FEHB 2007 GUIDE

Guide to Federal Employees Health Benefits Plans

For TCC and Former Spouse Enrollees/ Individuals Eligible To Enroll For:

- Temporary Continuation of Coverage (TCC)
- Coverage under the Spouse Equity Provisions of FEHB Law or similar statutes providing coverage to former spouses.

Center for Retirement and Insurance Services

Visit our web site at www.opm.gov/insure/health

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Health Provider Costs – Information for You

The following FEHB health plans have shown their commitment to OPM's healthcare cost transparency standards by making information about provider costs available on their websites for their plan members.

Aetna
APWU (Consumer Driven Health Plan)*
Av Med
Blue Choice (Ohio and Missouri)
Blue HMO of Ohio
CaliforniaCare
CareFirst BlueChoice
Foreign Service Benefit Plan*
HealthNet of California
HMO Health of Ohio
Humana Health Plans
Independent Health
Kaiser (California, Colorado and Northwest regions)
M Care
Rural Letter Carriers Health Plan*
SuperMed HMO
United Healthcare

Members of these plans will have access to healthcare cost information so they can make more informed choices when they need services. The website information available includes online decision tools with cost estimators for diagnoses and drugs as well as the costs paid to health care providers within geographic areas for common illnesses and conditions. Plus, these plans also describe the sources of this healthcare cost data and any limitations so plan members can understand what the information means to them.

Some examples of the types of surgical procedures for which you can obtain cost informa tion include: arthroscopy knee/shoulder, breast biopsy, cataract repair, cesarean delivery, colonoscopy, corneal surgery, gall bladder removal, heart catheterization, hysterectomy, inguinal hernia repair, knee replacement, and tonsillectomy. This information will help you to understand the true cost of your healthcare and enhance your ability to compare hospi tal, physician, and other provider costs as you make healthcare choices.

We are pleased that these health plans have shown their commitment to consumers who are seeking and utilizing these comparison tools. FEHB plans are working to expand the cost and quality information they provide to their members. The plans listed on this page met OPM's transparency standards at the time this Guide went to press. As other plans bring these tools on line, we will add them to the list on our website. So, please check the updat ed information at www.opm.gov/insure before you make your healthcare decisions.

* *An asterisk indicates a fee for service plan that provides members with links to provider quality information on its website.*

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Look for a health plan that:

- Received high survey ratings from its members on things that are important to you.
- Was evaluated highly by an accrediting organization.
- Has performed well on clinical measures of common conditions.
- Has the doctors and hospitals you want.
- Provides the services and benefits you want.

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.

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Eligibility Requirements

These individuals are eligible to enroll in the FEHB Program but do not receive a Government contribution toward the cost of their enrollment.

Individuals eligible for temporary continuation of coverage (TCC), including:

- former employees whose FEHB coverage ended because they separated from service, unless they were separated for gross misconduct, including employees who are not eligible to continue FEHB into retirement,
- children who lose FEHB coverage under a family enrollment, and
- former (divorced) spouses who are not eligible for FEHB coverage under the Spouse Equity provisions of FEHB law because they have remarried before age 55 or are not entitled to a portion of the Federal employee's annuity or a former spouse survivor annuity.

Do not cancel your enrollment before reading this section.

You may voluntarily cancel your enrollment at any time. However, once your cancellation takes effect, you **cannot reenroll**. You will **not** be entitled to a 31 day extension of coverage for conversion to a non group (private) policy. Family members who lose coverage upon your cancellation may enroll only if they are eligible in their own right as Federal employees or annuitants.

If your TCC enrollment terminates because you acquire other FEHB coverage, and that coverage ends before your original TCC eligibility period ends, you may reenroll for the time remaining until your original TCC ending date.

Note: *The office that maintained the other FEHB enrollment can advise you on your eligibility for a new TCC enrollment period.*

Strict time limits for electing TCC apply. As early as possible before (or after) the qualifying event for TCC occurs, contact the employee's Human Resources office or the annuitant's retirement system to get more facts about the requirements for electing coverage.

Former (divorced) spouses eligible to enroll under the Spouse Equity Provisions of FEHB Law or similar statutes. If you are the spouse of a Federal employee or annuitant and lose FEHB coverage because of divorce, you may elect FEHB coverage under certain circumstances. Contact the employee's Human Resources office or the annuitant's retirement system for the requirements for electing coverage.

Former spouses enrolled under the Spouse Equity Provisions of FEHB Law or similar statute who cancel their enrollment **cannot** reenroll as a former spouse unless they cancel because they acquire other coverage under the FEHB Program and that coverage ends.

You may *suspend* your FEHB enrollment because you are enrolling in one of the following programs:

- A Medicare Advantage health plan,
- Medicaid or similar State sponsored program of medical assistance for the needy,
- TRICARE (including Uniformed Services Family Health Plan or TRICARE for Life), or
- CHAMPVA

For more information on how to suspend your FEHB enrollment, contact the Human Resources office or retirement system that handles your account.

Time limitations and other restrictions apply. For instance, you must submit documentation that you are suspending FEHB for one of the reasons stated above in case you wish to reenroll in the FEHB Program at a later time.

If you had suspended FEHB coverage for one of these reasons (and had submitted the required documentation) but now want to enroll in the FEHB Program again, you may enroll during Open Season. You may reenroll outside of Open Season only if you *involuntarily* lose coverage under one of these programs. For more information on enrolling in the FEHB Program, contact your Human Resources office or retirement system.

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.

- **Group Benefits.** Under Spouse Equity coverage, you pay the total monthly premium. Under TCC, you pay the total monthly premium plus a 2 percent administrative charge.

- **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, Consumer Driv en plans, or High Deductible Health Plans.

- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enroll ment. This year the Open Season runs from November 13, 2006, through December 11, 2006.

- **Continued Group Coverage.** Eligibility for you or your family members may continue follow ing your retirement, divorce or death. See your Human Resources office or retirement system for more information.

- **Coverage after FEHB Ends.** You or your family members may be eligible for conversion to non group (private) coverage when FEHB coverage ends. See your Human Resources 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; read the Patients' Bill of Rights and the FEHB Program; and learn about your privacy protections when it comes to your medical information.

FEHB

Federal Employees
Health Benefits Program

Better Information
Better Choices
Better Health

FEHB Web Resources

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

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

- An interactive tool that allows you to make side by side comparisons of the costs, benefits, and quality indicators of the plans in your area.
- All health plan brochures and plan website addresses.
- A comparison of how FEHB plans perform in important medical areas under the Health Plan Employer Data and Information Set (HEDIS). HEDIS is a set of performance measures that allows users to compare managed care health plan performance across specific clinical areas. The performance measures are related to many significant diseases such as cancer, heart disease, asthma, and diabetes. Compare plan results at www.opm.gov/insure/health/hedis2007.
- Information on enrolling, including online enrollment for 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 more information on FEHB policies and procedures.
- Information on High Deductible Health Plans at www.opm.gov/hsa
- Information on FEHB plans that have demonstrated their commitment to health information technology (HIT) by making consumer's personal health information available to them through state of the art HIT capabilities.

Picking a Health Plan

Step 3: Think quality.

We have several sources for reviewing quality information: accreditation (independent evaluations from private organizations) and member survey results (evaluations by current plan members). How plans perform on clinical measures of common conditions is shown on our website at www.opm.gov/insure/health/hedis2007.

HMO Accreditation. Accreditation is a "seal of approval" granted by an accrediting organization. Health plans must meet national standards to be accredited. The evaluations are performed by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and URAC. The following are the accreditation levels used by each organization. Check your health plan's brochure for its accreditation level, or look for the Health Plan Accreditation link at www.opm.gov/insure/health.

National Committee for Quality Assurance (www.ncqa.org)	**Excellent** Levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement AND achieve health plan performance results that are in the highest range of national or regional performance	**Commendable** - Meets or exceeds NCQA's requirements for consumer protection and quality improvement.	**Accredited** Meets most of NCQA's requirements for consumer protection and quality improvement.	**Provisional** Meets some but not all of NCQA's requirements for consumer protection and quality improvement.	**New Health Plan** Applies to health plans that are less than two years old.
Joint Commission on Accreditation of Healthcare Organizations (www.jcaho.org)	**Accreditation with Full Compliance** Demonstrates satisfactory compliance with JCAHO standards in all performance areas	**Accreditation with Requirements for Improvement** Demonstrates satisfactory compliance with JCAHO standards in most performance areas	**Provisional** Demonstrates a previously unaccredited plan's satisfactory compliance with a subset of standards.	**Conditional** Demonstrates failure to meet standard(s) or specific policy requirement(s) but is believed capable to do so in a specified time period.	
URAC (www.urac.org)	**Full Accreditation** Demonstrates full compliance with standards	**Conditional** Meets most of the standards but needs some improvement before achieving full compliance.	**Provisional** A plan that has otherwise complied with all standards but has been in operation for less than 6 months.		

Note: This chart shows the accreditation levels available under each accrediting organization listed. It is not intended to draw comparisons among the different accrediting organizations.

Picking a Health Plan

Fee-for-Service/PPO accreditation.

Fee for Service (FFS) plans and their Preferred Provider Organizations (PPO) are organized much differently and perform different functions than Health Maintenance Organizations (HMO) and Point of Service (POS) plans. Consequently, the accreditation of these plans is different from HMOs and POS plans. The following chart shows activities common to FFS/PPO plans and the X indicates that your FFS/PPO plan (or a vendor with which it contracts) has achieved accreditation in these areas.

	Behavioral Health	Care Management	Disease Management	Health Utilization Management	Health Network Accreditation
APWU Health Plan	X	X	X	X	X
Blue Cross and Blue Shield		X			
GEHA			X	X	X
Mail Handlers				X	
NALC	X		X	X	
Association				X	X
Foreign Service	X		X	X	
Rural Carrier			X	X	
SAMBA		X		X	

Behavioral Health a utilization management program that specializes in mental health and substance abuse or chemical dependency services.

Care Management identifying plan members with special healthcare needs, developing a strategy that meets those needs, and coordinating and monitoring the ongoing care.

Disease Management Intensively managing a particular disease. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. Similar to care management but more focused on a defined set of diseases.

Health Utilization Management managing the use of medical services so that a patient receives necessary, appropriate, high quality care in a cost effective manner. It requires plans to use clinical personnel to make decisions.

Health Network Accreditation this standard includes key quality benchmarks for network management, provider credentialing, utilization management, quality management and improvement and consumer protection.

Definitions

Health Savings Account (HSA) - A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pre-tax basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax free, and that amount is available on a tax free basis to pay medical costs. To open an HSA you must be covered under a High Deductible Health Plan and cannot be eligible for Medicare or covered by another plan that is not a High Deductible Health Plan or a general purpose HCFSA or be a dependent on another person's tax return. HSAs are subject to a number of rules and limitations established by the Department of the Treasury. Visit www.ustreas.gov/offices/public.affairs/hsa for more information.

High Deductible Health Plan (HDHP) - A High Deductible Health Plan is a health insurance plan in which the enrollee pays a deductible of at least $1,100 (self only coverage) or $2,200 (family coverage). The annual out of pocket amount (including deductibles and copayments) the enrollee pays cannot exceed $5,250 (self only coverage) or $10,500 (family coverage). HDHPs can have first dollar coverage (no deductible) for preventive care and higher out of pocket copayments and coinsurance for services received from non network providers. HDHPs offered by the FEHB Program establish and partially fund HSAs for all eligible enrollees and provide a comparable HRA for enrollees who are ineligible for an HSA. The HSA premium funding or HRA credit amounts vary by plan.

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

Out-of-Network - You receive treatment from doctors, hospitals, and medical practitioners other than those with whom the plan has an agreement at additional cost. Members in a PPO only option who receive services outside the PPO network generally pay all charges

Point-of-Service (POS) - A product offered by a health plan that has both in network and out of network features. In a POS you don't have to use the plan's network of providers for every service but you generally pay more out of network.

Preferred Provider Organization (PPO) - FFS Plans and many HDHPs use PPOs which are a network of providers. PPOs give you the choice of using doctors and other providers in the network or using non network providers. You don't have to use the PPO, but there are advantages if you do. (Be aware, however, that some of the services provided in a PPO hospital may not be covered by PPO arrangements. Room and board will be covered, but anesthesia and radiology, for instance, may be covered under non PPO benefits.) Note that some FFS plans may offer an enrollment option that is "PPO only." You **must** use network providers to receive benefits from a PPO only plan.

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

Stop Health Care Fraud

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium. OPM's Office of the Inspector General investigates allegations of fraud, waste, and abuse in the FEHB Program 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

- Remember, FEHB covered family members may not include:
  - 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 became incapable of self support before age 22.
- If you have any questions about the eligibility of a dependent, check with your Human Resources office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Plan Comparisons

Nationwide Fee-For-Service Plans Open to All

(Pages 14 through 17)

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

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

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

Nationwide Fee-for-Service Plans Open to All

How to read this chart:

The chart 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.

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

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

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

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

Plan name	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
[illegible]	800 222 2798	471	472	416.24	941.14	424.56	959.96
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	431.64	988.41	440.27	1008.18
Blue Cross and Blue Shield Service Benefit Plan Basic (BCBS)	Local phone #	111	112	329.29	771.29	335.88	786.72
GEHA Benefit Plan High (GEHA)	800 821 6136	311	312	512.44	1115.27	522.69	1137.58
[illegible]	800 821 6136	314	315	288.41	655.40	294.18	668.51
Mail Handlers Benefit Plan High (MH)	800 410 7778	451	452	680.29	1434.88	693.90	1463.58
[illegible]	800 410 7778	454	455	412.97	922.09	421.23	940.53
NALC	888-636-6252	321	322	447.07	955.20	456.01	974.30

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

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

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

Plan	Benefit Type	Medical-Surgical – You Pay								
		Deductible			Copay ($)/Coinsurance (%)					
		Per Person		Hospital Inpatient	Doctors		Hospital Inpatient	Prescription Drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services	R&B	Level I	Level II / Level III	Mail Order Discounts
[illegible]	PPO	$275	None	None	$18	10%	10%	$8	25%/25%	Yes
	Non-PPO	$500	None	$300	30%	30%	30%	50%	50%/50%	No
BCBS Std	PPO	$250	None	$100	$15	10%	Nothing	25%	25%/25%	Yes
	Non-PPO	$250	None	$300	25%	25%	30%	45%+	45%+/45%+	No
[illegible] Basic	PPO	None	None	$100/day x 5	$20	$100	Nothing	$10	$30/$35 or 50%	No
CIGNA High	PPO	$350	None	$100	$20	10%	Nothing	$5	25%/N/A	No
	Non PPO	$350	None	$300	25%	25%	Nothing	$5	25%+/N/A	No
[illegible] Std	PPO	$400	None	None	$10	15%	15%	$5	50%/50%	No
	Non PPO	$400	None	None	35%	35%	35%	$5	50%+/50%+	No
MII High	PPO	$300	None	$100	$20/$10	10%	Nothing	$10	$25/$40	Yes
	Non PPO	$350	None	$300	30%	30%	30%	50%	50%/50%	Yes
MII Std	PPO	$350	None	$200	$20/$10	10%	Nothing	$10	$30/$50	Yes
	Non PPO	$450	None	$400	30%	30%	30%	50%	50%/50%	Yes
NALC	PPO	$250	None	None	$20	Nothing/10%	Nothing/10%	25%	25%/25%	Yes
	Non PPO	$300	$25	$100	30%	30%	30%	50%+	50%+/50%+	No

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 (with national averages for Fee for Service plans in each category)						
Plan Name	**Plan Code**	Overall plan satisfaction 79.4	Getting needed care 86.9	Getting care quickly 83.6	How well doctors communicate 94.1	Customer service 73.7	Claims processing 94.6
[illegible]	47	86.8	88.4	85.3	94.7	72.8	95.1
Blue Cross and Blue Shield Service Benefit Plan Std	10	80.2	89.7	84.6	93.9	77.8	96.1
[illegible]	11	62.8	85.3	80.7	92.5	71.8	92.9
GEHA Benefit Plan High	31	83.9	86.6	84.1	94.2	75.8	98.7
[illegible]	31	72.2	85.2	83	94	75	96.6
Mail Handlers Benefit Plan High	45	71.2	86.7	81.9	93.3	69.1	89.5
[illegible]	45	80.3	85.6	82.9	93.3	74.8	93.5
NALC	32	86.9	89.8	86.4	94.7	79.4	97.8

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Plan Comparisons

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

(Pages 20 through 22)

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

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

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

How to read this chart:

The chart 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.

For 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.

Usually, one day of **Hospital Inpatient Room and Board** covered charges is shown.

Plan Name	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
[illegible]	800 634 0069	421	422	440.16	1,013.98	448.96	1,034.26
Foreign Service Benefit Plan (FS)	202 833 4910	401	402	417.39	996.91	425.74	1,016.85
[illegible]	800 424 8156	431	432	374.51	781.73	382	797.36
Rural Carrier Benefit Plan (Rural)	800-638-8432	381	382	498.68	1,014.63	508.65	1,034.92
8	800 638 6589	441	442	518.27	1,220.53	528.64	1,244.94

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

Mail Order Discounts If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (i.e., 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 if it is not superior to its pharmacy benefit, the plan's response is "no."

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

Plan	Benefit Type	Medical-Surgical – You Pay								
		Deductible			Copay ($)/Coinsurance (%)					
		Per Person		Hospital Inpatient	Doctors		Hospital Inpatient	Prescription Drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services	R&B	Level I	Level II / Level III	Mail Order Discounts
[illegible]	PPO	$300	None	$100	$10	10%	Nothing	$5	$25/30% or $40	Yes
	Non PPO	$300	None	$300	30%	30%	Nothing	$5	$25/30% or $40	Yes
FS	PPO	$300	None	Nothing	10%	10%	Nothing	25%/$15 min.	25%/$25 min./N/A	Yes
	Non PPO	$300	None	$200	30%	30%	Nothing	25%/$15 min.	25%/$25 min./N/A	Yes
[illegible]	POS	None	None	$50	$10	Nothing	Nothing	40%	40%/40%	No
	[illegible]	None	None	$125	50%	50%	50%	40%	40%/40%	No
Retail	PPO	$350	$200	$100	$20	10%	Nothing	30%	30%/30%	Yes
	Non PPO	$400	$200	$300	25%	20%	Nothing	30%	30%/30%	Yes
[illegible]	PPO	$250	None	$200	$20/$0	10%	Nothing	$10	$25/$40	Yes
	Non PPO	$250	None	$300	30%	30%	30%	$10	$25/$40	Yes
SAMBA Std	PPO	$250	None	$200	$20/$0	15%	Nothing	$10	$30 + 1 refill/$45 + 1 refill	Yes
	Non PPO	$250	None	$300	30%	30%	30%	$10	$30 + 1 refill/$45 + 1 refill	Yes

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

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 (with national averages for Fee for Service plans in each category)						
Plan Name	**Plan Code**	Overall plan satisfaction 79.4	Getting needed care 86.9	Getting care quickly 83.6	How well doctors communicate 94.1	Customer service 73.7	Claims processing 94.6
[illegible]	42	85.1	87.3	84.6	95.3	77.3	96.6
Foreign Service Benefit Plan	40	77.2	82.4	80.8	92.6	67.4	92.5
[illegible]	43						
Rural Carrier Benefit Plan	38	84.6	91.1	86.5	94.8	79.2	96.5
[illegible]	44	79.5	87.5	83	94.7	70	91.7
NALC Std	44	78.3	84.9	84.9	95.6	67.3	91.4

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results (with national averages for HMO/POS plans in each category)					
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction 67	Getting needed care 80	Getting care quickly 79.3	How well doctors communicate 91.9	Customer service 72.5	Claims processing 85.2
District of Columbia											
[illegible] High	$15/$25	$150/day x3	$10	$25/$40	No	63.1	74.7	75.4	91.6	72.2	91.7
[illegible] Open Access Basic	$20/$30	$150/day x5	$10	$25/$40	No						
[illegible] Choice	$20/$30	$100 per adm	$10	$25/$40	Yes	65.7	77.4	76.8	91.5	67.9	84.8
Kaiser Foundation Health Plan Mid-Atlantic States-High	$10/$20	$100	$10/$20 Net	$20/$40/$35/$55	Yes	60.5	70.9	69.5	86.7	70.5	83.5
Kaiser Foundation Health Plan Mid Atlantic States Std	$30/$40	$250/dayx3	$15/$25Net	$25/$45/$40/$60	Yes						
M.D. IPA	$10/$20	$100	$7	$25/$40	No	61.9	74.8	71.6	87.8	76.7	92.4
Florida											
[illegible] Health Plan High	$15/$40	$150/dayx5	$15	$30/$50	No	77.2	81.4	72.6	89.2	77.9	84.4
Aetna Health Plan Std	$25/$45	$175/dayx5	$20	$40/$60	No						
[illegible]	$15/$25	$250	$15	$30/$50	No	81.7	82.1	75.6	91.1	82.5	97.1
Humana Medical Plan, Inc.	$15/$25	$200/day x 3	$10	$30/$50	No	63.8	73.1	69	88.3	73.7	87.8
[illegible]	$15/$25	$100/day x 5	$5	50%/50%	Yes						
Vista Healthplan of South Florida	$15/$30	$250 + $150x3 days	$20	$40/$60/20%	No	51.7	67	61.5	85.9	64.7	77.2
Georgia											
[illegible]	$20/$30	$150/day x 5	$10	$25/$40	Yes	65.2	77.1	76.5	91.7	70.8	88.7
Kaiser Foundation Health Plan Of GA, Inc.-High	$10/$20	$250	$10/$16	$20/$26/$20/$26	No	67.1	78.3	72.3	89	74.7	89
Kaiser Foundation Health Plan Of GA, Inc. Std	$15/$25	$250/dayx3	$15/$21	$25/$31/$25/$31	No						
United Healthcare of Georgia	$15/$30	$200 per day	$7	$25/$40	Yes						
Hawaii											
[illegible]	$10/$25	$100	$5	$10/$20	No	70.4	75	68.9	89.8	70.8	75.4
QuikCare Std	$15/$25	$250	$10	$20/$30	No	70	74.1	67.2	89.1	73.9	77.8
HMSA											
HMSA	In Network	$15/$15	None	$5	$20/50%	Yes	77.7	85.8	83.1	95	73.8	94.5
HMSA	Out of Network	30% sch + /30% sch +	30% sch +	$5 + 20% +	$20 + 20% + /50% +	No	77.7	85.8	83.1	95	73.8	94.5
Kaiser Foundation Health Plan of Hawaii-High		$12/$12	None	$10	$10/$10	Yes	65.7	75.2	72.4	91.8	71.5	85.1
Kaiser Foundation Health Plan of Hawaii Std		$20/$20	10%	$10	$10/$10	Yes						

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results (with national averages for HMO/POS plans in each category)					
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction 67	Getting needed care 80	Getting care quickly 74.3	How well doctors communicate 91.9	Customer service 72.5	Claims processing 89.2
[illegible]											
[illegible] Group Health Cooperative High	$15/$15	$200/day x 3	$15	$25/$50	Yes	67	79.2	83.8	92.7	74.8	89
Group Health Cooperative Std	$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes						
[illegible]											
[illegible] Open Access	$20/$30	$150/day x 5	$10	$25/$40	Yes	54.6	71.9	76.6	90.2	68.6	85.2
BlueCHOICE	$15/$15	$200	$10	$20/$30	Yes	70.5	79.6	81.7	92.5	71.3	96
[illegible] Plan Inc High	$20/$20	$200/day X 2	$10	$20/$45	Yes	73.7	85.8	81.6	94.2	74.9	95.7
Health Alliance HMO	$15/$15	$250	$10	$20/$40	No	75.6	83.4	84.8	93	76.3	93.7
[illegible]	$15/$25	$200/day x 3	$10	$25/$45/25%	No						
[illegible] Health Plan Inc. Std	$20/$30	$400/day x 3	$10	$25/$45/25%	No	55	76.3	74.1	89.8	65.1	75.5
[illegible]	$20/$20	$500	$10	$20/$40	Yes	75.8	81.4	85.8	95.4	76.9	92.4
PersonalCare HMO	$20/$20	$100/day x 5	$10	$20/$50	No	78.2	83.5	83.5	93.2	79.4	93
[illegible]	$15/$15	None	$5	$15/$25	Yes	61.8	72.4	72.8	89.6	69.8	77.3
[illegible] HMO Std	$20/$35	10%	$10	$25/$45	Yes						
[illegible]	$10/$10	None	$15	$15/$15	No						
United Healthcare of the Midwest	$10/$20	$250	$7	$25/$50	Yes	66.7	88.5	84.5	94.9	61.2	89.1
[illegible] Healthcare Plan of the River Valley Inc.	$15/$30	$100/5 days	$10	$30/$45	Yes	69.6	83.3	81.2	91.9	77	94.2
[illegible]											
[illegible] Health Solutions Inc High	$15/$30	$400x2/yr	$10	$30/$50	Yes	57	79	83.3	95.8	68	88.6
[illegible] Open Access	$20/$30	$150/day x 5	$10	$25/$40	Yes	54.6	71.9	76.6	90.2	68.6	85.2
[illegible]	$20/$30	$150/day x 5	$10	$25/$40	Yes	63.3	80.2	85	93.3	71.7	91.5
[illegible] HMO	$15/$25	$200	$10	$20/$40	Yes	73.6	86.6	85.7	93.4	76.4	93.4
[illegible] HMO	$15/$15	$250	$10	$20/$40	No	75.6	83.4	84.8	93	76.3	93.7
Humana Health Plan Inc. High	$15/$25	$200/day x 3	$10	$25/$45/25%	No	55	76.3	74.1	89.8	65.1	75.5
[illegible] Health Plan Inc Std	$20/$30	$400/day x 3	$10	$25/$45/25%	No						
[illegible] Plan	$10/$35	$100/day x 5	$5/$15	$25/50%	Yes						
[illegible] Health Plan of Northern Indiana	$15/$15	20%	$10	$20/$40/25%	Yes	64	88.6	84.4	93.5	75.5	95.5
[illegible] HMO High	$15/$15	None	$5	$15/$25	Yes	61.8	72.4	72.8	89.6	69.8	77.3
[illegible]	$20/$35	10%	$10	$25/$45	Yes						

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results (with national averages for HMO/POS plans in each category)					
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction 67	Getting needed care 80	Getting care quickly 79.3	How well doctors communicate 91.9	Customer service 72.5	Claims processing 89.4
New York											
Aetna Open Access High	$20/$30	$150/day x 5	$10	$25/$40	Yes	64.8	78.6	76.9	89.3	72.5	88.1
Aetna Open Access Basic	$15/$30	$500/day x 10	$5	$30/$50	Yes						
[illegible]	$20/$20	$100	$10	$25/$40	No	64.5	82.4	84.8	92.2	66.5	94.6
CDPHP Universal Benefits-High	$20/$30	$100 X 5	25%	25%/25%	No						
[illegible]	$25/$40	$500 + 10%	30%	30%/30%	No	79.3	86.7	83.7	94.7	82	96.2
CHE Health Plan In Network	$15/$15	$100/admx2	$15	$25/$50	Yes	57.3	76.1	75.8	90.4	64.3	88.2
CHE Health Plan Out-of-Network	+ 50% of sch./+ 50% of sch.	+ 50% of sch.	N/A	N/A	No	57.3	76.1	75.8	90.4	64.3	88.2
[illegible]	$25/$25	$250/daysx3	$10	$25/$50	Yes						
CHE HMO Select High	$10/$10	None	$10	$20/$30	Yes						
[illegible]	$20/$20	None	$10	$20/$30	Yes	51.1	75.1	80.5	92.5	66.9	78.3
CHE HMO Select High	$10/$10	None	$10	$20/$30	Yes						
[illegible]	$20/$20	None	$10	$20/$30	Yes	51.1	75.1	80.5	92.5	66.9	78.3
HIP of Greater New York High	$10/$10	None	$10	$15/$40	Yes	61.9	71.3	67.2	87.1	69.8	84.1
[illegible]	$10/$20	$500	$10	$20/$40	Yes						
HMO Blue	$20/$20	$240	$10	$25/$40	No	62.7	81.4	83.2	93.9	67.2	90.8
[illegible]	$20/$20	$240	$10	$25/$40	No	62.7	81.4	83.2	93.9	67.2	90.8
Independent Health Assoc In-Network	$15/$15	None	$10	$20/$35	No	76.7	87.6	82.9	95.1	78.3	95.6
Independent Health Assoc Out of Network	Ded. + 25%/25%	Ded. + 25%	N/A	N/A	No	76.7	87.6	82.9	95.1	78.3	95.6
[illegible]	$20/$20	$240 per year	$10	$30/$50	Yes	69.7	84.8	83.9	94.6	79	91.4
MVP Health Care Std	$25/$40	$500	$10	$30/$50	Yes						
[illegible]	$20/$20	$240 per year	$10	$30/$50	Yes	69.7	84.8	83.9	94.6	79	91.4
MVP Health Care Std	$25/$40	$500	$10	$30/$50	Yes						
[illegible]	$20/$20	$240 per year	$10	$30/$50	Yes	69.7	84.8	83.9	94.6	79	91.4
MVP Health Care-Std	$25/$40	$500	$10	$30/$50	Yes						
[illegible]	$20/$20	$250	$10	$30/$50	Yes	76.1	86.3	85.9	94.6	80.4	92.5
Oxford Healthcare	$20/$20	None	$10	$20/$45	No	73.5	83.6	82.7	92.4	77.9	94.6
[illegible]	$20/$20	None	$10	$20/$45	No	73.5	83.6	82.7	92.4	77.9	94.6
North Carolina											
Aetna Open Access	$20/$30	$150/day x 5	$10	$25/$40	Yes						

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

See page 23 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
North Dakota							
[illegible] Open Access Deductible - Eastern North Dakota	952 883 5000	534	535	434.79	1000.03	443.49	1020.03
Heart of America Health Plan - Northcentral North Dakota	800-525-5661	RU1	RU2	324.46	833.82	330.95	850.50
Ohio							
Aetna Open Access - Cleveland and Toledo Areas	800 537 9384	7D1	7D2	392.62	934.48	400.47	953.17
Aetna Open Access - Columbus Area	800-537-9384	ND1	ND2	382.29	922.83	389.94	941.29
Aetna Open Access - Greater Cincinnati Area	800 537 9384	RD1	RD2	437.95	1082.86	446.71	1104.52
AultCare HMO High - Stark/Carroll/Holmes/Tuscarawas/Wayne Co.	330-363-6360	3A1	3A2	478.92	1175.76	488.50	1199.28
[illegible]	800 228 4375	R51	R52	507.67	1160.79	517.82	1184.01
CHN Health Ohio - Northeast Ohio	800-522-2066	L41	L42	433.36	1108.55	442.03	1130.72
Kaiser Foundation Health Plan of Ohio High - Cleveland/Akron areas	800 686 7100	641	642	451.08	1106.91	460.10	1129.05
Kaiser Foundation Health Plan of Ohio-Std - Cleveland/Akron areas	800-686-7100	644	645	342.49	840.39	349.34	857.20
[illegible] - Northwest/North Central Ohio	800 462 3589	P21	P22	462.24	1223.78	471.48	1248.26
SummaCare Health Plan - Cleveland, Akron and Canton areas	330-996-8700	5W1	5W2	435.02	1044.07	443.72	1064.95
[illegible] - Northeast Ohio	800 522 2066	5M1	5M2	687.81	1759.40	701.57	1794.59
The Health Plan of the Upper Ohio Valley - Eastern Ohio	800-624-6961	U41	U42	360.77	829.77	367.99	846.37
[illegible] - Cleveland	877 835 9861	AK1	AK2	390.00	936.07	397.80	954.79
United Healthcare of Ohio, Inc. - Columbus	877-835-9861	CA1	CA2	438.17	1011.05	446.93	1031.27
Oklahoma							
Aetna Open Access High - Oklahoma City/Tulsa Areas	800-537 9384	SL1	SL2	467.63	1084.85	476.98	1106.55
Aetna Open Access-Basic - Oklahoma City/Tulsa Areas	800-537-9384	SL4	SL5	329.85	885.11	336.45	902.81
[illegible] - Oklahoma	877 280 2990	IM1	IM2	361.75	871.87	368.99	889.31
PacifiCare of Oklahoma - Central/Northeastern Oklahoma	866-546-0510	2N1	2N2	448.41	1048.71	457.38	1069.68
Oregon							
Kaiser Foundation Health Plan of Northwest High - Portland/Salem areas	800 813 2000	571	572	454.07	1044.38	463.15	1065.27
Kaiser Foundation Health Plan of Northwest-Std - Portland/Salem areas	800-813-2000	574	575	376.44	865.84	383.97	883.16
[illegible] - Metro Portland/Salem/Corvallis/Eugene	866 546 0510	7Z1	7Z2	483.75	1085.37	493.43	1107.08

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results (with national averages for HMO/POS plans in each category)					
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction 67	Getting needed care 80	Getting care quickly 79.3	How well doctors communicate 91.9	Customer service 72.5	Claims processing 89.2
Pennsylvania											
Aetna Open Access High	$20/$30	$150/day x 5	$10	$25/$40	Yes	61.6	80.3	79.9	93.6	70	91.8
Aetna Open Access Basic	$15/$30	$500/day x 10	$5	$30/$50	Yes						
Aetna Open Access	$20/$30	$150/day x 5	$10	$25/$40	Yes	61.6	80.3	79.9	93.6	70	91.8
Geisinger Health Plan-High	$15/$25	Nothing	$10	$25/$40	Yes						
Geisinger Health Plan Std	$20/$35	Nothing afth Ded	$15	$30/$45	Yes						
HealthAmerica Pennsylvania-High	$10/$25	None	$5	$25/$40	Yes	66.9	87.2	84.1	93.5	77	93.8
HealthAmerica Pennsylvania Std	$20/$30	Ded. + 10%	$5	$35/$50	Yes	65.5	82.1	83.9	95.5	75.1	92
HealthAmerica Pennsylvania-High	$10/$25	None	$5	$25/$40	Yes	66.9	87.2	84.1	93.5	77	93.8
HealthAmerica Pennsylvania Std	$20/$30	Ded. + 10%	$5	$35/$50	Yes	65.5	82.1	83.9	95.5	75.1	92
HealthAmerica Pennsylvania High	$10/$25	None	$5	$25/$40	Yes	66.9	87.2	84.1	93.5	77	93.8
HealthAmerica Pennsylvania Std	$20/$30	Ded. + 10%	$5	$35/$50	Yes	65.5	82.1	83.9	95.5	75.1	92
HealthAmerica Pennsylvania High	$10/$25	None	$5	$25/$40	Yes	66.9	87.2	84.1	93.5	77	93.8
HealthAmerica Pennsylvania Std	$20/$30	Ded. + 10%	$5	$35/$50	Yes	65.5	82.1	83.9	95.5	75.1	92
Keystone Health Plan Central High	$15/$20	$200 copay	$10	$25/$40	Yes	75.4	80.3	81.7	92.3	71.9	90.1
Keystone Health Plan Central Std	$20/$25	$100 x 5	$5	$35/$60	Yes						
Keystone Health Plan East High	$20/$25	$125 perday x 5	$10	$20/$35	Yes	60.3	79.2	78.4	92.3	69.7	87.8
Keystone Health Plan East Std	$20/$40	20% after ded	$20	$40/$60	Yes						
UPMC Health Plan-High	$20/$20	None	$10	$20/$40	Yes	65.8	87.3	80.6	91.4	80.4	93.4
Puerto Rico											
Humana Health Plans of PR Inc. In Network	$5/$5	None	$2.50	$8/$12/30%	No	82.5	86	70.2	92.5	72.7	80.4
Humana Health Plans of PR Inc. Out of Network	$8/$8	$50	N/A	N/A/N/A	No	82.5	86	70.2	92.5	72.7	80.4
Triple S In-Network	$7.50/$10	None	$5	$8/$12	Yes	82.8	92.6	75.5	95.3	83.9	83.7
Triple S Out-of-Network	$7.50 + 10%/$10 + 10%	None	25%	25%/25%	No	82.8	92.6	75.5	95.3	83.9	83.7
Rhode Island											
BCBS of RI Coordinated Health Plan											
BCBS of RI In Network	$15/$25	$500	$7	$30/$50	Yes	62.2	86.9	81.7	93.9	68.5	85.6
BCBS of RI Coordinated Health Plan											
BCBS of RI Out of Network	30%/30%	None	$50 + 20%	$50 + 20%	No	62.2	86.9	81.7	93.9	68.5	85.6

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results (with national averages for HMO/POS plans in each category)					
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction 67	Getting needed care 80	Getting care quickly 79.3	How well doctors communicate 91.9	Customer service 72.5	Claims processing 89.2
South Carolina											
[illegible]	$20/$30	$500	$10	$20/$50	Yes	58.5	85.4	81.6	93.8	65.8	86.4
South Dakota											
[illegible] Open Access Deductible	$15/$15	$100	$6	$12/$35	No	74	83.6	85.8	92.1	73.2	91.5
Sioux Valley Health Plan - In Network	$20/$30	$100/day x 5	$15	$30/$50	No	49.6	81.3	83.8	94	70	89.8
Sioux Valley Health Plan - Out-of-Network	40%/40%	40%	N/A	N/A	No	49.6	81.3	83.8	94	70	89.8
[illegible] Health Plan - In Network	$25/$25	$100/day x 5	$15	$30/$50	No						
[illegible] Health Plan - Out of Network	40%/40%	40%	N/A	N/A/N/A	No						
Tennessee											
[illegible] Open Access	$20/$30	$150/day x 5	$10	$25/$40	Yes	73.5	80.6	77.2	94	71.5	83.2
Aetna Open Access	$20/$30	$150/day x 5	$10	$25/$40	Yes	73.5	80.6	77.2	94	71.5	83.2
Texas											
[illegible] Open Access	$20/$30	$150/day x 5	$10	$25/$40	Yes	64	75.8	76	90.1	70.6	86.8
Aetna Open Access	$20/$30	$150/day x 5	$10	$25/$40	Yes	61.3	76.6	76.2	91.1	71.7	92.9
[illegible] Open Access High	$20/$30	$150/day x 5	$10	$25/$40	Yes	64.9	73.3	78.1	90.9	66.2	91.3
Aetna Open Access Basic	$15/$30	$500/day x 10	$5	$30/$50	Yes						
[illegible]	$20/$40	$150/dayX5	$10	$20/$40	No	70.6	82.4	82.8	92.8	76.7	94.7
[illegible]-Care	$20/$40	$150/dayX5	$10	$20/$40	No	64.2	83.1	77.5	91.2	74.1	93.7
[illegible] Texas	$20/$30	$150/dayx5	$10	$25/$40	Yes	67.6	74.6	71.6	89.1	70.1	86.8
Humana Health Plan of Texas-High	$15/$25	$200/day x 3	$10	$30/$50/25%	No	69.2	80.5	75.2	89.3	75.5	87.1
Humana Health Plan of Texas Std	$20/$30	$400/day x 3	$10	$30/$50/25%	No						
Mercy Health Plans - In Network	$10/$10	None	$7	$12/$25	Yes	79	81.8	71.5	91.8	82.6	96.6
Mercy Health Plans - Out-of-Network	40%/40%	40%	N/A	N/A/N/A	No	79	81.8	71.5	91.8	82.6	96.6
[illegible] of Texas	$20/$40	$250/day x 3	$10	$30/$50	Yes	69.8	81.6	79.5	91.1	74.5	89.3
Utah											
[illegible] Plans High	$10/$15	None	$10	$20/$40	Yes	60	77.4	77.5	92.4	67.7	88.4
Vermont											
MVP Health Care High	$20/$20	$240	$10	$30/$50	Yes	69.7	84.8	83.9	94.6	79	91.4
MVP Health Care Std	$25/$40	$500	$10	$30/$50	Yes						

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

See page 23 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Virgin Islands							
Aetna US Virgin Islands	800 981 3241	851	852	392.56	891.50	400.41	909.33
Virginia							
Aetna Open Access High - Northern/Central/Richmond Virginia Area	800 537 9384	JN1	JN2	483.21	1082.34	492.87	1103.99
Aetna Open Access-Basic - Northern/Central/Richmond Virginia Area	800-537-9384	JN4	JN5	302.86	708.70	308.92	722.87
[illegible] Blue Cross - Northern Virginia	866 296 7363	2G1	2G2	434.76	978.03	443.46	997.59
Kaiser Foundation Health Plan Mid-Atlantic States-High -Washington, DC area	800-777-7902	E31	E32	427.66	1007.74	436.21	1027.89
Kaiser Foundation Health Plan Mid Atlantic States Std - Washington DC area	800 777 7902	E34	E35	254.76	606.30	259.86	618.43
MD IPA - N VA/Cntrl VA/Richmond/Tidewater/Roanoke	800-251-0956	JP1	JP2	421.29	971.49	429.72	990.92
[illegible] Plan - Hampton Roads and Richmond areas	800 206 1060	9R1	9R2	448.05	1060.15	457.01	1081.35
Piedmont Community Healthcare High - Lynchburg area	888-674 3368	2C1	2C2	427.31	978.49	435.86	998.06
Washington							
Aetna Open Access - Seattle and Puget Sound Areas	800 537 9384	8J1	8J2	439.40	1117.44	448.19	1139.79
Group Health Cooperative-High -Most of Western Washington	888-901-4636	541	542	444.71	1003.97	453.60	1024.05
Group Health Cooperative Std - Most of Western Washington	888 901 4636	544	545	373.95	844.20	381.43	861.08
Group Health Cooperative-High -Central WA/Spokane/Pullman	888-901-4636	VR1	VR2	492.14	1131.87	501.98	1154.51
Group Health Cooperative Std - Central WA/Spokane/Pullman	888 901 4636	VR4	VR5	381.72	877.93	389.35	895.49
Kaiser Foundation Health Plan of Northwest-High -Vancouver/Longview	800-813-2000	571	572	454.07	1044.38	463.15	1065.27
Kaiser Foundation Health Plan of Northwest Std - Vancouver/Longview	800 813 2000	574	575	376.44	865.84	383.97	883.16
KPS Health Plans Std - All of Washington	800-552-7114	L11	L12	372.28	803.51	379.73	819.58
[illegible] Plans - All of Washington	800 552 7114	VT1	VT2	454.59	993.33	463.68	1013.20
PacifiCare of Oregon - Clark County	800 546-0510	7Z1	7Z2	483.75	1085.37	493.43	1107.08
[illegible] of Washington - Puget Sound/Most of Western Washington	866 546 0510	SA1	SA2	371.37	870.11	378.80	887.51

Plan Name		Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results (with national averages for HMO-POS plans in each category)					
				Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction 67	Getting needed care 80	Getting care quickly 79.3	How well doctors communicate 91.9	Customer service 72.5	Claims processing 89.2
Virgin Islands												
[illegible]	In Network	$7.50/$10	None	$5	$8/$12	Yes						
[illegible]	Out of Network	$7.50 + 10%/$10 + 10%	None	25%	25%/25%	No						
Virginia												
[illegible] Access High		$15/$25	$150/day x3	$10	$25/$40	No	63.1	74.7	75.4	91.6	72.2	91.7
[illegible] Access Basic		$20/$30	$150/day x5	$10	$25/$40	No						
[illegible] Blue Choice		$20/$30	$100 per adm	$10	$25/$40	Yes	65.7	77.4	76.8	91.5	67.9	84.8
Kaiser Foundation Health Plan Mid-Atlantic States-High		$10/$20	$100	$10/$20 Net	$20/$40/$35/$55	Yes	60.5	70.9	69.5	86.7	70.5	83.5
Kaiser Foundation Health Plan Mid Atlantic States Std		$30/$40	$250/dayx3	$15/$25Net	$25/$45/$40/$60	Yes						
M.D. IPA		$10/$20	$100	$7	$25/$40	No	61.9	74.8	71.6	87.8	76.7	92.4
[illegible] Health Plan		$10/$20	$250	$10	$20/$40	Yes	74.2	83.8	78.8	93.2	80	96.3
Piedmont Community Healthcare	In Network	$25/$25	20%	$15	$30/$55	Yes						
Piedmont Community Healthcare	Out of Network	30%/30%	30%	$15	$30/$55	Yes						
Washington												
[illegible] Access		$20/$30	$150/day x 5	$10	$25/$40	Yes	59.4	74.9	84.1	92.9	64.4	83.9
Group Health Cooperative-High		$15/$15	$200/day x 3	$15	$25/$50	Yes	67	79.2	83.8	92.7	74.8	89
[illegible] 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	67	79.2	83.8	92.7	74.8	89
Group Health Cooperative Std		$20 + 20%/$20 + 20%	$200/day x 3	$20	$30/$60	Yes						
Kaiser Foundation Health Plan of Northwest-High		$15/$15	$100	$15	$30/$30	Yes	64.1	75.9	72.9	88.8	73.2	88.4
Kaiser Foundation Health Plan of Northwest Std		$20/$30	$250	$20	$40/$40	Yes						
KPS Health Plans	In Network	$15/3 or 20%/20%	$100/day x 5	$10	$30/50%	Yes	72.1	87.2	87.4	93.2	76.1	93.7
KPS Health Plans	Out of Network	$15/3 or 45%/45%	$100/day x 5	Not Covered	Not Covered/Not Covered	No	72.1	87.2	87.4	93.2	76.1	93.7
[illegible] Health Plans	In Network	$20/$20	None	$5	$20/50%	Yes	78.7	88.7	88.7	94.4	78	94.3
KPS Health Plans	Out of Network	$20 + 45%/$20 + 45%	None	Not covered	N/A/N/A	No	78.7	88.7	88.7	94.4	78	94.3
Pacific [illegible] of Oregon		$15/$30	$200/day x 3	$10	$30/$50	Yes	57.9	81.3	86	95.4	63.3	88.9
[illegible] of Washington		$15/$30	$200/day x 3	$10	$30/$50	Yes	63.8	80.8	85.4	95.2	64.4	87.5

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

See page 23 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
West Virginia							
[illegible] Upper Ohio Valley - Northern/Central West Virginia	800 624 6961	U41	U42	360.77	829.77	367.99	846.37
Wisconsin							
[illegible] Plan - South Central Wisconsin	800 279 1301	WD1	WD2	402.76	1067.32	410.82	1088.67
Group Health Cooperative - South Central Wisconsin	608-828-4827	WJ1	WJ2	361.99	965.01	369.23	984.31
[illegible] Classic - Wisconsin	952 883 5000	531	532	554.21	1275.73	565.29	1301.24
HealthPartners Open Access Deductible - Wisconsin	952-883-5000	534	535	434.79	1000.03	443.49	1020.03
[illegible] Primary Choice Plan - West Central Wisconsin	952 883 5000	HQ1	HQ2	650.63	1497.71	663.64	1527.66
Wyoming							
[illegible] Partners - Wyoming	307 638 7700	PV1	PV2	483.21	1106.50	492.87	1128.63

High Deductible and Consumer-Driven Health Plans

Nationwide and Regional High Deductible Health Plans with a Health Savings Account or Health Reimbursement Arrangement and Consumer-Driven Plans

(Pages 52 through 73)

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

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

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

The HDHP features higher annual deductibles (a minimum of $1,100 for Self Only and $2,200 for Self and Family coverage) and annual out of pocket limits (not to exceed $5,250 for Self and $10,500 for Family coverage) than other insurance plans. Depending on the HDHP you choose, you may have the choice of using in network and out of network providers. There may be higher deductibles and out of pocket limits when you use out of network providers. Using in network providers will save you money.

Health Savings Account (HSA)

Health Savings Accounts are available to members who do not have Medicare or another health plan. The amount of the "premium pass through" is based on whether you have a Self Only or Self and Family enrollment. You have the option to make tax free contributions to your account, provided the total contributions do not exceed the limits established by law, which are typically not more than the plan deductible. If you are over 55, you can make an additional "catch up" contribution. You can use funds in your account to help pay your health plan deductible. However, if you enroll in an HDHP with an HSA, you are not eligible to participate in a Health Care Flexible Spending Account.

Features of an HSA include:
- Tax deductible deposits you make to the HSA.
- Tax deferred interest earned on the account.
- Tax free withdrawals for qualified medical expenses.
- Carryover of unused funds and interest from year to year.
- Portability, the account is owned by you and is yours to keep – even when you retire.

Health Reimbursement Arrangement (HRA)

For members who are not eligible for an HSA, have Medicare or another non High Deductible Health Plan, the HDHP will provide and administer a Health Reimbursement Arrangement.

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

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

High Deductible and Consumer-Driven Health Plans

	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
ELIGIBILITY	You must enroll in a High Deductible Health Plan. No other general medical insurance cover age permitted including an HCFSA. You cannot be enrolled in Medicare Part A or Part B.	You must enroll in a High Deductible Health Plan or Consumer Driven Health Plan.
FUNDING	The plan deposits a monthly "premium pass through" into your account. The plan will send you forms to complete to establish your account.	The plan makes a credit into your HRA. The plan will send you forms to complete to establish your account.
CONTRIBUTIONS	The maximum allowed is a combination of the health plan "premium pass through" and the member contribution up to the amount of the plan deductible.	Only that portion of the premium specified by the health plan will be credited. You cannot add your own money to an HRA.
DISTRIBUTIONS	May be used to pay the out of pocket medical expenses for yourself, your spouse, or your dependents, or to pay the plan's deductible. See IRS Publication 502 for a partial list of eligi ble expenses. Over the counter drugs, for instance, are eligible expenses but health bene fit premiums are not.	May be used to pay the out of pocket expenses for qualified medical expenses for individuals covered under the health plan, or to pay the plan's deductible. See IRS Publication 502 for a partial list of eligi ble expenses. Over the counter drugs, for instance, are eligible expenses but health benefit premiums are not.
PORTABLE	Yes, you can take this account with you when you terminate employment or retire.	If you retire and remain in your health plan you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while cov ered under that health plan will be eligible for reimbursement, subject to timely filing require ments. Unused credits are forfeited.
ANNUAL ROLLOVER	Yes, funds accumulate without a maximum cap.	Yes, credits accumulate without a maximum cap.

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

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

High Deductible and Consumer-Driven Health Plans

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

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

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

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

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

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

Plan Name	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self Only	Self & Family	Self Only	Self & Family	Self Only	Self & Family
[illegible] Nationwide	866 833 3463	474	475	354.42	797.33	361.51	813.28
[illegible] High Deductible Health Plan - Nationwide	800-821-6136	341	342	380.81	869.79	388.43	887.19
[illegible] Consumer Option - Nationwide	800 694 9501	481	482	292.98	663.91	298.84	677.19

High Deductible and Consumer-Driven Health Plans

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

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

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

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

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

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs
[illegible] Health Plan	In Network	N/A	$600/$1,200	$3,000/$4,500	15%	None	15%	Nothing	25%/25%/25%
[illegible] Provider	Out of Network	N/A	$600/$1,200	$9,000/$9,000	40%	None	40%	Nothing up to $1200	Not Covered
HSA HDHP	In-Network	$90/$180	$1,500/$3,000	$5,000/$10,000	15%	15%	15%	Nothing	30%/30%/30%
HRA HDHP	Out of Network	$90/$180	$1,500/$3,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
[illegible] Health Plan [illegible]	In Network	$83/$166	$2,000/$4,000	$5,000/$10,000	$15	$75/day $750	Nothing	Nothing	$10/$25/$40
[illegible] Health Plan [illegible]	Out of Network	$83/$166	$2,000/$4,000	$7,500/$15,000	40%	40%	40%	Not Covered	Not Covered

High Deductible and Consumer-Driven Health Plans

See page 52 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self Only	Self & Family	Self Only	Self & Family	Self Only	Self & Family
Alabama							
[illegible] HDHP - Most of Alabama	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Most of Alabama	800-537-9384	224	225	315.97	720.40	322.29	734.81
Alaska							
[illegible] HDHP - Anchorage and Fairbanks Areas	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Anchorage and Fairbanks Areas	800-537-9384	224	225	315.97	720.40	322.29	734.81
Arizona							
[illegible] HDHP - Phoenix and Tucson Areas	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Phoenix and Tucson Areas	800-537-9384	224	225	315.97	720.40	322.29	734.81
[illegible] - Phoenix Area	888 393 6765	DB1	DB2	250.79	576.81	255.81	588.35
Arkansas							
[illegible] HDHP - Little Rock/Central/Northeast/Northwest	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Little Rock/Central/Northeast/Northwest	800-537-9384	224	225	315.97	720.40	322.29	734.81
California							
[illegible] HDHP - Northern/Central Valley/Southern CA	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Northern/Central Valley/Southern CA	800-537-9384	224	225	315.97	720.40	322.29	734.81
Colorado							
[illegible] HDHP - All of Colorado	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - All of Colorado	800 537 9384	224	225	315.97	720.40	322.29	734.81
[illegible] - Denver Area	888 393 6765	7T1	7T2	278.66	640.90	284.23	653.72
Illumina CoverageFirst CDHP - Colorado Springs Area	888 393 6765	FC1	FC2	292.57	672.95	298.42	686.41

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Arizona									
[illegible]	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
[illegible]	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP	In Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	Out-of Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
Arkansas									
Aetna HealthFund CDHP	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
Aetna HealthFund CDHP	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP	In Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	Out-of Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
California									
[illegible]	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
[illegible]	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP	In Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP -	Out-of-Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
[illegible]	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50
[illegible]	Out of Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+
Colorado									
[illegible]	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
[illegible]	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP	In Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	Out-of-Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
Connecticut									
[illegible]	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
[illegible]	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP	In Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP -	Out-of-Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
[illegible]	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50/+
[illegible]	Out of Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+
Aetna CoverageFirst	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50/+
Aetna CoverageFirst	Out of Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+

High Deductible and Consumer-Driven Health Plans

See page 52 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self Only	Self & Family	Self Only	Self & Family	Self Only	Self & Family
Connecticut							
Aetna HealthFund CDHP All of Connecticut	800-537-9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP All of Connecticut	800-537-9384	224	225	315.97	720.40	322.29	734.81
Delaware							
Aetna HealthFund CDHP All of Delaware	800-537-9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP All of Delaware	800-537-9384	224	225	315.97	720.40	322.29	734.81
[illegible] HDHP Most of Delaware	800 833 7423	LK1	LK2	284.05	688.26	289.73	702.03
District of Columbia							
Aetna HealthFund CDHP All of Washington DC	800-537-9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP All of Washington DC	800-537-9384	224	225	315.97	720.40	322.29	734.81
[illegible] Definity HDHP Washington DC, Maryland and Virginia	877 835 9861	E91	E92	273.24	598.72	278.70	610.69
Florida							
Aetna HealthFund CDHP Most of Florida	800-537-9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP Most of Florida	800-537-9384	224	225	315.97	720.40	322.29	734.81
Humana CoverageFirst CDHP Pensacola Area	888 393 6765	BP1	BP2	306.52	704.97	312.65	719.07
Humana CoverageFirst CDHP Daytona Area	888-393-6765	DL1	DL2	334.40	769.10	341.09	784.48
Humana CoverageFirst CDHP Tampa Area	888 393 6765	MJ1	MJ2	306.52	704.97	312.65	719.07
Humana CoverageFirst CDHP Jacksonville Area	888-393-6765	MQ1	MQ2	306.52	704.97	312.65	719.07
Humana CoverageFirst CDHP South Florida Area	888 393 6765	QP1	QP2	278.66	640.90	284.23	653.72
Humana CoverageFirst CDHP - Orlando Area	888-393-6765	YG1	YG2	306.52	704.97	312.65	719.07

High Deductible and Consumer-Driven Health Plans

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

Plan Name	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self Only	Self & Family	Self Only	Self & Family	Self Only	Self & Family
Georgia							
Aetna HealthFund CDHP - Most of Georgia	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Most of Georgia	800 537 9384	224	225	315.97	720.40	322.29	734.81
[illegible] HDHP - Southern/Central	800 755 3901	MM4	MM5	433.81	930.11	442.49	948.71
Humana CoverageFirst CDHP - Atlanta Area	888-393-6765	AD1	AD2	236.84	544.79	241.58	555.69
[illegible] CDHP - Macon Area	888 393 6765	LM1	LM2	292.57	672.95	298.42	686.41
Kaiser Foundation Health Plan of Georgia Inc. HDHP - Atlanta Area	888-865 5813	GW1	GW2	331.11	814.93	337.73	831.23
Idaho							
[illegible] CDHP - Kootenai County	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Kootenai County	800-537-9384	224	225	315.97	720.40	322.29	734.81
Illinois							
[illegible] CDHP - Chicago Area/Eastern/Northern/SW IL	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Chicago Area/Eastern/Northern/SW IL	800 537 9384	224	225	315.97	720.40	322.29	734.81
[illegible] HDHP - Southern/Central	800 755 3901	MM4	MM5	433.81	930.11	442.49	948.71
Humana CoverageFirst CDHP - Chicago Area	888-393-6765	MW1	MW2	236.84	544.77	241.58	555.67
[illegible] HDHP - Central/Central Northwestern Illinois	800 673 5222	9F4	9F5	328.55	818.05	335.12	834.41
[illegible] - Chicagoland Area	888-234-8855	721	722	277.51	606.80	283.06	618.94

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
[illegible]									
[illegible] Health Solutions Inc. HDHP		$66.66/$133.33	$1550/$3100	$4,050/$8,100	20%	20%	20%	20%	$10 after Ded/$30 after Ded/$50 after Ded
Aetna HealthFund CDHP -	In-Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
Aetna HealthFund CDHP	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
[illegible] HDHP	In Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
[illegible] HDHP	Out of Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
Bluegrass Family Health, Inc. HDHP	In Network	$110/$220	$2,200/$4,000	$4,000/$8,000	20%	20%	20%	Nothing	20%/20%/20%
Bluegrass Family Health Inc. HDHP -	Out-of-Network	$110/$220	$4,000/$8,000	$8,000/$16,000	40%	40%	40%	Ded + 40%	N/A
[illegible]	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50/+
[illegible]	Out of Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+
HumanaCoverageFirst	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50/+
HumanaCoverageFirst -	Out-of-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+
[illegible]	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50/+
[illegible]	Out of Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+
[illegible] HMO HDHP	In Network	$104/$208	$2,000/$4,000	$5,000/$10,000	10%	10%	10%	Nothing to $300	$10/$20/$40
[illegible] HMO HDHP	Out of Network	$104/$208	$4,000/$8,000	$10,000/$20,000	30%	30%	30%	Ded/30% to $300	$10+30%/$20+30%/$40+30%
[illegible]									
[illegible] Health Care of Iowa HDHP		$41.66/$83.33	$1,100/$2,200	$5,000/$10,000	$20	10%	10%	$20/$30/10%	$10/$20/$45
[illegible]									
[illegible]	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
[illegible]	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP	In-Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP -	Out-of-Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
[illegible] Health Care of Kansas Inc (HDHP)		$41.66/$83.33	$1,100/$2,200	$5,000/$10,000	$20	20%	20%	$20/$35/20%	$15/$25/$50
Coventry Health Care of Kansas (Kansas City) - HDHP		$41.66/$83.33	$1,100/$2,200	$5,000/$10,000	$20	20%	20%	$20/$35/20%	$15/$25/$50
[illegible]	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50/+
[illegible]	Out of Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
[illegible]									
[illegible]	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
[illegible]	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP	In Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	Out-of-Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
[illegible] HDHP	In Network	$41.66/$83.33	$1,500/$3,000	$4,000/$8,000	$15	None	Nothing	$15/$25	No copay/$25/$50
[illegible] HDHP	Out of Network	$41.66/$83.33	$1,500/$3,000	$4,000/$8,000	30%	30%	30%	30%	N/A
United HealthCare Definity HDHP	In Network	$83/$167	$3,000/$6,000	$5,000/$10,000	$0/10%	10%	10%	10%	$10/$30/$50
United HealthCare Definity HDHP -	Out-of-Network	$83/$167	$6,000/$12,000	$10,000/$20,000	30%	30%	30%	30%	$10/$30/$50
[illegible]chusetts									
[illegible]	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
[illegible]	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP	In Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP -	Out-of-Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
[illegible] Health Plan HDHP		$63/$125	$1500/$3000	$3000/$6000	Ded/$20	Ded/$0	Ded/$0	Nothing	$10/$25/$50
Michigan									
[illegible]	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
[illegible]	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP	In Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	Out-of-Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+
[illegible]	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50/+
[illegible]	Out of Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+
Humana CoverageFirst	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50/+
Humana CoverageFirst	Out of Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+
[illegible]	In Network	$83.33	$1,000/$2,000	Stated Copays	$20	$100/day x 5	0/$50	$20/$35	$10/$30/$50/+
[illegible]	Out of Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$30+/$50+
Mississippi									
[illegible]	In Network	$83/$167	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	Nothing	$10/$25/$40
[illegible]	Out of Network	$83/$167	$1,000/$2,000	$4,000/$8,000	40%	40%	40%	Fund/Ded/40%	40%+/40%+/40%+
Aetna HealthFund HDHP -	In-Network	$125/$250	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	Out-of-Network	$125/$250	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+/30%+/30%+

High Deductible and Consumer-Driven Health Plans

See page 52 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Total Monthly Premium		102% of Total Monthly Premium	
		Self Only	Self & Family	Self Only	Self & Family	Self Only	Self & Family
South Carolina							
Aetna HealthFund CDHP - The Midlands and Upstate	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - The Midlands and Upstate	800-537-9384	224	225	315.97	720.40	322.29	734.81
Tennessee							
Aetna HealthFund CDHP - Most of Tennessee	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Most of Tennessee	800-537-9384	224	225	315.97	720.40	322.29	734.81
Humana CoverageFirst CDHP - Nashville Area	888 393 6765	BT1	BT2	306.52	704.97	312.65	719.07
Humana CoverageFirst CDHP - Memphis Area	888 393-6765	L61	L62	306.52	704.97	312.65	719.07
Texas							
Aetna HealthFund CDHP - Most of Texas	800 537 9384	221	222	284.44	654.23	290.13	667.31
Aetna HealthFund HDHP - Most of Texas	800-537-9384	224	225	315.97	720.40	322.29	734.81
Humana CoverageFirst CDHP - Houston Area	888 393 6765	T21	T22	306.52	704.97	312.65	719.07
Humana CoverageFirst CDHP - Dallas/Ft. Worth Area	888-393 6765	T81	T82	306.52	704.97	312.65	719.07
Humana CoverageFirst CDHP - Corpus Christi Area	888 393 6765	TP1	TP2	292.57	672.95	298.42	686.41
Humana CoverageFirst-CDHP - San Antonio Area	888-393-6765	TU1	TU2	278.66	640.90	284.23	653.72
Humana CoverageFirst CDHP - Austin Area	888 393 6765	TV1	TV2	306.52	704.97	312.65	719.07
Utah							
Aetna Student Plans HDHP - Wasatch Front	800 377 4161	9K4	9K5	464.19	961.68	473.47	980.91

FEHB
Federal Employees Health Benefits Program

TEMPORARY CONTINUATION OF COVERAGE

Health Benefits Election Form

Form Approved: OMB No. 3206-0160

Part A - Enrollee and Family Member Information ***(For additional family members use a separate sheet and and attach.)***

1. Enrollee Name *(last, first, middle initial)*	2. Social Security Number	3. Date of birth	4. Sex ☐ M ☐ F	5. Are you married? ☐ Yes ☐ No
6. Home Mailing Address *(including ZIP Code)*		7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	8. TRICARE ☐	9. Other insurance ☐
		10. Name of Insurance		11. Insurance policy no.
12. Name of family member *(last, first, middle initial)*	13. Social Security Number	14. Date of birth	15. Sex ☐ M ☐ F	16. Relationship code
17. Address *(if different from enrollee)*		18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	19. TRICARE ☐	20. Other insurance ☐
		21. Name of Insurance		22. Insurance policy no.
Name of family member *(last, first, middle initial)*	Social Security Number	Date of birth	Sex ☐ M ☐ F	Relationship code
Address *(if different from enrollee)*		Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	TRICARE ☐	Other insurance ☐
		Name of Insurance		Insurance policy no.
Name of family member *(last, first, middle initial)*	Social Security Number	Date of birth	Sex ☐ M ☐ F	Relationship code
Address *(if different from enrollee)*		Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	TRICARE ☐	Other insurance ☐
		Name of Insurance		Insurance policy no.
Name of family member *(last, first, middle initial)*	Social Security Number	Date of birth	Sex ☐ M ☐ F	Relationship code
Address *(if different from enrollee)*		Medicare *(See note - page 2)* ☐ A ☐ B ☐ D	TRICARE ☐	Other insurance ☐
		Name of Insurance		Insurance policy no.

Part B - Present Plan

1. Plan name	2. Enrollment code
N/A	N/A

Part C - New Plan

1. Plan name	2. Enrollment code

Part D - Event Code

1. Event code	2. Date of event
4A	

Part E - Employees Only (Election NOT to Enroll)

☐ I do NOT want to enroll in the FEHB Program.

My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation

☐ I CANCEL my enrollment.

My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension (Annuitants/Former Spouses Only)

☐ I SUSPEND my enrollment.

My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

Part H - Signature

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.)

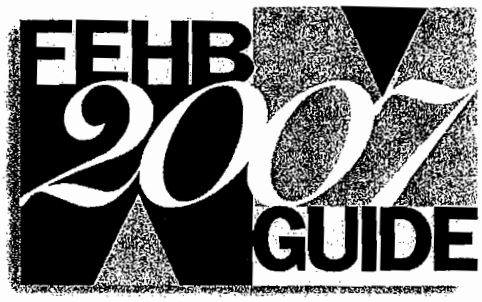
1. Your signature *(do not print)*	2. Date *(mm/dd/yyyy)*	3. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS P.L. 100-654 (5USC 8905a) Child / Ex-Spouse: Orginal Employee

SSN# DOB Date of Qualifying Event

1. Date received	2. Effective date of action	3. Personnel telephone number (202) 225-1435	4. Name and address of agency or retirement system
5. Authorizing official *(please print)*	6. Signature of authorized agency official		Employee Services Office of Finance & Procurement U.S. House of Representatives
7. Payroll office number 00004832	8. Payroll office contact *(please print)* Employee Services Generalist	9. Payroll telephone number (202) 225-1435	B215 Longworth HOB Washington, DC 20515


FEHB
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