners - All of Rhode Island	401/459-5500	DA1	DA2	$39.52	$141.05	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 3 for details. A lower number means a better accreditation.

Plan Name		Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
				Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Pennsylvania												
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes	○	◒	◒	◒	◒	◒
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes						
Aetna HealthFund	- In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
	- Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
HealthAmerica Pennsylvania-High		$10/$20	None	$10	$20/$40	Yes	○	●	●	●	◒	○
HealthAmerica Pennsylvania-Std		$20/$30	$200/day x 3	$10	$35/$60	Yes	○	●	●	●	◒	○
HealthAmerica Pennsylvania-High		$10/$20	None	$10	$20/$40	Yes						
HealthAmerica Pennsylvania-Std		$20/$30	$200/day x 3	$10	$35/$60	Yes						
HealthAmerica Pennsylvania-High		$10/$20	None	$10	$20/$40	Yes	○	●	●	●	◒	○
HealthAmerica Pennsylvania-Std		$20/$30	$200/day x 3	$10	$35/$60	Yes	○	●	●	●	◒	○
HealthAmerica Pennsylvania-High		$10/$20	None	$10	$20/$40	Yes						
HealthAmerica Pennsylvania-Std		$20/$30	$200/day x 3	$10	$35/$60	Yes						
Keystone Health Plan Central		$15/$20	None	$10	$25/$40	Yes	●	●	●	●	◒	●
Keystone Health Plan East		$10/$15	None	$5	$15/$25	Yes	○	◒	◒	◒	●	◒
UPMC Health Plan		$10/$10	None	$5	$15/$35	Yes	◒	●	◒	◒	◒	◒
Puerto Rico												
Humana Health Plans of Puerto Rico	- In-Network	$5/$5	None	$2.50	$5	No						
	- Out-of-Network	$8/$8	$50	N/A	N/A	No						
Triple-S	- In-Network	$7.50/$10	None	$5	$8/$12	Yes	●	●	○	●	●	◒
	- Out-of-Network	$7.50 + 10%/$10 + 10%	None	25%	25%	No						
Rhode Island												
Blue Chip, Coord Hlth Partners	- In-Network	$15/$25	$500	$7	$25/$40	Yes	○	●	●	●	◒	◒
	- Out-of-Network	30%/30%	None	$40+20%	$40+20%	No						

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

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Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
South Dakota						
Avera Health Plans - Eastern and Central South Dakota	888/322-2115	AV1	AV2	$16.29	$38.03	
Sioux Valley Health Plan-High -Eastern/Central/Rapid City Areas	800/752-5863	AU1	AU2	$70.34	$164.13	NCQA 2
Sioux Valley Health Plan-Std - Eastern/Central/Rapid City Areas	800/752-5863	AU4	AU5	$38.00	$89.71	NCQA 2
Tennessee						
Aetna Health Inc. - Nashville Area	800/537-9384	6J1	6J2	$15.57	$37.56	NCQA 1
Aetna Health Inc. - Memphis Area	800/537-9384	UB1	UB2	$14.91	$39.90	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Memphis	888/393-6765	L61	L62	$10.81	$24.86	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

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Plan Name		Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
				Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
South Dakota												
Avera Health Plans		$10/$15	$100/dayx3	$10	$20	No						
Sioux Valley Health Plan	- In-Network - Out-of-Network	$20/$30 40%/40%	$100/day x 5 40%	$15 N/A	$30/$50 N/A	No No	○	◒	●	◒	◒	○
Sioux Valley Health Plan	- In-Network - Out-of-Network	$25/$25 40%/40%	$100/day x 5 40%	$15 N/A	$30/$50 N/A	No No	○	◒	●	◒	◒	○
Tennessee												
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	◒	◒	●	○
Aetna Health Inc.		$20/$25	$250/day x 3	$10	$25/$40	Yes	◒	◒	◒	◒	●	○
Humana CoverageFirst	- In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						

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Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Texas						
Aetna Health Inc. - Austin/San Antonio Areas	800/537-9384	P11	P12	$14.38	$36.22	NCQA 1
Aetna Health Inc. - Dallas/Ft Worth/Houston Areas	800/537-9384	PU1	PU2	$17.28	$56.30	NCQA 1
FIRSTCARE - Waco area	800/884-4901	6U1	6U2	$16.86	$36.21	
FIRSTCARE - West Texas	800/884-4901	CK1	CK2	$45.77	$79.05	
HMO Blue Texas - Houston	800/833-5318	YM1	YM2	$17.41	$51.81	NCQA 2
Humana CoverageFirst (Consumer Driven Plan) - Houston	888/393-6765	T21	T22	$12.97	$29.83	
Humana CoverageFirst (Consumer Driven Plan) - Dallas/Ft. Worth	888/393-6765	T81	T82	$12.43	$28.59	
Humana CoverageFirst (Consumer Driven Plan) - Corpus Christi	888/393-6765	TP1	TP2	$11.35	$26.10	
Humana CoverageFirst (Consumer Driven Plan) - San Antonio	888/393-6765	TU1	TU2	$10.81	$24.86	
Humana CoverageFirst (Consumer Driven Plan) - Austin	888/393-6765	TV1	TV2	$11.89	$27.34	
Humana Health Plan of Texas-High -San Antonio area	888/393-6765	UR1	UR2	$27.30	$65.32	
Humana Health Plan of Texas-Std - San Antonio area	888/393-6765	UR4	UR5	$15.41	$35.45	
Mercy Health Plans/Premier Health Plans - Webb/Zapata/Duval/Jim Hogg Counties	800/617-3433	HM1	HM2	$30.79	$108.17	
PacifiCare Southwest Region (TX) - San Antonio/Dallas/Ft.Worth	800-531-3341	GF1	GF2	$23.78	$58.83	NCQA 1
Utah						
Altius Health Plans - Wasatch Front	800/377-4161	9K1	9K2	$38.05	$71.90	
Vermont						
MVP Health Care - All of Vermont	888/687-6277	VW1	VW2	$22.79	$101.86	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Texas											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes						
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes						
FIRSTCARE	$15/$25	$100	$10	$20/$40	Yes	◒	●	●	●	◒	◒
FIRSTCARE	$15/$25	$100	$10	$20/$40	Yes	◒	●	◒	●	●	●
HMO Blue Texas	$20/$20	$100/dayx4	$10	$25/$40	Yes	○	○	○	◒	○	○
Humana CoverageFirst - In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst - In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst - In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst - In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana CoverageFirst - In-Network - Out-of-Network	$20*/$35* 30%*/30%*	$100/day x 5* 30%*	$10/$25* $10/$25+30%*	$25/$50* $25/$50+30%*	No* No*						
Humana Health Plan of Texas-High	$10/$20	$100/day x 3	$5/$20	$20/$40	No	◒	◒	○	◒	●	◒
Humana Health Plan of Texa-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	◒	○	◒	●	◒
Mercy Health Plans/Premier - In-Network - Out-of-Network	$10/$10 40%/40%	None None	$7 N/A	$12/$25 N/A	Yes No	●	◒	○	●	●	●
PacifiCare Southwest Region (OK & TX)	$20/$40	$400/day x 5	$20	$40/$50	Yes	◒	○	○	○	◒	○
Utah											
Altius Health Plans	$10/$15	None	$10	$20/$40	Yes	○	◒	○	○	○	○
Vermont											
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	●	●	◒

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Hospital per Stay Deductible is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
Virginia						
Aetna Health Inc.-High -Northern/Central/Richmond, Virginia Area	800/537-9384	JN1	JN2	$18.11	$40.78	NCQA 1
Aetna Health Inc.-Std - Northern/Central/Richmond, Virginia Area	800/537-9384	JN4	JN5	$11.90	$27.84	NCQA 1
Aetna HealthFund (Consumer Driven Plan) - Northern/Central/Richmond VA Areas	888/238-6240	221	222	$14.56	$33.49	
CareFirst BlueChoice - Northern Virginia	866/520-6099	2G1	2G2	$38.32	$81.51	NCQA 2
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	$16.42	$39.09	NCQA 2
M.D. IPA - N.VA/Cntrl VA/Richmond/Tidewater/Roanoke	800/251-0956	JP1	JP2	$16.52	$39.64	NCQA 1
Optima Health Plan - Peninsula/Southside Hampton Roads	800/206-1060	9R1	9R2	$23.43	$67.46	NCQA 1
Piedmont Community Healthcare - Lynchburg area	888/674-3368	2C1	2C2	$18.83	$44.18	
Washington						
Aetna Health Inc. - Western/Southeast Washington	800/537-9384	8J1	8J2	$13.38	$34.02	
Aetna HealthFund (Consumer Driven Plan) - Seattle/Western Washington	888/238-6240	221	222	$14.56	$33.49	
Group Health Cooperative-High -Most of Western Washington	888/901-4636	541	542	$26.20	$55.56	NCQA 1
Group Health Cooperative-Std - Most of Western Washington	888/901-4636	544	545	$15.96	$36.04	NCQA 1
Group Health Cooperative-High -Central WA/Spokane/Pullman	888/901-4636	VR1	VR2	$17.91	$61.10	NCQA 1
Group Health Cooperative-Std - Central WA/Spokane/Pullman	888/901-4636	VR4	VR5	$15.52	$35.71	NCQA 1
Kaiser Permanente-High -Vancouver/Longview	800/813-2000	571	572	$27.30	$64.45	NCQA 1
Kaiser Permanente-Std - Vancouver/Longview	800/813-2000	574	575	$16.84	$38.64	NCQA 1
KPS Health Plans - High -All of Western Washington	800/552-7114	VT1	VT2	$35.55	$63.72	
KPS Health Plans - Std - All of Western Washington	800/552-7114	L11	L12	$16.20	$35.40	
PacifiCare of Oregon - Clark County	800-531-3341	7Z1	7Z2	$23.83	$48.98	NCQA 1

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 3 for details. A lower number means a better accreditation.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Virginia											
Aetna Health Inc.-High	$15/$20	$150/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna Health Inc.-Std	$20/$25	$250/day x 3	$10	$25/$40	No	○	◒	○	◒	◒	◒
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
CareFirst BlueChoice	$20/$30	$100/day x 5	$10	$25/$40	Yes	○	○	○	◒	○	○
Kaiser Permanente	$10/$20	$100	$10/$20Net	$20/$40	Yes	◒	○	○	○	◒	◒
M.D. IPA	$10/$20	$100	$8	$20/$35	No	◒	◒	◒	◒	●	●
Optima Health Plan	$10/$20	$250	$10	$20/$40	Yes	●	●	◒	◒	●	●
Piedmont Community Healthcare - In-Network	$25/$25	None	$15	$30	Yes						
Piedmont Community Healthcare - Out-of-Network	40%/30%	None	$15	$30	No						
Washington											
Aetna Health Inc.	$20/$25	$250/day x 3	$10	$25/$40	Yes	○	◒	◒	◒	○	○
Aetna HealthFund - In-Network	15%*/15%*	15%*	$10*	$25*/$40*	Yes*						
Aetna HealthFund - Out-of-Network	40%*/40%*	40%*	$10*	$25*/$40*	Yes*						
Group Health Cooperative-High	$15/$15	$200/day x 3	$15	$25/$50	Yes	◒	◒	●	◒	◒	◒
Group Health Cooperative-Std	$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes	◒	◒	●	◒	◒	◒
Group Health Cooperative-High	$15/$15	$200/day x 3	$15	$25/$50	Yes	◒	◒	●	◒	◒	◒
Group Health Cooperative-Std	$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes	◒	◒	●	◒	◒	◒
Kaiser Permanente-High	$10/$10	None	$10	$20	Yes	◒	◒	○	○	●	◒
Kaiser Permanente-Std	$15/$15	None	$15	$30	Yes	◒	◒	○	○	●	◒
KPS Health Plans - In-Network	$15/$25	None	$5	$20/50%	Yes	●	●	●	●	●	●
KPS Health Plans - Out-of-Network	$15+45%/$25+45%	None	N/A	N/A	No						
KPS Health Plans - In-Network	$15/x3 or 20%/20%	$100/day x 5	$10	$30/50%	Yes						
KPS Health Plans - Out-of-Network	$15/x3 or 45%/45%	$100/day x 5	N/A	N/A	No						
PacifiCare of Oregon	$20/$45	$400/day x 5	$20	$40/$50	Yes						

** See Brochure for details on patient's payment responsibility.*

Health Maintenance Organization (HMO) and Point of Service (POS) 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.* This chart does not show all of your possible out-of-pocket costs.

Primary Care Specialist/Office 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 is the amount you pay when you are admitted into a hospital.

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self only	Self & family	Self only	Self & family	
West Virginia						
The Health Plan of the Upper Ohio Valley - Northern/Central West Virginia	800/624-6961	U41	U42	$17.38	$39.96	NCQA 1
Wisconsin						
Dean Health Plan - South Central Wisconsin	800/279-1301	WD1	WD2	$15.23	$41.11	NCQA 1
Group Health Cooperative - South Central Wisconsin	608/251-3356	WJ1	WJ2	$14.90	$40.27	NCQA 1
HealthPartners Classic-High -West Central Wisconsin	952-883-5000	531	532	$50.11	$137.10	NCQA 1
HealthPartners Open Access-Basic - West Central Wisconsin	952-883-5000	534	535	$20.64	$66.36	NCQA 1
HealthPartners Primary Clinic Plan - West Central Wisconsin	952-883-5000	HQ1	HQ2	$96.57	$248.60	NCQA 1
Humana CoverageFirst (Consumer Driven Plan) - Milwaukee	888/393-6765	FB1	FB2	$11.89	$27.34	
Wyoming						
WINhealth Partners - Wyoming	307/638-7700	PV1	PV2	$27.94	$135.26	

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
West Virginia											
The Health Plan of the Upper Ohio Valley	$10/$20	$250	$15	$30/$50	Yes	◒	●	●	●	●	●
Wisconsin											
Dean Health Plan	$10/$10	None	$10	30%	No	●	●	●	◒	◒	●
Group Health Cooperative	$20/$20	None	$6	$12	No	◒	◒	●	◒	◒	●
HealthPartners Classic-High	$15/$15	$100	$12	$12/$24	No	○	◒	◒	◒	○	◒
HealthPartners Open Access-Basic	$15/$15	$100	$10	$10/$35	No	○	◒	◒	◒	○	◒
HealthPartners Primary Clinic Plan	$20/$20	$200	$12	$12/$24	No	○	◒	◒	◒	○	◒
Humana CoverageFirst - In-Network	$20*/$35*	$100/day x 5*	$10/$25*	$25/$50*	No*						
Humana CoverageFirst - Out-of-Network	30%*/30%*	30%*	$10/$25+30%*	$25/$50+30%*	No*						
Wyoming											
WINhealth Partners	$10/$10	None	$10	$15/$40	Yes						

** See Brochure for details on patient's payment responsibility.*


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