



Guide to Federal Employees

HEALTH BENEFITS PLANS

For United States Postal Service Nurses



**United States
Office of
Personnel
Management**

Retirement and
Insurance Service

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

**RI 70-2B
Revised November 2001**

Program Features

- **No Waiting Periods.** You can use your benefits as soon as your coverage becomes effective (January 12, 2002). There are no pre-existing condition limitations.
- **A Choice of Coverage.** Choose between self only or self and family.
- **A Choice of Plans and Options.** Select from Fee-For-Service (FFS), Health Maintenance Organization (HMO), or Point of Service (POS) plans.
- **A Contribution.** The Postal Service makes a generous contribution towards the total cost of your premium, but not more than 88.75 percent of the total premium for any plan.
- **Salary Deduction.** As a Postal employee, you pay your share of the premium through a payroll deduction using pretax dollars.
- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enrollment. This year the Open Season runs from November 12, 2001 through December 10, 2001, and all open season enrollment changes become effective January 12, 2002.
- **Continued Group Coverage.** Eligible participants can continue coverage following 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.



Federal Employees
Health Benefits Program

Better Information
Better Choices
Better Health

Table of Contents

Page:

FEHB and You

| | |
|---|---|
| Overview..... | 1 |
| Coverage | 1 |
| FEHB Open Season | 2 |
| Getting Information and Selecting a Health Plan | 4 |
| Quality | |
| • Enrollee Survey Results | |
| • Accreditation | |
| Benefits | |
| Cost | |
| How the Plan Works | |
| Patient Safety | 8 |
| Pre-Tax Payment of Premium Contribution | 9 |

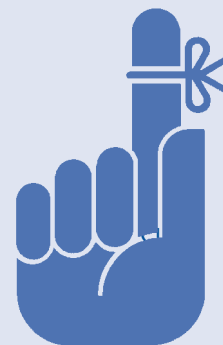
| | |
|----------------------------|----|
| Web Resources | 12 |
|----------------------------|----|

Plan Comparisons

| | |
|--|----|
| Nationwide Fee-For-Service Plans Open to All | 13 |
| Nationwide Fee-For-Service Plans Open Only to Specific Groups | 17 |
| Health Maintenance Organization Plans and Plans Offering a Point of Service Product | 21 |

Things to Remember

- A number of plans withdrew from the FEHB Program. Make sure your plan will be offered in 2002.
- Be aware of benefit changes within your current plan for 2002.
- Check for premium changes for the 2002 plan year.
- Paying your premium contributions on a pre-tax basis restricts your ability to reduce or cancel coverage outside of FEHB Open Season. Please be certain to read pages 9-11 of this guide and review the Qualified Life Status Changes that allow this type of enrollment change.



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

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FEHB and You

Overview

The United States Postal Service (USPS) provides health benefits to Nurses by participating in the Federal Employees Health Benefits (FEHB) Program, which is administered by the U.S. Office of Personnel Management (OPM), Office of Insurance Programs. FEHB began operation in July 1960 and almost 9 million people, including 2.3 million federal and postal employees 1.9 million retirees and eligible family members, are members of the program. 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 2002 Guide to Federal Employees Health Benefits (FEHB) Plans is to provide information about enrollment and premium features that USPS Nurses must consider when selecting a health insurance plan under the FEHB Program. The Guide is a summary of FEHB plans -- the plan brochures give specific benefit information. You can get individual plan brochures directly from the health plans or from your local personnel office. OPM's web site, www.opm.gov/insure, also provides this guide, various plan brochures, and other helpful information.

You may choose from among Fee-for-Service (FFS) plans regardless of where you live (see pages 13 through 15) and from Health Maintenance Organizations (HMOs) plan if you live (or sometimes if you work) within the area serviced by the plan (see pages 21 through 57). 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 2002 are the same for federal and USPS employees alike, there are some important differences in premium that apply to postal employees only. The Postal Service pays a higher percentage contribution than the rest of the federal government, which makes health benefits more affordable for postal employees. Your employee premium rates are calculated using the "Big Six Formula", which covers postal service Nurses only.

PLEASE NOTE: The premium rates listed in this guide are different than those printed for postal employees on the individual plan brochures. You should be certain to consider the premium rates listed in this guide ONLY when making your health benefits election. The rates in this guide were calculated using the Big Six Formula.

Coverage

New employees have the opportunity to select a health plan when hired and current employees have an opportunity to select or change plans when certain life events occur and during an open season that occurs each fall. **There is a 60-day time limit for making these elections, so when a life event occurs, immediately check with your local personnel office to determine the effect on your eligibility and coverage and the action you must take.**

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). Further information for determining family members' eligibility appears on page 2 of the Health Benefits Election Form, SF 2809 (July 1999 edition).

When an event occurs that causes you or your family member to lose coverage, the FEHB Program offers a con-

FEHB and You

Continuation of coverage feature, either temporarily or by permanent conversion to a private sector policy. Such events include but are not limited to:

- Separation
- Retirement
- Divorce
- Death
- Relocation
- Leave without pay
- Child reaching age 22

It is your responsibility to understand and report life events that may cause you or your family member to lose eligibility. Certain rules about coverage, timelines, and premium amounts apply. 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 plans during an open season. **The 2001 Open Season is from November 12 through close of business December 10.** 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 option
- 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 9-11)
- Cancel enrollment

If you decide to do any of the above actions, you must submit an election form (Standard Form 2809) to your local personnel office by close of business on **December 10, 2001.**

Your new enrollment or any changes that you make to your existing coverage will take effect on **January 12, 2002.** If you decide NOT to change your enrollment, DO NOTHING, and your present enrollment will continue automatically unless your plan is not participating in 2002. If your plan is not participating in 2002, 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 2001 plan year.

Note: The new plan year benefits will take effect January 12, 2002. The change in premium rate deductions will be seen in your February 1, 2002 earnings statement. Of special note is that the 2002 plan year will end on December 31, 2002. Based on current information provided by the Office of Personnel Management (OPM), the 2003 plan year and all future plan years will begin on January 1.

If you decide to cancel your coverage, you must submit a Standard Form 2809 that clearly reflects your acceptance of the consequences of cancellation. A cancellation generally is effective at the end of the pay period in which it is received by the local personnel office and must be in accordance with Internal Revenue Service (IRS) pre-tax regulations. However, if cancellation is elected during open season, it will become effective on January 11, 2002. If during the plan year you pay premium contributions on a pre-tax basis you will not be able to cancel or reduce (change from Self and Family to Self Only) coverage unless you experience a qualified life status change and your election is in keeping with the change. See pages 9-11.

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

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

F E H B a n d Y o u

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 IRS restrictions for reducing or canceling coverage (pages 9-11).

After referring to these sources, if you still have questions regarding eligibility, enrollment criteria, continued coverage after certain life events, or if you need an election form (SF 2809), 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.

Getting information and selecting a health plan

Use this Guide and plan brochures to make your health plan decision. The Guide is a summary of FEHB plans; the plan brochures give specific benefit information. You can get brochures from the health plans or your local personnel office. OPM's web site, www.opm.gov/insure provides the Guide, brochures, and other helpful information.

Before selecting a health plan:

- Consider quality (look for accreditation and survey results)
- Compare benefits in the brochures
- Review costs (premiums, deductibles, copayments, etc)
- Understand how the plan works

Quality

Quality matters to your health. Some health plans, just like doctors and hospitals, do a better job at caring for patients than others. Health plans today play an important role in improving quality. They can provide services for wellness and prevention; coordinate care; and help doctors, patients, and families work together. These things - when done well - can help produce good results.

The better performing plans practice patient-centered care that recognizes the individual member as the plan's primary customer; the plan's commitment to quality involves members' perceptions and experiences; and the plan's relationship with its providers reinforces a commitment to quality.

* **Enrollee Survey Results** in this Guide have been collected, scored, and reported by an independent organization - not by the health plans. We list here the survey categories and suggestions for what the health plan can do to make things better. Note: A plan may not be rated for one of three reasons: 1) It is new to the FEHB Program, 2) It has fewer than 500 Federal enrollees, or 3) It did not administer the survey as we asked; these plans are identified with an X.

Getting Needed Care. Did you have problems getting a referral to a specialist or did you experience delays in obtaining care?

- Health plans can educate members up-front about the scope and limitations of covered benefits, referral requirements, and preauthorizations. They can speed-up referrals for routine preventive care or established diagnoses, especially for chronic conditions. They can empower their own customer service staff to resolve problems at the outset and to take patients out of the middle of disputes about covered benefits or services.

FEHB and You

Getting Care Quickly. When you called during the doctor's regular office hours, did you get the advice or help you needed? Could you get an appointment for regular or routine care as soon as you wanted?

- Health plans can track the performance of contracting doctors or medical groups to see if there are problems with patients getting needed appointments. They can use members' definitions of "urgent" and "routine" needs - and not physicians' - to measure providers' performance against members' expectations.

How Well Doctors Communicate. Did your doctor listen carefully to you and explain things in a way you could understand? Did he spend enough time with you?

- Health plans can survey members of specific medical groups or practices and provide physicians with feedback on their performance. They can recruit physicians with the best reputations in the community, and they can develop guidelines that aid physicians in communication with patients with specific diseases or conditions.

Customer Service. When you called your plan's customer service department, were they helpful? Did you have paperwork problems? Were the plan's written materials understandable?

- Health plans can train customer service teams to deal solely with FEHB enrollees. Plans can also look for ways to reach out directly to members, to elicit their concerns, and inform them about changes in policies and practices that would affect them. Just as importantly, they could issue "report cards" to members about the performance of contracted medical groups on key measures of quality, including patients' reported experiences with each group.

Claims Processing. Did your plan pay your claims correctly and in a reasonable time?

- Health plans can inform you if there will be a delay in processing a claim, e.g., additional information is needed from the doctor. The plan's Explanation of Benefits should be clear and understandable.

Overall Plan Satisfaction. How would you rate your overall experience with your health plan?

- The plan should value you as a customer.

* **Accreditation** is the most widely accepted way to measure and evaluate health system performance. It is a rigorous and comprehensive evaluation by independent organizations that assess the quality of the key systems and processes that health care organizations use. It also assesses the care and service health plans deliver in areas such as immunization rates, mammography rates, and member satisfaction. The National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the American Accreditation Healthcare Commission/URAC (URAC) are independent, private, not-for-profit organizations dedicated to assessing and reporting on the quality of health care organizations

Use the following key to compare the accreditation status of different health plans (a lower number means a better accredited plan). See their web sites for further information on definitions.

NCQA (www.ncqa.org):

N1 = Excellent

N2 = Commendable

N3 = Accredited

N4 = Provisional

N6 = New Health Plan Accreditation

JCAHO (www.jcaho.org):

J1 = Accreditation with commendations

J2 = Accreditation without recommendations

J3 = Accreditation with recommendations

J5 = Provisional

J6 = Conditional

URAC (www.urac.org):

U1 = Accredited

F E H B a n d Y o u

Benefits

Check to see if the plan offers the type of services you might need. Does it offer a prenatal program or programs for people with chronic diseases? Can you get preventive care or help in stop smoking? Given the trend toward reducing hospital stays, will your plan pay for home health care? See if there are limits on the number of visits for the services you need. Don't assume benefits will be the same as they were last year. Check the plan brochure for details.

- **Read plan brochures carefully.**
- **Know what services are covered**
- **Know what services are not covered**

Cost

The premium you pay is an important consideration. When thinking about premiums, what can you afford biweekly or monthly? Plans that offer two options distinguish the difference between the two by the benefits or services provided, and this in turn affects the premium and out-of-pocket costs you pay. What benefits and services do you need, and what are you willing to pay for?

You also need to consider other costs. Because health care is expensive, pay attention to the plan's annual out-of-pocket maximum to see how you are protected. If you need to go to the hospital, how much will you have to pay? What will you pay for an emergency room visit? If you have children, what will you pay for a well-child visit? What will you pay for a prescription?

Do you have to pay a deductible for the services you want? You share medical expenses by paying a coinsurance (a percentage of the bill) or a copayment (a fixed dollar amount). Which option do you prefer? Does the plan limit the dollar amount it will pay for certain services, making you pay the rest?

- **Review the costs summarized in this Guide.**
- **Check plan brochures for specific information.**

How the Plan Works

Different types of plans help you get and pay for care differently. Fee-For-Service (FFS) plans generally use two approaches. You can choose your doctors and hospitals yourself. This approach may be more expensive for you and require extra paperwork. You can generally use a Fee-For-Service plan's Preferred Provider Organization (PPO), which offers you a choice of doctors and hospitals within a network. Most networks are quite wide, but they may not have all the doctors or hospitals you want. This approach usually will save you money and reduce your paperwork.

Enrolling in a FFS plan does not guarantee that a PPO will be available in your area. PPOs have a stronger presence in some regions than others, and *in areas where there is no PPO, the non-PPO benefit is the standard benefit.*

Be sure to look at the primary care physicians, specialists, and hospitals with whom your health plan contracts (the provider network). Does it promote prevention, which is less costly than early detection and intervention? Does it have the specialists to treat your chronic condition? Does it contract with a hospital close to your home?

Health Maintenance Organizations (HMOs) use networks of physicians and facilities that are generally located in a particular geographic or service area. Your eligibility to enroll in an HMO is determined by where you live or, in some plans, where you work. You must use their network to get covered services and follow the plan's rules for referrals and other services. HMOs limit your out-of-pocket costs to the relatively low amounts shown in the benefit brochures.

F E H B a n d Y o u

Some plans are Point Of Service (POS) plans and have features similar to both Fee-For-Service (FFS) plans and Health Maintenance Organizations (HMO).

If you are in a FFS plan and do not use the Preferred Provider Organization (PPO) (or one is not available):

- You will generally pay more when you get care
- Fewer preventive health care services may be covered
- You will have to file claims for services yourself

If you are in a FFS plan and use the PPO:

- You will generally pay less when you get care
- More preventive health care services may be covered
- You may have less paperwork

If you belong to an HMO:

- You will have limitations on the doctors and other providers you can use
- You will usually pay less when you get care
- You will have little, if any, paperwork
- More preventive health care services may be covered

If you belong to a POS plan and use only the providers in that network:

- You will pay less when you get care
- You will get full network benefits and coverage
- You will have very little paperwork

If you belong to a POS and do not use network providers or referral procedures:

- You will pay more when you get care
- Some services may not be covered out of network at all
- You generally have to file claims for services yourself

Things to do to make a plan work best for you

- When you need care, use your brochure to find out about the plan's **rules and coverage**. Know what services require precertification, prior approval, or referral before you use them.
- Use your plan's **mail order** drug program if it has one. You get the convenience of a 90-day supply instead of a 30-day supply, usually with lower out-of-pocket expense.
- Request **generic drugs** instead of brand name drugs. A generic medication is a copy of a brand name drug. It has the same active ingredients and receives the same Food and Drug Administration approval but costs less.
- If you're in a FFS plan, use the plan's **PPO** if it has one. (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.)
- **Ask questions.** You deserve a voice in your own health care.

Nowadays, the distinctions among different plan types (i.e., FFS, PPO, POS, HMO) are blurring. FFS plans use networks of providers in their PPO arrangements; POS plans let you get care in or out-of-network; HMOs increasingly are letting members visit specialists without a referral from the primary care physician. Rather than make decisions based on plan type, compare quality indicators, compare benefits, compare premiums and out-of-pocket costs, and look at the rules for getting care.

Patient Safety

Medical error and patient safety aren't well understood by most Americans. When we need vital or risky health care services, we want to believe that someone else has made sure that we'll get safe care. Sadly, every hour, 10 Americans die in a hospital due to avoidable errors; another 50 are disabled. Too many patients get the wrong medicines, the wrong tests and the wrong diagnosis. 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 Speak up if you have questions or concerns.** Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.
- 2 Keep a list of all the medicines you take.** Tell your doctor and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.
- 3 Make sure you get the results of any test or procedure.** Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected -- in person, on the phone, or in the mail - don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.
- 4 Talk with your doctor and health care team about your options if you need hospital care.** If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows *results often are better at hospitals doing a lot of these procedures*. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.
- 5 Make sure you understand what will happen if you need surgery.** Ask your doctor and surgeon: Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

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 postal enrollees from reducing coverage at any time. Read the "Reducing Coverage" section for details.

Pre-Tax Withholding

If you are a career USPS 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), 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 below.

Most employees prefer paying their premiums with pre-tax money because they save on taxes.

Nevertheless, if for any reason you do not want this method of payment, and instead wish to have premiums paid with after-tax money, you must submit a form to your local personnel office to waive the pre-tax treatment. For more information, see the section, How to Waive Pre-Tax Payment on page 11.

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 one of the following qualified life status changes occur:

Qualified Life Status Changes

1. You marry (including a valid common law marriage, in accordance with applicable state law), divorce, legally separate, or your marriage is annulled.
2. You add a qualified dependent (for example, by birth, or you adopt a child, or your dependent now satisfies eligibility requirements).
3. You lose a qualified dependent (for example, by death, or your child is placed for adoption, or your dependent now ceases to satisfy eligibility requirements).
4. You, your spouse, or your dependent has a change in work site or residence.

FEHB and You

5. Your spouse or your dependent starts or ends employment, or an unpaid leave of absence, or a strike or lock-out; or has a change in employment status making that person eligible or ineligible for a benefit plan.
6. A court order, judgment or decree (resulting from a change in marital status or legal custody) requires you to begin providing coverage for your child or requires another person to do so.
7. You, your spouse or your dependent becomes or ceases to be eligible for Medicare or Medicaid.
8. You begin or end an unpaid leave of absence.
9. Your spouse or your dependent elects to change health coverage under another employer's plan, either based upon a qualified life status change or for a period of coverage that is different from USPS--you may then eliminate any duplicate coverage.

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

A qualified life status change does not allow you the opportunity to change plans or options, only to reduce (go from Self and Family to Self only) or cancel your current plan.

To reduce your FEHB coverage outside of FEHB Open Season, submit Standard Form (SF) 2809, Health Benefits Election Form, to your local personnel office **no later than 60 days after a qualified life status change has occurred**. You must provide any supporting documenta-

tion 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 SF 2809 is received. The effective date of a cancellation will be the last day of the pay period in which your SF 2809 is received.

If you are the only person left in your Self and Family enrollment as a result of a change in marital or family status (divorce, legal separation, annulment, or loss of a qualified dependent, for example, through death or because your child reaches age 22), you must elect to reduce the enrollment (elect Self Only coverage, or cancel coverage) **WITHIN 60 DAYS** of the qualified life status change. Otherwise, your self and family enrollment will continue until another event (that is, a qualified life status change or FEHB Open Season) occurs that allows you to elect to reduce coverage. The election cannot become effective retroactively, therefore, there will be no retroactive premium adjustment.

Retirement is **NOT** a qualified life status change that allows cancellation prior to separation. If you wish to cancel an enrollment at retirement, your personnel office will accept your completed SF 2809 and forward it to OPM for processing after separation from the Postal Service. (Annuitants' FEHB premiums contributions are not withheld as a pre-tax payment, thus 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 may be 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.

How to Waive Pre-tax Payments

If you wish to pay your premiums with after-tax money, you should contact your local personnel office and ask for Postal Service (PS) Form 8201, Pre-tax Health Insurance Premium Waiver/Restoration Form. Complete the form and return it to your local personnel office by close of business December 10, 2001.

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 in the event of a qualified life status change.

If you pay premiums with after-tax money, you will not be affected by the IRS guidelines described above that restrict reductions in coverage. You may reduce your level of FEHB coverage at any time of year without having a qualified life status change.

Your Right to More Information

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

FEHB Web Resources

Visit OPM's web page at www.opm.gov/insure to find

- **Federal Employees Health Benefits (FEHB) Program home page**
- **FEHB Open Season Plan Comparison Page**

Visit the FEHB Home Page and the FEHB Open Season Plan Comparison Page for the most up-to-date information on the FEHB Program.

The **FEHB Home Page** has information on the FEHB Program and important information on health care. On this page you'll find:

- *The FEHB Handbook for Enrollees and Employing Offices* - detailed and in-depth information about the FEHB Program
- The FEHB law and regulations
- Information on disputed claims, patient safety, former spouses, FEHB and Medicare
- Questions and Answers on prescription drugs, dental benefits, premiums, enrollment and other topics
- *FEHB Facts* - Information for Federal Civilian Employees on the FEHB Program
- A page for Agency Human Resources Personnel with links to FEHB Benefits Administration Letters
- Health plan information disclosure requirements under the Patients' Bill of Rights

The **FEHB Open Season Plan Comparison Page** has information you'll need to make an informed health insurance election. Be sure to look at our new section on how to use this web site.

On this page you'll find:

- General information about plans including plan quality, benefits, and cost
- Links to individual plan web sites and other web sites where you can find more about health care quality.

You can also look at and download:

- All of the FEHB Guides including the Guide For Federal Civilian Employees (Postal and Non-Postal), the Guide for Federal Retirees and Their Survivors, the Guide For Certain Temporary Employees, the Guide For Individuals Receiving Compensation From the Office of Workers' Compensation Programs, and the Guide for Temporary Continuation of Coverage (TCC) and Former Spouse Enrollees
- Plan Brochures that include the benefits, cost, and other major features and provisions of each health plan.

Plan Comparisons

2002 Plan Year List of Health Plans with Biweekly Premium Rates for USPS Nurses

Nationwide Fee-for-Service Plans Open to All

(Pages 14 through 16)

Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO) — A FFS option 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 may not be covered by the PPO agreement.

Fee-for-Service (FFS) Plans (non-PPO) — A traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse you after you have filed an insurance claim for each covered medical expense. When you need medical attention, you visit the doctor or hospital of your choice.

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

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 Home delivery 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 **Per Stay Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

What you pay for **Doctors** (inpatient visits and surgical services) and **Outpatient Tests** (provided, or ordered, and billed by a physician or physicians' group).

| Plan name (with Acronyms) | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|--|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Alliance Health Plan (AHP) | 202/939-6325 | 1R1 | 1R2 | 48.95 | 99.99 |
| APWU Health Plan (APWU) | 800/222-2798 | 471 | 472 | 37.47 | 86.81 |
| Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS) | Local phone # | 104 | 105 | 29.75 | 83.10 |
| Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS) | Local phone # | 111 | 112 | 17.23 | 64.01 |
| GEHA Benefit Plan-High (GEHA) | 800/821-6136 | 311 | 312 | 48.33 | 107.77 |
| GEHA Benefit Plan-Std (GEHA) | 800/821-6136 | 314 | 315 | 12.37 | 28.12 |
| Mail Handlers-High (MH) | 800/410-7778 | 451 | 452 | 43.71 | 87.47 |
| Mail Handlers-Std (MH) | 800/410-7778 | 454 | 455 | 11.54 | 25.06 |
| NALC (NALC) | 888/636-6252 | 321 | 322 | 34.50 | 71.99 |
| PBP Health Plan-High (PBP) | 800/544-7111 | 361 | 362 | 152.05 | 328.59 |
| PBP Health Plan-Std (PBP) | 800/544-7111 | 364 | 365 | 39.58 | 86.77 |

Your share of **Hospital Inpatient Room and Board** and **Other** (e.g., nursing, supplies, and medications) covered charges are shown, usually after any per stay deductible. Services provided and billed by the hospital for outpatient care (other than surgery) are shown as **Hospital Outpatient Other** expenses.

A **Generic** drug is a copy of the manufacturer's **Brand Name** drug and is approved by the Food and Drug Administration. **Non-formulary** drugs are Brand Names that are not on your health plan's list of preferred drugs.

Prescription drug benefits have become more complex as you can see from the many variations. Multiple numbers for a plan mean there are different levels of cost sharing. For instance, you may pay one amount for your first prescription (e.g., 10% or \$5) and then a different amount for some refills (e.g. 50%). You may have to pay the greater of a dollar amount or a percentage (e.g., \$10 or 20%). In some cases, you'll pay less for a Brand Name drug that has no Generic equivalent than for a Brand Name that has a Generic (e.g., \$15 versus \$30). A few plans have lower copays for Medicare members. Plans vary in the number of days supply of drugs you get for the copays shown, and you'll almost always pay more if you use a non-PPO pharmacy (e.g., the + sign means you pay the amount shown plus a differential). **Read the brochures for details.**

| Plan (acronym only) | Benefit type | Medical-Surgical – You pay | | | | | | | | | | | |
|---------------------------|-----------------|----------------------------|----------------------|-----------------------------------|----------------------------------|-----------|---------|---------------------|--------------------|---------------|-------------------|---------------|-----------|
| | | Deductible | | | Copay (\$)/Coinsurance (%) | | | | | | | | |
| | | Per Person | | Per stay Hospital inpatient | Doctors & Outpatient Tests | Hospital | | | Prescription drugs | | | | |
| | | Calendar Year | Prescription Drug | | | Inpatient | | Outpatient other | Generic | Brand Name | Non- formulary | Home Delivery | |
| R&B | Other | | | Generic | Brand Name | | | | | | | | |
| AHP | PPO | \$100 | \$200 | \$150 | 10% | 10% | 10% | 10% | 10%/50% | 10%/50% | 10%/50% | 20% | 20% |
| | Non-PPO | \$300 | \$200 | \$250 | 30% | 30% | 30% | 30% | 10%/50% + | 10%/50% + | 10%/50% + | 20% | 20% |
| APWU | PPO | \$275 | None | None | 10% | 10% | 10% | 10% | \$7 | 25% | 25% | \$10 | 20% |
| | Non-PPO | \$350 | None | \$200 | 30% | 30% | 30% | 30% | 45% | 45% | 45% | \$10 | 20% |
| BCBS | PPO | \$250 | None | \$100 | 10% | Nothing | Nothing | 10% | 25% | 25% | 25% | \$10/25% | \$35/25% |
| | Non-PPO | \$250 | None | \$300 | 25% | 30% | 30% | 25% | 45% | 45% | 45% | 45% | 45% |
| BCBS | PPO only | None | None | \$100/day;\$500 | \$20/\$30 | Nothing | Nothing | \$30 | \$10 | \$25 | \$35 or 50% | \$10 | \$25 |
| GEHA | PPO | \$300 | None | None | 10% | Nothing | 10% | 10% | \$5/50% | \$15/\$30/50% | \$15/\$30/50% | \$10 | \$35/\$50 |
| | Non-PPO | \$300 | None | None | 25% | Nothing | 25% | 25% | \$5 or 50% | \$15/\$30/50% | \$15/\$30/50% | \$10 | \$35/\$50 |
| GEHA | PPO | \$450 | None | None | 15% | 15% | 15% | 15% | \$5 | 50% | 50% | \$15 | 50% |
| | Non-PPO | \$450 | None | None | 35% | 35% | 35% | 35% | \$5 + | 50% + | 50% + | \$15 | 50% |
| MH | PPO | \$200 | \$250 | None | 10% | Nothing | Nothing | 10% | 25% | 25% | 25% | \$10 | \$30/\$45 |
| | Non-PPO | \$200 | \$250 | \$250 | 30% | Nothing | Nothing | 30% | 50% | 50% | 50% | \$10 | \$30/\$45 |
| MH | PPO | \$250 | \$600 | \$150 | 10% | Nothing | Nothing | 10% | 30% | 30% | 30% | \$10 | \$40/\$55 |
| | Non-PPO | \$250 | \$600 | \$300 | 30% | Nothing | Nothing | 30% | 50% | 50% | 50% | \$10 | \$40/\$55 |
| NALC | PPO | \$250 | None | None | 15% | 10% | 10% | 15% | 25% | 25% | 25% | \$12 | \$25 |
| | Non-PPO | \$300 | \$25 for Retail | \$100 | 30% | 30% | 30% | 30% | 40%+ | 40%+ | 40%+ | \$12 | \$25 |
| PBP | PPO | \$200 | \$100 | None | 10% | 10% | 10% | 10% | \$10 or 20% | \$25 or 20% | \$40 or 20% | \$10 | \$25 |
| | Non-PPO | \$400 | \$150 | \$150 | 20% | 25% | 25% | 20% | 20%+ | 20%+ | 20%+ | \$10 | \$25 |
| PBP | PPO | \$250 | \$100 | None | 10% | 10% | 10% | 10% | \$15 or 20% | \$30 or 20% | \$40 or 20% | \$15 | \$30 |
| | Non-PPO | \$500 | \$150 | \$250 | 30% | 30% | 30% | 30% | 30%+ | 30%+ | 30%+ | \$15 | \$30 |

Nationwide Fee-for-Service Plans Open to All

Enrollee Survey Results — See pages 4-5 for a description.

| | | Enrollee 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 |
| Alliance Health Plan | 1R | ● | ○ | ● | ● | ◐ | ◐ |
| APWU Health Plan | 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 | ○ | ◐ | ● | ● | ○ | ○ |

Plan Comparisons

2002 Plan Year List of Health Plans with Biweekly Premium Rates for USPS Nurses

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

(Pages 18 through 20)

Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO) — A FFS option 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 may not be covered by the PPO agreement.

Fee-for-Service (FFS) Plans (non-PPO) — A traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse you after you have filed an insurance claim for each covered medical expense. 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 Home delivery 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 **Per Stay Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

What you pay for **Doctors** (inpatient visits and surgical services) and **Outpatient Tests** (provided, or ordered, and billed by a physician or physicians' group).

| Plan name (with Acronyms) | 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 | 39.50 | 99.19 |
| Foreign Service (FS) | 202/833-4910 | 401 | 402 | 26.07 | 93.46 |
| Panama Canal Area (PCA) | 732/222-2229 | 431 | 432 | 26.24 | 58.64 |
| Rural Carrier Benefit Plan (Rural) | 800/638-8432 | 381 | 382 | 48.79 | 86.72 |
| SAMBA (SAMBA) | 800/638-6589 | 441 | 442 | 55.60 | 153.03 |
| Secret Service (SS) | 800/424-7474 | Y71 | Y72 | 14.11 | 57.18 |

Your share of **Hospital Inpatient Room and Board** and **Other** (e.g., nursing, supplies, and medications) covered charges are shown, usually after any per stay deductible. Services provided and billed by the hospital for outpatient care (other than surgery) are shown as **Hospital Outpatient Other** expenses.

A **Generic** drug is a copy of the manufacturer's **Brand Name** drug and is approved by the Food and Drug Administration. **Non-formulary** drugs are Brand Names that are not on your health plan's list of preferred drugs.

Prescription drug benefits have become more complex as you can see from the many variations. Multiple numbers for a plan mean there are different levels of cost sharing. For instance, you may pay one amount for your first prescription (e.g., 10% or \$5) and then a different amount for some refills (e.g. 50%). You may have to pay the greater of a dollar amount or a percentage (e.g., \$10 or 20%). In some cases, you'll pay less for a Brand Name drug that has no Generic equivalent than for a Brand Name that has a Generic (e.g., \$15 versus \$30). A few plans have lower copays for Medicare members. Plans vary in the number of days supply of drugs you get for the copays shown, and you'll almost always pay more if you use a non-PPO pharmacy (e.g., the + sign means you pay the amount shown plus a differential).

Read the brochures for details.

| Plan (acronym only) | Benefit type | Medical-Surgical – You pay | | | | | | | | | | | |
|---------------------------|-----------------|----------------------------|----------------------|-----------------------------------|----------------------------------|-----------|---------|---------------------|--------------------|---------------|-------------------|------------|---------------|
| | | Deductible | | | Copay (\$)/Coinsurance (%) | | | | | | | | |
| | | Per Person | | Per stay Hospital inpatient | Doctors & Outpatient Tests | Hospital | | | Prescription drugs | | | | |
| | | Calendar Year | Prescription Drug | | | Inpatient | | Outpatient other | Generic | Brand Name | Non- formulary | Mail Order | |
| | | | | | | R&B | Other | | | | | Generic | Brand Name |
| ABP | PPO | \$300 | None | \$100 | 10% | Nothing | Nothing | 10% | \$10 | \$20 | \$30 | \$15 | \$30/\$45 |
| | Non-PPO | \$300 | None | \$200 | 25% | 25% | 25% | \$10 | \$20 | \$30 | \$15 | \$30/\$45 | |
| FS | PPO | \$300 | None | Nothing | 10% | Nothing | Nothing | 10% | \$10 | \$20 | \$20 | \$15 | \$25 |
| | Non-PPO | \$300 | None | \$200 | 30% | 20% | 20% | 30% | \$10 | \$20 | \$20 | \$15 | \$25 |
| PCA | No PPO | None | \$400 | \$125 | 50% | 50% | 50% | 50% | 50% | 50% | 50% | N/A | N/A |
| Rural | PPO | \$350 | CY Applies | Nothing | 10% | Nothing | Nothing | Nothing | 25% | 25% | 25% | \$13 | \$18 |
| | Non-PPO | \$350 | CY Applies | \$200 | 15% | Nothing | 20% | Nothing | 25% | 25% | 25% | \$13 | \$18 |
| SAMBA | PPO | \$300 | None | \$200 | 10% | Nothing | 10% | 10% | \$15 | \$25/\$30 | \$25/\$30 | \$15 | \$25/\$30 |
| | Non-PPO | \$300 | None | \$300 | 30% | 30% | 30% | 30% | \$15 | \$25/\$30 | \$25/\$30 | \$15 | \$25/\$30 |
| SS | No PPO | \$200 | \$200 | \$100 | 20% | Nothing | Nothing | Nothing | \$10 | \$20 | \$20 | \$20 | \$40 |

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

Enrollee Survey Results — See pages 4-5 for a description.

| | | Enrollee 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 | 40 | ● | ◐ | ◐ | ○ | ○ | ○ |
| Panama Canal Area | 43 | | | | | | |
| Rural Carrier Benefit Plan | 38 | ● | ● | ● | ◐ | ● | ● |
| SAMBA | 44 | ◐ | ○ | ○ | ◐ | ○ | ○ |
| Secret Service | Y7 | ○ | ● | ◐ | ◐ | ○ | ○ |

Plan Comparisons

2002 Plan Year List of Health Plans with Biweekly Premium Rates for USPS Nurses

Health Maintenance Organization Plans and Plans Offering a Point of Service Product

(Pages 22 through 57)

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. 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 deductible or coinsurance for in-hospital 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 received from a provider not in the plan’s network is not covered unless it’s emergency care or the plan has a reciprocity arrangement.

Plans Offering a Point of Service (POS) Product — A product offered by an HMO or FFS plan that has features of both.

In an HMO, the POS product lets you use providers who are not part of the HMO network. However, 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 a FFS plan. The HMO plan wants you to use its network of providers, but recognizes that sometimes enrollees want to choose their own provider.

In a FFS plan, the plan’s regular benefits include deductibles and coinsurance. But in some locations, the plan has set up a POS network of providers similar to what you would find in an HMO, which means you usually must select a primary care physician and obtain a referral to see other providers. The plan encourages you to use these providers, usually by waiving the deductibles and applying a copayment that is smaller than the normal coinsurance. Generally there is no paperwork when you use a network provider.

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.

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Alabama | | | | | |
| PrimeHealth of Alabama, Inc. - Southern Alabama and the Montgomery Area | 800/236-9421 | AA1 | AA2 | 17.02 | 88.32 |
| The Oath - A Health Plan for Alabama, Inc. - Birmingham/Other areas | 800/947-5093 | DF1 | DF2 | 22.88 | 103.05 |
| Arizona | | | | | |
| Aetna U. S. Healthcare, Inc. - Phoenix/Tucson areas | 800/537-9384 | WQ1 | WQ2 | 11.61 | 55.35 |
| Health Net of Arizona, Inc. - Maricopa/Pima/Other AZ counties | 800/289-2818 | A71 | A72 | 13.08 | 78.62 |
| PacifiCare Health Plans - Maricopa/Pima/parts of Apache Junction | 800/531-3341 | A31 | A32 | 13.05 | 89.93 |
| California | | | | | |
| Aetna U. S. Healthcare, Inc. - Southern California area | 800/537-9384 | 2X1 | 2X2 | 10.80 | 25.22 |
| Blue Cross- HMO - Most of California | 800/235-8631 | M51 | M52 | 11.84 | 33.44 |
| Blue Shield of CA Access+ - Most of California | 800/334-5847 | SJ1 | SJ2 | 12.61 | 42.87 |
| CIGNA HealthCare of California - Northern/Southern California | 800/244-6224 | 9T1 | 9T2 | 13.12 | 28.87 |
| Health Net - Most of California | 800/522-0088 | LB1 | LB2 | 12.94 | 37.19 |
| Kaiser Permanente - Northern California | 800/464-4000 | 591 | 592 | 11.96 | 28.55 |
| Kaiser Permanente - Southern California | 800/464-4000 | 621 | 622 | 12.60 | 29.11 |
| PacifiCare Health Plans - Most of California | 800/531-3341 | CY1 | CY2 | 10.51 | 27.39 |
| UHP HEALTHCARE - LA/Orange/San Bernardino Counties | 800/544-0088 | C41 | C42 | 8.97 | 19.11 |
| Universal Care - Southern California | 800/257-3087 | 6Q1 | 6Q2 | 9.45 | 24.96 |
| Western Health Advantage - Northern California | 888/563-2250 | 5Z1 | 5Z2 | 12.25 | 29.40 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ● average, ○ below average | | | | | | |
|--|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Alabama | | | | | | | | | | | | |
| PrimeHealth of Alabama, Inc. | \$10 | None | \$7 | \$12 | \$30 | | | | | | | |
| The Oath - A Health Plan for Alabama, Inc. | \$15 | \$100 | \$5 | \$15 | \$25 | ● | ● | ● | ● | ● | ○ | |
| Arizona | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ○ | ○ | ○ | ○ | ○ | ○ | N2 |
| Health Net of Arizona, Inc. | \$10 | \$100 | \$10 | \$20 | \$40 | ○ | ○ | ○ | ○ | ● | ● | N2 |
| PacifiCare Health Plans | \$10 | None | \$5 | \$15 | \$15 | ○ | ○ | ○ | ○ | ○ | ● | N2 |
| California | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ○ | ○ | ○ | ○ | ○ | ○ | N2 |
| Blue Cross- HMO | \$10 | None | \$5 | \$10 | 50% | ○ | ○ | ○ | ○ | ○ | ● | N2 |
| Blue Shield of CA Access+ | \$10 | None | \$5 | \$10 | \$25 | ○ | ○ | ○ | ○ | ○ | ○ | N2 |
| CIGNA HealthCare of California | \$10 | None | \$5 | \$15 | \$35 | ○ | ○ | ○ | ○ | ○ | ○ | N2 |
| Health Net | \$10 | None | \$5 | \$10 | \$35 | ○ | ○ | ○ | ○ | ○ | ● | N2 |
| Kaiser Permanente | \$10 | None | \$10 | \$20 | \$20 | ● | ○ | ○ | ○ | ● | ○ | N1 |
| Kaiser Permanente | \$10 | None | \$10 | \$20 | \$20 | ● | ● | ○ | ○ | ● | ● | N2 |
| PacifiCare Health Plans | \$10 | None | \$5 | \$15 | \$15 | ○ | ○ | ○ | ○ | ○ | ● | N2 |
| UHP HEALTHCARE | \$10 | None | \$5 | \$5 | \$5 | | | | | | | J3 |
| Universal Care | \$10 | None | \$5 | \$10 | \$30 | ○ | ○ | ○ | ○ | ○ | ○ | N3 |
| Western Health Advantage | \$10 | None | \$5 | \$10 | \$20 | ● | ○ | ○ | ● | ● | ● | N6 |

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

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Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Colorado | | | | | |
| Kaiser Permanente - Denver/Colorado Springs areas | 800/632-9700 | 651 | 652 | 13.13 | 62.41 |
| PacifiCare of Colorado-High -Denver/Colorado Springs/Ft.Collins | 800/877-9777 | D61 | D62 | 20.83 | 105.05 |
| PacifiCare of Colorado-Std - Denver/Colorado Springs/Ft.Collins | 800/877-9777 | D64 | D65 | 8.70 | 22.52 |
| Rocky Mountain HMO-High -Most of Colorado | 800/346-4643 | XJ1 | XJ2 | 49.20 | 135.40 |
| Rocky Mountain HMO-Std - Most of Colorado | 800/346-4643 | XJ4 | XJ5 | 33.36 | 98.35 |
| Connecticut | | | | | |
| ConnectiCare - All of Connecticut | 800/251-7722 | TE1 | TE2 | 12.62 | 58.56 |
| Health Net, Inc. - All of Connecticut | 877/747-9585 | DP1 | DP2 | 39.39 | 180.17 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|-----------------------------|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Colorado | | | | | | | | | | | | |
| Kaiser Permanente | \$10 | None | \$5 | \$15 | \$15 | ◐ | ◐ | ◐ | ○ | ● | ◐ | N1 |
| PacifiCare of Colorado-High | \$10 | None | \$5 | \$10 | \$20 | ○ | ○ | ◐ | ◐ | ○ | ◐ | N2 |
| PacifiCare of Colorado-Std | \$15 | \$300 | \$10 | \$20 | \$30 | ○ | ○ | ◐ | ◐ | ○ | ◐ | N2 |
| Rocky Mountain HMO-High | \$10 | \$200 | \$10 | \$20 | \$35 | ◐ | ● | ● | ● | ○ | ● | N1 |
| Rocky Mountain HMO-Std | \$25 | \$500 | \$10 | \$20 | \$35 | ◐ | ● | ● | ● | ○ | ● | N1 |
| Connecticut | | | | | | | | | | | | |
| ConnectiCare | \$10 | None | \$10 | \$20 | \$35 | ● | ● | ● | ● | ● | ● | N1 |
| Health Net, Inc. | \$10 | None | \$10 | \$20 | \$35 | ● | ● | ● | ◐ | ◐ | ● | |

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|--|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| District of Columbia | | | | | |
| Aetna U. S. Healthcare, Inc.-High -Washington, DC area | 800/537-9384 | JN1 | JN2 | 22.50 | 69.55 |
| Aetna U. S. Healthcare, Inc.-Std - Washington, DC area | 800/537-9384 | JN4 | JN5 | 10.79 | 25.24 |
| CareFirst BlueChoice - Washington, DC area | 800/680-9495 | 2G1 | 2G2 | 18.34 | 51.85 |
| Kaiser Permanente - Washington, DC area | 301/468-6000 | E31 | E32 | 12.04 | 29.75 |
| MD-IPA - Washington, DC area | 800/251-0956 | JP1 | JP2 | 13.56 | 54.22 |
| Florida | | | | | |
| Av-Med Health Plan - G'ville/Jax/Orlando/So.FL/Tampa | 800/882-8633 | EM1 | EM2 | 13.83 | 102.78 |
| Capital Health Plan - Tallahassee area | 850/383-3311 | EA1 | EA2 | 12.81 | 68.82 |
| Foundation Health - Southern Florida | 800/441-5501 | 5E1 | 5E2 | 9.01 | 24.77 |
| HIP Health Plan of FL - South Florida | 800/447-8255 | 3N1 | 3N2 | 12.21 | 67.74 |
| Humana Medical Plan - South Florida | 888/393-6765 | EE1 | EE2 | 11.98 | 31.11 |
| Total Health Choice - Broward/Dade/Palm Beach Counties | 305/408-5823 | 4A1 | 4A2 | 10.60 | 26.40 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|-----------------------------------|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| District of Columbia | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc.-High | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ○ | ○ | ○ | ◐ | ○ | ○ | N2 |
| Aetna U. S. Healthcare, Inc.-Std | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ○ | ○ | ◐ | ○ | ○ | N2 |
| CareFirst BlueChoice* | \$10 | None | \$10 | \$20 | \$35 | ◐ | ◐ | ◐ | ◐ | ○ | ○ | N2 |
| Kaiser Permanente | \$10 | \$100 | \$10 | \$20 | \$20 | ◐ | ○ | ◐ | ○ | ● | ○ | N2 |
| MD-IPA | \$10 | None | \$5 | \$15 | \$30 | ● | ● | ◐ | ◐ | ● | ◐ | N1 |
| Florida | | | | | | | | | | | | |
| Av-Med Health Plan | \$10 | \$100 | \$5 | \$10 | \$25 | ◐ | ○ | ○ | ◐ | ● | ◐ | N2,J2 |
| Capital Health Plan | \$10 | \$100 | \$7 | \$20 | \$35 | ● | ● | ● | ● | ● | ● | N1 |
| Foundation Health | \$10 | \$200 per year | \$7 | \$14 | \$34 | ○ | ○ | ○ | ○ | ○ | ○ | N4 |
| HIP Health Plan of FL | \$10 | \$250 | \$5 | \$10 | \$35 | ○ | ○ | ○ | ◐ | ◐ | ◐ | N2 |
| Humana Medical Plan | \$10 | None | \$5 | \$20 | \$40 | ○ | ○ | ○ | ○ | ◐ | ◐ | N2,U1 |
| Total Health Choice | \$10 | \$100 | \$5 | \$15 | \$15 | | | | | | | |

* Previously CapitalCare, which had Commendable NCQA accreditation.

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Georgia | | | | | |
| Aetna U. S. Healthcare, Inc. - Atlanta and Athens areas | 800/537-9384 | 2U1 | 2U2 | 12.59 | 58.81 |
| Kaiser Permanente - Atlanta area | 800/611-1811 | F81 | F82 | 11.89 | 33.15 |
| Guam | | | | | |
| PacifiCare Asia Pacific-High -Guam/N. Mariana Islands/Palau | 671/647-3526 | JK1 | JK2 | 25.39 | 118.55 |
| PacifiCare Asia Pacific-Std - Guam/N. Mariana Islands/Palau | 671/647-3526 | JK4 | JK5 | 12.42 | 56.37 |
| Hawaii | | | | | |
| HMSA - All of Hawaii | 808/948-6499 | 871 | 872 | 12.10 | 26.94 |
| Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu/Kauai | 808/597-5955 | 631 | 632 | 13.75 | 29.56 |
| Kaiser Permanente-Std - Islands of Hawaii/Maui/Oahu/Kauai | 808/597-5955 | 634 | 635 | 10.49 | 22.56 |
| Idaho | | | | | |
| Group Health Cooperative - Kootenai and Latah | 800/497-2210 | VR1 | VR2 | 13.42 | 71.48 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked. **Accredited** — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|------------------------------|----------------------------------|------------------------------------|--------------------|---------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| Georgia | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ○ | ○ | ○ | ◐ | ○ | ○ | N1 |
| Kaiser Permanente | \$10 | None | \$5/\$11 Comm | \$5/\$11 Comm | \$5/\$11 Comm | ● | ● | ◐ | ○ | ● | ◐ | N1 |
| Guam | | | | | | | | | | | | |
| PacifiCare Asia Pacific-High | \$10 | None | \$5 | \$20 | \$20 | ● | ◐ | ○ | ◐ | ◐ | ○ | |
| PacifiCare Asia Pacific-Std | \$15 | \$150 | \$5 | \$20 | \$20 | ● | ◐ | ○ | ◐ | ◐ | ○ | |
| Hawaii | | | | | | | | | | | | |
| HMSA | - In-Network 20% | None | \$5 | \$15 | \$15 or 50% | ● | ● | ● | ● | ● | ● | |
| | - Out-of-Network 30% | 30% | \$5 + 20% | \$15+20% | \$15 or 50%+ | | | | | | | |
| Kaiser Permanente-High | \$10 | None | \$7 | \$7 | \$7 | ● | ● | ◐ | ● | ● | ● | N1 |
| Kaiser Permanente-Std | \$15 | None | \$7 | \$7 | \$7 | ● | ● | ◐ | ● | ● | ● | N1 |
| Idaho | | | | | | | | | | | | |
| Group Health Cooperative | \$10 | \$100-\$300 | \$10 | \$20 | \$20 | ◐ | ◐ | ◐ | ◐ | ◐ | ◐ | N1 |

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|--|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Illinois | | | | | |
| BlueCHOICE - St. Clair and Madison | 800/634-4395 | 9G1 | 9G2 | 30.67 | 66.39 |
| Group Health Plan - Southern/Metro East/Central | 800/743-3901 | MM1 | MM2 | 39.89 | 86.95 |
| Health Alliance HMO - Central/E.Central/N.West/South/West IL | 800/851-3379 | FX1 | FX2 | 29.02 | 87.54 |
| Humana Health Plan Inc. - Chicago area | 888/393-6765 | 751 | 752 | 12.27 | 29.43 |
| John Deere Health Plan - Bloomington/Joliet/Moline/Peoria/RockIsld | 800/247-9110 | YH1 | YH2 | 17.59 | 91.62 |
| Mercy Health Plans/Premier - Southwest Illinois | 800/327-0763 | 7M1 | 7M2 | 24.85 | 76.71 |
| OSF HealthPlans - Central/Central-Northwestern Illinois | 800/673-5222 | 9F1 | 9F2 | 12.78 | 63.66 |
| PersonalCare's HMO - Central Illinois | 800/431-1211 | GE1 | GE2 | 10.17 | 26.15 |
| UNICARE HMO - Chicagoland area | 312/234-8855 | 171 | 172 | 9.46 | 29.48 |
| Union Health Service - Chicago area | 312/829-4224 | 761 | 762 | 10.92 | 27.09 |
| Indiana | | | | | |
| Advantage Health Plan, Inc. - Most of Indiana | 800/553-8933 | 6Y1 | 6Y2 | 13.79 | 52.65 |
| Aetna U. S. Healthcare, Inc. - Southern Indiana | 800/537-9384 | 7L1 | 7L2 | 12.95 | 49.23 |
| Aetna U. S. Healthcare, Inc. - Southeastern Indiana | 800/537-9384 | RD1 | RD2 | 32.19 | 122.55 |
| Arnett HMO - Lafayette area | 765/448-7440 | G21 | G22 | 16.02 | 90.53 |
| Health Alliance HMO - Fountain/Vermillion/Warren Counties | 800/851-3379 | FX1 | FX2 | 29.02 | 87.54 |
| Humana Health Plan - Southern Indiana | 888/393-6765 | D21 | D22 | 15.59 | 76.94 |
| Humana Health Plan Inc. - Lake/Porter/LaPorte Counties | 888/393-6765 | 751 | 752 | 12.27 | 29.43 |
| M*Plan - Indiana Metropolitan areas | 317/571-5320 | IN1 | IN2 | 30.29 | 85.02 |
| Physicians HP of N. Indiana - Northeast Indiana | 219/432-6690 | DQ1 | DQ2 | 13.76 | 39.77 |
| UNICARE HMO - Lake/Porter Counties | 888/234-8855 | 171 | 172 | 9.46 | 29.48 |
| Welborn HMO - Evansville area | 812/426-6600 | H31 | H32 | 25.13 | 112.21 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|--|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Illinois | | | | | | | | | | | | |
| BlueCHOICE | \$10 | None | \$5 | \$10 | \$15 | ○ | ◐ | ● | ● | ◐ | ◐ | N2 |
| Group Health Plan | \$10 | \$100 | \$8 | \$20 | \$35 | ◐ | ◐ | ● | ● | ◐ | ● | |
| Health Alliance HMO | \$10 | \$100 | \$7 | \$14 | \$25 | ● | ● | ● | ● | ◐ | ● | N1 |
| Humana Health Plan Inc. | \$10 | None | \$3 | \$10 | \$25 | ○ | ◐ | ○ | ○ | ○ | ○ | N2 |
| John Deere Health Plan | \$15 | \$100 | \$10 | \$20 | \$35 | ● | ● | ● | ● | ● | ● | N1 |
| Mercy Health Plans/Premier - In-Network | \$10 | None | \$7 | \$12 | \$25 | ● | ● | ● | ◐ | ● | ● | |
| - Out-of-Network | 30% | 30% | N/A | N/A | N/A | | | | | | | |
| OSF HealthPlans | \$10 | \$100-\$300 | \$7 | \$15 | \$25 | ◐ | ◐ | ● | ● | ◐ | ● | N3 |
| PersonalCare's HMO | \$10 | \$100 | \$5 | \$15 | \$35 | ● | ● | ● | ◐ | ● | ● | N1 |
| UNICARE HMO | \$15 | None | \$5 | \$15 | \$25 | ○ | ○ | ○ | ○ | ○ | ○ | N2 |
| Union Health Service | \$10 | None | \$10 | \$10 | \$10 | | | | | | | |
| Indiana | | | | | | | | | | | | |
| Advantage Health Plan, Inc. | \$10 | \$200 | \$10 | \$20 | \$45 | | | | | | | N6 |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ○ | ◐ | ● | ○ | ○ | N2 |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ◐ | ● | ● | ○ | ○ | |
| Arnett HMO | \$10 | None | \$5 | \$15 | \$30 | ● | ● | ● | ● | ● | ● | N1 |
| Health Alliance HMO | \$10 | \$100 | \$7 | \$14 | \$25 | ● | ● | ● | ● | ◐ | ● | N1 |
| Humana Health Plan | \$10 | None | \$5 | \$20 | \$40 | ◐ | ○ | ◐ | ◐ | ○ | ○ | N2 |
| Humana Health Plan Inc. | \$10 | None | \$3 | \$10 | \$25 | ○ | ◐ | ○ | ○ | ○ | ○ | N2 |
| M*Plan | \$10 | None | \$5 | \$10 | \$30 | ◐ | ◐ | ◐ | ◐ | ◐ | ◐ | N1 |
| Physicians HP of N. Indiana | \$10 | 20%of\$2500 | \$5 | \$15 | \$40 | ● | ● | ● | ◐ | ● | ● | |
| UNICARE HMO | \$15 | None | \$5 | \$15 | \$25 | ○ | ○ | ○ | ○ | ○ | ○ | N2 |
| Welborn HMO | \$10 | None | \$5 | \$15 | \$25 | ● | ● | ● | ◐ | ◐ | ● | |

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Iowa | | | | | |
| Avera Health Plan - Northwestern Iowa | 888/322-2115 | AV1 | AV2 | 26.30 | 60.36 |
| Coventry Health Care of Iowa - Central Iowa/Cedar Rapids/Sioux City | 800/257-4692 | SV1 | SV2 | 13.12 | 79.88 |
| Health Alliance HMO - Central/Eastern Iowa | 800/851-3379 | FX1 | FX2 | 40.39 | 99.27 |
| John Deere Health Plan - Central/Eastern Iowa | 800/247-9110 | YH1 | YH2 | 17.59 | 91.62 |
| SecureCare of Iowa - Central/Eastern Iowa | 888/881-8820 | 3Q1 | 3Q2 | 11.35 | 29.73 |
| Kansas | | | | | |
| Coventry HC Kansas Cty formerly Kaiser - Kansas City area | 800-969-3343 | HA1 | HA2 | 9.85 | 25.41 |
| Coventry Health Care of Kansas - Wichita/Salinas areas | 800/664-9251 | 7W1 | 7W2 | 13.64 | 73.95 |
| Humana Health Plan, Inc.-High -Kansas City area | 888/393-6765 | MS1 | MS2 | 12.79 | 37.61 |
| Humana Health Plan, Inc.-Std - Kansas City area | 888/393-6765 | MS4 | MS5 | 9.75 | 23.38 |
| Preferred Plus of Kansas - S. Central Area | 800/660-8114 | VA1 | VA2 | 28.78 | 131.95 |
| Kentucky | | | | | |
| Aetna U. S. Healthcare, Inc. - Louisville area | 800/537-9384 | 7L1 | 7L2 | 12.95 | 49.23 |
| Aetna U. S. Healthcare, Inc. - Northern Kentucky area | 800/537-9384 | RD1 | RD2 | 32.19 | 122.55 |
| Humana Health Plan - Louisville area | 888/393-6765 | D21 | D22 | 15.59 | 76.94 |
| United Health Care of Ohio, Inc. - Northern Kentucky | 800/231-2918 | 3U1 | 3U2 | 39.53 | 107.01 |

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| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|--|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Iowa | | | | | | | | | | | | |
| Avera Health Plan | \$10 | \$250 | \$10 | \$20 | \$35 | | | | | | | |
| Coventry Health Care of Iowa | \$10 | None | \$5 | \$15 | \$30 | ○ | ● | ● | ◐ | ○ | ◐ | N2 |
| Health Alliance HMO | \$10 | \$100 | \$7 | \$14 | \$25 | ● | ● | ● | ● | ◐ | ● | N1 |
| John Deere Health Plan | \$15 | \$100 | \$10 | \$20 | \$35 | ● | ● | ● | ● | ● | ● | N1 |
| SecureCare of Iowa | \$10 | \$100 | \$5 or 25% | \$5 or 25% | \$5 or 25% | | | | | | | |
| Kansas | | | | | | | | | | | | |
| Coventry HC Kansas Cty formerly Kaiser | \$10 | None | \$5 | \$15 | \$45 | | | | | | | |
| Coventry Health Care of Kansas | \$10 | None | \$5 | \$10 | \$20 | ◐ | ○ | ● | ◐ | ◐ | ● | |
| Humana Health Plan, Inc.-High | \$10 | None | \$5 | \$20 | \$40 | ○ | ○ | ◐ | ○ | ○ | ○ | N2 |
| Humana Health Plan, Inc.-Std | \$15 | \$100 | \$10 | \$25 | \$45 | ○ | ○ | ◐ | ○ | ○ | ○ | N2 |
| Preferred Plus of Kansas | \$10 | \$50/day\$500 | \$5 | \$15 | \$15 | | | | | | | J3 |
| Kentucky | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ○ | ◐ | ● | ○ | ○ | |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ◐ | ● | ● | ○ | ○ | |
| Humana Health Plan | \$10 | None | \$5 | \$20 | \$40 | ◐ | ○ | ◐ | ◐ | ○ | ○ | N2 |
| United Health Care of Ohio, Inc. | \$15 | \$100 | \$10 | \$15 | \$30 | ◐ | ● | ◐ | ◐ | ◐ | ○ | N1 |

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Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Louisiana | | | | | |
| Amcare Health Plans - New Orleans area | 800/772-2995 | ZH1 | ZH2 | 10.24 | 26.82 |
| Amcare Health Plans - Baton Rouge/Alexandria/Shreveport areas | 800/772-2995 | ZQ1 | ZQ2 | 12.43 | 54.25 |
| Coventry Healthcare Louisiana former Maxicare LA - New Orleans area | 800/993-6294 | BJ1 | BJ2 | 12.99 | 33.12 |
| Coventry Healthcare Louisiana former Maxicare LA - Baton Rouge area | 800/341-6613 | JA1 | JA2 | 25.01 | 76.63 |
| Vantage Health Plan - Monroe area | 888/823-1910 | AQ1 | AQ2 | 28.79 | 135.14 |
| Vantage Health Plan - Shreveport/Alexandria areas | 888/823-1910 | MV1 | MV2 | 37.07 | 157.36 |
| Maryland | | | | | |
| Aetna U. S. Healthcare, Inc.-High -North/Central/Southern Maryland | 800/537-9384 | JN1 | JN2 | 22.50 | 69.55 |
| Aetna U. S. Healthcare, Inc.-Std - North/Central/Southern Maryland | 800/537-9384 | JN4 | JN5 | 10.79 | 25.24 |
| CareFirst BlueChoice - all of Maryland | 800/680-9495 | 2G1 | 2G2 | 18.34 | 51.85 |
| Kaiser Permanente - Baltimore/Washington, DC areas | 301/468-6000 | E31 | E32 | 12.04 | 29.75 |
| MD-IPA - All of Maryland | 800/251-0956 | JP1 | JP2 | 13.56 | 54.22 |
| Massachusetts | | | | | |
| Blue Chip, Coord Hlth Partners - Southeastern Massachusetts | 401/459-5500 | DA1 | DA2 | 22.18 | 101.32 |
| Fallon Community Health Plan - Central/Eastern Massachusetts | 800/868-5200 | JV1 | JV2 | 29.47 | 67.85 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|--|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Louisiana | | | | | | | | | | | | |
| Amcare Health Plans | \$10 | None | \$5 | \$15 | 50% | | | | | | | N6 |
| Amcare Health Plans | \$10 | None | \$5 | \$15 | 50% | | | | | | | N6 |
| Coventry Healthcare Louisiana former Maxicare LA | \$15 | \$100/day | \$10 | \$20 | \$45 | | | | | | | |
| Coventry Healthcare Louisiana former Maxicare LA | \$15 | \$100/day | \$10 | \$20 | \$45 | X | X | X | X | X | X | |
| Vantage Health Plan | \$15 | \$250 | \$10 | \$20 | \$35 | | | | | | | |
| Vantage Health Plan | \$15 | \$250 | \$10 | \$20 | \$35 | | | | | | | |
| Maryland | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc.-High | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ○ | ○ | ○ | ◐ | ○ | ○ | N2 |
| Aetna U. S. Healthcare, Inc.-Std | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ○ | ○ | ◐ | ○ | ○ | N2 |
| CareFirst BlueChoice* | \$10 | None | \$10 | \$20 | \$35 | ◐ | ◐ | ◐ | ◐ | ○ | ○ | N2 |
| Kaiser Permanente | \$10 | \$100 | \$10 | \$20 | \$20 | ◐ | ○ | ◐ | ○ | ● | ○ | N2 |
| MD-IPA | \$10 | None | \$5 | \$15 | \$30 | ● | ● | ◐ | ◐ | ● | ◐ | N1 |
| Massachusetts | | | | | | | | | | | | |
| Blue Chip, Coord Hlth Partners - In-Network | \$10 | None | \$5 | \$15 | \$30 | ● | ● | ● | ● | ● | ◐ | N1 |
| - Out-of-Network | 20% | None | \$30 + 20% | \$30 + 20% | \$30 + 20% | | | | | | | |
| Fallon Community Health Plan | \$10 | None | \$5 | \$10 | \$10 | ● | ● | ● | ● | ● | ◐ | N1 |

* Previously CapitalCare, which had Commendable NCQA accreditation.

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Michigan | | | | | |
| Bluecare Network of MI - Cheboygan and Roscommon Counties Area | 800/662-6667 | G71 | G72 | 104.32 | 304.89 |
| Bluecare Network of MI - Midland County Area | 800/662-6667 | K51 | K52 | 13.58 | 102.32 |
| Bluecare Network of MI - Kalamazoo County Area | 800/662-6667 | KF1 | KF2 | 42.44 | 182.45 |
| Bluecare Network of MI - Genesee County Area | 800/662-6667 | KN1 | KN2 | 20.19 | 126.62 |
| Bluecare Network of MI - Kent County Area | 800/662-6667 | KR1 | KR2 | 21.45 | 142.21 |
| Bluecare Network of MI - Mid Michigan | 800/662-6667 | LN1 | LN2 | 50.36 | 149.12 |
| Bluecare Network of MI - Southeast MI | 800/662-6667 | LX1 | LX2 | 10.02 | 31.35 |
| Grand Valley Health Plan - Grand Rapids area | 616/949-2410 | RL1 | RL2 | 13.16 | 93.66 |
| Health Alliance - Southeastern Michigan/Flint area | 800/422-4641 | 521 | 522 | 14.50 | 92.69 |
| HealthPlus MI - Flint/Saginaw areas | 800/332-9161 | X51 | X52 | 15.03 | 69.50 |
| M-Care - Mid and Southeastern Michigan | 800/658-8878 | EG1 | EG2 | 11.42 | 33.77 |
| OmniCare - Southeastern Michigan | 800/477-6664 | KA1 | KA2 | 11.55 | 28.99 |
| The Wellness Plan - Detroit/Flint/Muskegon Areas | 800/875-9355 | K31 | K32 | 10.24 | 27.86 |
| Total Health Care - Greater Detroit/Flint areas | 800/826-2862 | N21 | N22 | 11.88 | 30.69 |
| Minnesota | | | | | |
| HealthPartners Classic-High -Minneapolis/St. Paul areas | 952/883-5000 | 531 | 532 | 34.50 | 109.78 |
| HealthPartners Classic-Std - Minneapolis/St. Paul areas | 952/883-5000 | 534 | 535 | 29.11 | 96.88 |
| HealthPartners Primary Clinic Plan - Minneapolis/St. Paul/St. Cloud areas | 952/883-5000 | HQ1 | HQ2 | 56.73 | 163.17 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|------------------------------------|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Michigan | | | | | | | | | | | | |
| Bluecare Network of MI | \$10 | None | \$10 | \$20 | \$20 | ◐ | ○ | ● | ● | ○ | ◐ | N1 |
| Bluecare Network of MI | \$10 | None | \$10 | \$20 | \$20 | ◐ | ○ | ● | ● | ○ | ◐ | N1 |
| Bluecare Network of MI | \$10 | None | \$10 | \$20 | \$20 | ◐ | ○ | ● | ● | ○ | ◐ | N1 |
| Bluecare Network of MI | \$10 | None | \$10 | \$20 | \$20 | ◐ | ○ | ● | ● | ○ | ◐ | N1 |
| Bluecare Network of MI | \$10 | None | \$10 | \$20 | \$20 | ◐ | ○ | ● | ● | ○ | ◐ | N1 |
| Bluecare Network of MI | \$10 | None | \$10 | \$20 | \$20 | ◐ | ○ | ● | ● | ○ | ◐ | N1 |
| Bluecare Network of MI | \$10 | None | \$10 | \$20 | \$20 | ◐ | ○ | ● | ● | ○ | ◐ | N1 |
| Grand Valley Health Plan | \$10 | None | \$5 | \$5 | \$5 | ● | ◐ | ● | ● | ● | ● | N1 |
| Health Alliance | \$10 | None | \$2 | \$2 | \$2 | ● | ◐ | ◐ | ◐ | ◐ | ◐ | N1 |
| HealthPlus MI | \$10 | None | \$5 | \$5 | \$5 | ● | ● | ● | ● | ● | ● | N1 |
| M-Care | \$10 | None | \$5 | \$10 | \$10 | ● | ◐ | ◐ | ◐ | ● | ● | N1 |
| OmniCare | \$10 | None | \$2 | \$2 | \$2 | ○ | ○ | ○ | ○ | ○ | ○ | N4 |
| The Wellness Plan | \$10 | None | \$5 | \$5 | \$5 | ○ | ○ | ○ | ○ | ○ | ○ | |
| Total Health Care | \$10 | None | Nothing | Nothing | Nothing | | | | | | | |
| Minnesota | | | | | | | | | | | | |
| HealthPartners Classic-High | \$15 | None | \$10 | \$20 | \$20 | ◐ | ● | ◐ | ◐ | ◐ | ◐ | N1 |
| HealthPartners Classic-Std | \$20 | \$200 | \$11 | \$22 | \$22 | ◐ | ● | ◐ | ◐ | ◐ | ◐ | N1 |
| HealthPartners Primary Clinic Plan | \$15 | None | \$10 | \$10 | \$10 | ◐ | ● | ◐ | ◐ | ◐ | ◐ | N1 |

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Missouri | | | | | |
| BlueCHOICE - StLouis/Central/SW/Poplar Bluff area | 800/634-4395 | 9G1 | 9G2 | 13.80 | 30.44 |
| Coventry HC Kansas Cty formerly Kaiser - Kansas City area | 800-969-3343 | HA1 | HA2 | 9.85 | 25.41 |
| Group Health Plan - St. Louis area | 800/743-3901 | MM1 | MM2 | 39.89 | 86.95 |
| Humana Health Plan, Inc.-High -Kansas City area | 888/393-6765 | MS1 | MS2 | 12.79 | 37.61 |
| Humana Health Plan, Inc.-Std - Kansas City area | 888/393-6765 | MS4 | MS5 | 9.75 | 23.38 |
| Mercy Health Plans/Premier - East/Central/Southwest Missouri | 800/327-0763 | 7M1 | 7M2 | 24.85 | 76.71 |
| Nevada | | | | | |
| Aetna U. S. Healthcare, Inc. - Southern Nevada/Las Vegas area | 800/537-9384 | 8L1 | 8L2 | 12.65 | 57.04 |
| Health Plan of Nevada - Las Vegas/Reno areas | 702/871-0999 | NM1 | NM2 | 11.00 | 28.18 |
| PacifiCare Health Plans - Clark County | 800/531-3341 | K91 | K92 | 13.29 | 65.57 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|---|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Missouri | | | | | | | | | | | | |
| BlueCHOICE | \$10 | None | \$5 | \$10 | \$15 | ○ | ◐ | ● | ● | ◐ | ◐ | N2 |
| Coventry HC Kansas Cty formerly Kaiser | \$10 | None | \$5 | \$15 | \$45 | X | X | X | X | X | X | |
| Group Health Plan | \$10 | \$100 | \$8 | \$20 | \$35 | ◐ | ◐ | ● | ● | ◐ | ● | |
| Humana Health Plan, Inc.-High | \$10 | None | \$5 | \$20 | \$40 | ○ | ○ | ◐ | ○ | ○ | ○ | N2 |
| Humana Health Plan, Inc.-Std | \$15 | \$100 | \$10 | \$25 | \$45 | ○ | ○ | ◐ | ○ | ○ | ○ | N2 |
| Mercy Health Plans/Premier - In-Network | \$10 | None | \$7 | \$12 | \$25 | ● | ● | ● | ◐ | ◐ | ● | |
| Mercy Health Plans/Premier - Out-of-Network | 30% | 30% | N/A | N/A | N/A | | | | | | | |
| Nevada | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ○ | ○ | ○ | ○ | ◐ | ○ | N6 |
| Health Plan of Nevada - In-Network | \$10 | \$100/dayX2 | \$5 | \$20 | \$35 | ○ | ○ | ○ | ○ | ○ | ○ | N3 |
| Health Plan of Nevada - Out-of-Network | 20% | 20% | 20% | 20% | 20% | | | | | | | |
| PacifiCare Health Plans | \$10 | None | \$5 | \$15 | \$15 | ○ | ○ | ○ | ○ | ○ | ◐ | N2 |

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|--|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| New Jersey | | | | | |
| Aetna U. S. Healthcare, Inc. - All of New Jersey | 800/537-9384 | P31 | P32 | 34.65 | 138.95 |
| AmeriHealth HMO - All of New Jersey | 800/454-7651 | FK1 | FK2 | 17.43 | 66.79 |
| GHI Health Plan - Northern New Jersey | 212/501-4444 | 801 | 802 | 34.91 | 125.20 |
| HealthNet of Pennsylvania - Phila. and 7 adjacent PA and NJ counties | 800/998-2840 | 271 | 272 | 41.54 | 119.21 |
| New Mexico | | | | | |
| Cimarron Health Plan - All of New Mexico | 800/473-0391 | PX1 | PX2 | 12.75 | 62.81 |
| Lovelace Health Plan - All of New Mexico | 800/244-6224 | Q11 | Q12 | 12.64 | 56.95 |
| Presbyterian Health Plan - All NM counties except Otero & S. Eddy | 505/923-5678 | P21 | P22 | 12.20 | 47.69 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | | |
|------------------------------|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|--|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited | |
| | | | | | | | | | | | | | |
| New Jersey | | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ◐ | ● | ● | ● | ◐ | ◐ | N1 | |
| AmeriHealth HMO | \$30 | None | \$15 | \$25 | \$35 | ◐ | ● | ● | ◐ | ◐ | ◐ | N1 | |
| GHI Health Plan | - In-Network | \$15 | None | \$10 | \$20 | \$50 | ● | ● | ◐ | ◐ | ○ | ○ | |
| | - Out-of-Network | 50% of sch. | None | N/A | N/A | N/A | | | | | | | |
| HealthNet of Pennsylvania | \$10 | None | \$10 | \$20 | \$35 | ◐ | ◐ | ● | ● | ○ | ◐ | | |
| New Mexico | | | | | | | | | | | | | |
| Cimarron Health Plan | \$10 | None | \$5 | \$8 | \$8 | ○ | ○ | ○ | ◐ | ○ | ◐ | N3 | |
| Lovelace Health Plan | \$10 | None | \$5 | \$15 | \$35 | ◐ | ● | ○ | ○ | ◐ | ○ | N2 | |
| Presbyterian Health Plan | \$10 | None | \$5 | \$15 | \$15 | ◐ | ○ | ○ | ○ | ◐ | ◐ | N2 | |

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

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Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|--|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| New York | | | | | |
| Aetna U. S. Healthcare, Inc. - NYC area and Dutchess/Sullivan/Ulster | 800/537-9384 | JC1 | JC2 | 12.61 | 46.74 |
| Aetna U. S. Healthcare, Inc. - Syracuse area | 800/537-9384 | TG1 | TG2 | 11.32 | 28.56 |
| Blue Choice - Rochester area | 800/462-0108 | MK1 | MK2 | 22.68 | 95.39 |
| C.D.P.H.P. - Albany/Cooperstown areas | 518/862-3750 | PW1 | PW2 | 13.38 | 69.26 |
| C.D.P.H.P. - Hudson Valley area | 518/862-3750 | QB1 | QB2 | 14.45 | 82.41 |
| C.D.P.H.P. - Capital District area | 518/862-3750 | SG1 | SG2 | 13.25 | 66.63 |
| GHI Health Plan - All of New York | 212/501-4444 | 801 | 802 | 34.91 | 125.20 |
| GHI HMO Select - Bronx/Brklyn/Manhattan/Queens/Westchester | 877/244-4466 | 6V1 | 6V2 | 18.96 | 87.18 |
| GHI HMO Select - Capital/Hudson Valley Regions | 877/244-4466 | X41 | X42 | 12.85 | 59.35 |
| HIP of Greater New York - New York City area | 800/HIP-TALK | 511 | 512 | 12.25 | 91.65 |
| HMO Blue - Utica/Rome/Central New York areas | 800/722-7884 | AH1 | AH2 | 14.52 | 81.81 |
| HMO-CNY - Syracuse/Binghamton/Elmira areas | 800/828-2887 | EB1 | EB2 | 22.47 | 114.13 |
| Independent Health Assoc - Western New York | 800/453-1910 | QA1 | QA2 | 10.57 | 29.47 |
| MVP Health Plan - Eastern Region | 888/687-6277 | GA1 | GA2 | 12.90 | 61.14 |
| MVP Health Plan - Central Region | 888/687-6277 | M91 | M92 | 13.32 | 70.59 |
| MVP Health Plan - Mid-Hudson Region | 888/687-6277 | MX1 | MX2 | 20.43 | 99.74 |
| Physicians Health Services of New York, Inc. - NYC/LI/Dtchs/Orng/Putnm/Rklnd/Wschs | 877/747-9585 | PD1 | PD2 | 59.65 | 201.40 |
| Preferred Care - Rochester area | 716/325-3113 | GV1 | GV2 | 13.37 | 82.20 |
| Univera Healthcare - CNY - Syracuse/Southern Tier areas | 315/638-2133 | QE1 | QE2 | 21.09 | 110.37 |
| Univera Healthcare - CNY - Utica area | 315/797-7019 | SH1 | SH2 | 21.09 | 110.37 |
| Univera Healthcare - WNY - Western New York | 716/847-0881 | Q81 | Q82 | 11.55 | 56.14 |
| Vytra Health Plans - Queens/Nassau/Suffolk Counties | 800/406-0806 | J61 | J62 | 39.13 | 153.59 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked. **Accredited** — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | | |
|--|----------------------------------|------------------------------------|--------------------|-------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|--|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited | |
| | | | | | | | | | | | | | |
| New York | | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ◐ | ◐ | ○ | ◐ | ◐ | ○ | N1 | |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ◐ | ◐ | ○ | ◐ | ◐ | ○ | N1 | |
| Blue Choice | \$10 | None | \$5 | \$15 | \$30 | ● | ● | ● | ● | ● | ● | N2 | |
| C.D.P.H.P. | \$10 | None | \$5 | \$20 | \$20 | ● | ● | ● | ◐ | ● | ● | N1 | |
| C.D.P.H.P. | \$10 | None | \$5 | \$20 | \$20 | ● | ● | ● | ◐ | ● | ● | N1 | |
| C.D.P.H.P. | \$10 | None | \$5 | \$20 | \$20 | ● | ● | ● | ◐ | ● | ● | N1 | |
| GHI Health Plan | - In-Network - Out-of-Network | \$15 50% of sch. | None None | \$10 N/A | \$20 N/A | \$50 N/A | ● | ● | ◐ | ◐ | ○ | ○ | |
| GHI HMO Select | \$10 | None | \$10 | \$20 | \$30 | ○ | ○ | ● | ◐ | ○ | ○ | N6 | |
| GHI HMO Select | \$10 | None | \$10 | \$20 | \$30 | ○ | ○ | ● | ◐ | ○ | ○ | N6 | |
| HIP of Greater New York | \$10 | None | \$10 | \$15 | \$35 | ◐ | ◐ | ○ | ○ | ◐ | ○ | | |
| HMO Blue | \$10 | None | \$5 | \$20 | \$35 | ◐ | ● | ● | ◐ | ○ | ○ | N2 | |
| HMO-CNY | \$10 | None | \$5 | \$20 | \$35 | ◐ | ● | ● | ● | ◐ | ◐ | N1 | |
| Independent Health Assoc | \$10 | None | \$5 | \$15 | \$30 | ● | ● | ● | ● | ● | ● | N1 | |
| MVP Health Plan | \$10 | None | \$5 | \$20 | \$20 | ● | ● | ● | ● | ● | ● | N2 | |
| MVP Health Plan | \$10 | None | \$5 | \$20 | \$20 | ● | ● | ● | ● | ● | ● | N2 | |
| MVP Health Plan | \$10 | None | \$5 | \$20 | \$20 | ● | ● | ● | ● | ● | ● | N2 | |
| Physicians Health Services of New York, Inc. | \$10 | None | \$10 | \$20 | \$35 | ◐ | ● | ◐ | ◐ | ◐ | ○ | | |
| Preferred Care | \$10 | None | \$10 | \$20 | \$35 | ● | ● | ● | ● | ● | ● | N1 | |
| Univera Healthcare - CNY | \$10 | None | \$5 | \$15 | \$35 | ◐ | ● | ● | ◐ | ◐ | ◐ | N3 | |
| Univera Healthcare - CNY | \$10 | None | \$5 | \$15 | \$35 | ◐ | ● | ● | ◐ | ◐ | ◐ | N3 | |
| Univera Healthcare - WNY | \$10 | None | \$5 | \$15 | \$35 | ● | ● | ● | ● | ● | ● | N1 | |
| Vytra Health Plans | \$10 | None | \$5 | \$5 | \$5 | ● | ● | ◐ | ◐ | ◐ | ◐ | | |

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|--|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| North Dakota | | | | | |
| Heart of America HMO - Northcentral North Dakota | 701/776-5848 | RU1 | RU2 | 11.94 | 37.71 |
| Ohio | | | | | |
| Aetna U. S. Healthcare, Inc. - Cleveland and Toledo areas | 800/537-9384 | 7D1 | 7D2 | 26.34 | 99.90 |
| Aetna U. S. Healthcare, Inc. - Greater Cincinnati area | 800/537-9384 | RD1 | RD2 | 32.19 | 122.55 |
| AultCare HMO - Stark/Carroll/Holmes/Tuscarawas/Wayne Co | 330/438-6360 | 3A1 | 3A2 | 10.71 | 26.84 |
| Health Maintenance Plan(HMP) - Most of Ohio | 800/228-4375 | R51 | R52 | 25.10 | 81.38 |
| Health Plan Upper OH Valley - Eastern Ohio | 800/624-6961 | U41 | U42 | 13.20 | 87.52 |
| HMO Health Ohio - Northeast Ohio | 800/522-2066 | L41 | L42 | 19.57 | 94.31 |
| Kaiser Permanente - Akron/Cleveland areas | 800/686-7100 | 641 | 642 | 13.25 | 53.87 |
| Paramount Health Care - Northwest/North Central Ohio | 800/462-3589 | U21 | U22 | 20.52 | 108.89 |
| SummaCare Health Plan - Cleveland, Akron areas | 330/996-8415 | 5W1 | 5W2 | 11.31 | 41.43 |
| SuperMed HMO - Northeast Ohio | 800/522-2066 | 5M1 | 5M2 | 35.70 | 135.58 |
| United Health Care of Ohio, Inc. - Cincinnati/Dayton/Springfield | 800/231-2918 | 3U1 | 3U2 | 39.53 | 107.01 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|----------------------------------|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| North Dakota | | | | | | | | | | | | |
| Heart of America HMO | \$10 | None | 50% | 50% | 50% | | | | | | | |
| Ohio | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ◐ | ● | ● | ○ | ○ | N2 |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ◐ | ● | ● | ○ | ○ | N2 |
| AultCare HMO | \$10 | None | \$5 | \$10 | \$10 | ● | ● | ● | ● | ● | ● | |
| Health Maintenance Plan(HMP) | \$10 | None | \$8 | \$15 | \$25 | ◐ | ● | ● | ● | ◐ | ◐ | |
| Health Plan Upper OH Valley | \$10 | None | \$10 | \$20 | \$35 | ● | ● | ● | ● | ● | ● | N1 |
| HMO Health Ohio | \$10 | None | \$10 | \$20 | \$20 | ◐ | ◐ | ◐ | ◐ | ○ | ○ | N2 |
| Kaiser Permanente | \$10 | None | \$5 | \$15 | \$15 | ◐ | ● | ◐ | ○ | ● | ◐ | N1 |
| Paramount Health Care | \$10 | None | \$5 | \$15 | \$25 | ● | ● | ● | ● | ● | ● | N2 |
| SummaCare Health Plan | \$10 | None | \$5 | \$10 | \$10 | ● | ● | ● | ● | ◐ | ◐ | N1 |
| SuperMed HMO | \$10 | None | \$10 | \$20 | \$20 | ◐ | ◐ | ◐ | ◐ | ○ | ○ | N2 |
| United Health Care of Ohio, Inc. | \$15 | \$100 | \$10 | \$15 | \$30 | ◐ | ● | ◐ | ◐ | ◐ | ○ | N1 |

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Oklahoma | | | | | |
| Amcare Health Plans - Oklahoma City/Tulsa areas | 800/772-2993 | ZX1 | ZX2 | 11.61 | 35.01 |
| PacifiCare Health Plans - Central/Northeastern Oklahoma | 800/531-3341 | 2N1 | 2N2 | 11.52 | 32.68 |
| Oregon | | | | | |
| Kaiser Permanente-High -Portland/Salem areas | 800/813-2000 | 571 | 572 | 24.87 | 72.61 |
| Kaiser Permanente-Std - Portland/Salem areas | 800/813-2000 | 574 | 575 | 13.50 | 40.26 |
| PacifiCare Health Plans - Metro Portland/Salem/Corvallis/Eugene | 800/531-3341 | 7Z1 | 7Z2 | 57.68 | 134.67 |
| Panama | | | | | |
| Panama Canal Area - Republic of Panama | 507/227-7555 | 431 | 432 | 26.24 | 58.64 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|------------------------------------|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| Oklahoma | | | | | | | | | | | | |
| Amcare Health Plans | \$10 | None | \$5 | \$15 | 50% | | | | | | | N6 |
| PacifiCare Health Plans | \$10 | None | \$5 | \$15 | \$15 | ◐ | ○ | ○ | ○ | ◐ | ● | N1 |
| Oregon | | | | | | | | | | | | |
| Kaiser Permanente-High | \$10 | None | \$10 | \$20 | \$20 | ◐ | ● | ○ | ○ | ● | ● | N1 |
| Kaiser Permanente-Std | \$15 | None | \$15 | \$30 | \$30 | ◐ | ● | ○ | ○ | ● | ● | N1 |
| PacifiCare Health Plans | \$10 | None | \$5 | \$15 | \$15 | ○ | ○ | ◐ | ◐ | ○ | ● | N1 |
| Panama | | | | | | | | | | | | |
| Panama Canal Area - In-Network | \$10 | \$75 | 50% | 50% | 50% | | | | | | | |
| Panama Canal Area - Out-of-Network | 50% | \$125 | 50% | 50% | 50% | | | | | | | |

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Pennsylvania | | | | | |
| Aetna U. S. Healthcare, Inc. - Southeastern PA | 800/537-9384 | P31 | P32 | 34.65 | 138.95 |
| HealthAmerica Pennsylvania - Greater Pittsburgh area | 800/735-4404 | 261 | 262 | 12.98 | 64.82 |
| HealthAmerica Pennsylvania - Central Pennsylvania | 800/788-8445 | SW1 | SW2 | 14.91 | 87.64 |
| HealthGuard - Berks/Cmbrlnd/Dauphine/Lanc/Lebanon/York | 800/822-0350 | NQ1 | NQ2 | 11.20 | 29.13 |
| Keystone Health Plan Central - Harrisburg/Northern Region/Lehigh Valley | 800/622-2843 | S41 | S42 | 35.96 | 116.16 |
| Keystone Health Plan East - Philadelphia area | 800/227-3115 | ED1 | ED2 | 19.37 | 103.76 |
| KeystoneBlue - Pittsburgh/Altoona/Erie areas | 800/421-0959 | EF1 | EF2 | 36.26 | 196.48 |
| HealthNet of Pennsylvania - Phila. and 7 adjacent PA and NJ counties | 800/736-2096 | 271 | 272 | 41.54 | 119.21 |
| HealthNet of Pennsylvania - Scranton/Wilkes Barre areas | 800/736-2096 | 2K1 | 2K2 | 19.94 | 81.89 |
| UPMC Health Plan - Pittsburgh Area | 412/454-7529 | 8W1 | 8W2 | 10.52 | 26.84 |
| Puerto Rico | | | | | |
| Triple-S - All of Puerto Rico | 787/749-4777 | 891 | 892 | 10.25 | 22.02 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | | |
|------------------------------|----------------------------------|------------------------------------|--------------------|------------|-----------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|--|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited | |
| Pennsylvania | | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ◐ | ● | ● | ● | ◐ | ◐ | | |
| HealthAmerica Pennsylvania | \$10 | None | \$8 | \$14 | \$35 | ● | ● | ● | ● | ● | ● | N1 | |
| HealthAmerica Pennsylvania | \$10 | None | \$8 | \$14 | \$35 | ● | ● | ● | ● | ● | ● | N1 | |
| HealthGuard | \$10 | None | \$10 | \$25 | \$40 | ● | ● | ● | ◐ | ● | ● | N1 | |
| Keystone Health Plan Central | \$10 | None | \$10 | \$10 | \$10 | ● | ● | ● | ● | ● | ● | N1 | |
| Keystone Health Plan East | \$10 | None | \$5 | \$5 | \$5 | ◐ | ● | ● | ● | ● | ● | N1 | |
| KeystoneBlue | \$10 | \$100 | \$8 | \$14 | \$14 | ● | ● | ● | ◐ | ● | ● | N1 | |
| HealthNet of Pennsylvania | \$10 | None | \$10 | \$20 | \$35 | ◐ | ◐ | ● | ● | ○ | ◐ | | |
| HealthNet of Pennsylvania | \$10 | None | \$10 | \$20 | \$35 | | | | | | | | |
| UPMC Health Plan | \$10 | None | \$5 | \$15 | \$15 | X | X | X | X | X | X | | |
| Puerto Rico | | | | | | | | | | | | | |
| Triple-S | - In-Network - Out-of-Network | \$7.50 \$7.50 + 10% | None Most | \$2 25% | \$5/\$10 25% | \$10 or 20% 25% | ● | ● | ○ | ● | ● | ○ | |

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|---|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Rhode Island | | | | | |
| Blue Chip, Coord Hlth Partners - All of Rhode Island | 401/459-5500 | DA1 | DA2 | 22.18 | 101.32 |
| South Dakota | | | | | |
| Avera Health Plan - Eastern and Central South Dakota | 888/322-2115 | AV1 | AV2 | 11.83 | 27.16 |
| Sioux Valley Health Plan - Eastern/Central/Rapid City areas | 800/752-5863 | AU1 | AU2 | 44.79 | 94.48 |
| Tennessee | | | | | |
| Aetna U. S. Healthcare, Inc. - Nashville/Middle Tennessee areas | 800/537-9384 | 6J1 | 6J2 | 16.12 | 114.18 |
| Aetna U. S. Healthcare, Inc. - Memphis area | 800/537-9384 | UB1 | UB2 | 11.65 | 80.40 |
| HealthSpring - Nashville/Middle Tennessee areas | 615/291-5030 | 6K1 | 6K2 | 13.09 | 89.16 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|---|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Rhode Island | | | | | | | | | | | | |
| Blue Chip, Coord Hlth Partners - In-Network | \$10 | None | \$5 | \$15 | \$30 | ● | ● | ● | ● | ● | ◐ | N1 |
| - Out-of-Network | 20% | None | \$30 + 20% | \$30 + 20% | \$30 + 20% | | | | | | | |
| South Dakota | | | | | | | | | | | | |
| Avera Health Plan | \$10 | \$250 | \$10 | \$20 | \$35 | | | | | | | |
| Sioux Valley Health Plan - In-Network | \$10 | \$100 | \$10 | \$20 | \$20 | | | | | | | J3,N6 |
| - Out-of-Network | 40% | 40% | 40% | 40% | 40% | | | | | | | |
| Tennessee | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ○ | ◐ | ◐ | ○ | ○ | N1 |
| Aetna U. S. Healthcare, Inc. | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ◐ | ◐ | ○ | ◐ | ◐ | ◐ | N1 |
| HealthSpring | \$10 | None | \$10 | \$20 | \$35 | | | | | | | N1 |

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

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Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|--|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Texas | | | | | |
| Amcare Health Plans - Houston/El Paso areas | 800/782-8373 | 2V1 | 2V2 | 11.58 | 34.32 |
| Amcare Health Plans - Austin/San Antonio /Dallas/Ft. Worth areas | 800/782-8373 | ZG1 | ZG2 | 11.45 | 31.38 |
| FIRSTCARE - Waco area | 800/884-4901 | 6U1 | 6U2 | 26.78 | 57.04 |
| FIRSTCARE - West Texas | 800/884-4901 | CK1 | CK2 | 41.94 | 89.58 |
| HMO Blue Texas - Austin/C.Christi/S.Antonio/Victoria/Houston | 800/833-5318 | YM1 | YM2 | 13.45 | 57.60 |
| HMO Blue Texas - Dallas/Ft. Worth/East & West Texas | 877/299-2377 | YX1 | YX2 | 24.25 | 88.59 |
| Humana Health Plan of Texas - San Antonio area | 888/393-6765 | UR1 | UR2 | 11.59 | 29.78 |
| Mercy Health Plans/Premier - Webb/Zapata/Duval/Jim Hogg Counties | 800/617-3433 | HM1 | HM2 | 17.86 | 82.59 |
| PacifiCare Health Plans - San Antonio/Dallas/Ft Worth | 800/531-3341 | GF1 | GF2 | 11.21 | 29.30 |
| Utah | | | | | |
| Altius Health Plans - Wasatch Front | 800/377-4161 | 9K1 | 9K2 | 37.44 | 87.54 |
| Vermont | | | | | |
| MVP Health Plan - All of Vermont | 888/687-6277 | VW1 | VW2 | 77.87 | 248.12 |

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Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ● average, ○ below average | | | | | | |
|--|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Texas | | | | | | | | | | | | |
| Amcare Health Plans | \$10 | None | \$5 | \$15 | 50% | X | X | X | X | X | X | N6 |
| Amcare Health Plans | \$10 | None | \$5 | \$15 | 50% | | | | | | | N6 |
| FIRSTCARE | \$10 | None | \$10 | \$20 | \$30 | ○ | ● | ● | ● | ● | ● | |
| FIRSTCARE | \$10 | None | \$10 | \$20 | \$30 | ● | ● | ● | ● | ● | ● | |
| HMO Blue Texas | \$10 | \$100 | \$5 | \$10 | \$25 | ○ | ○ | ○ | ● | ○ | ○ | N2 |
| HMO Blue Texas | \$10 | \$100 | \$5 | \$10 | \$25 | ○ | ○ | ○ | ● | ● | ● | N2 |
| Humana Health Plan of Texas | \$10 | None | \$5 | \$20 | \$40 | ○ | ○ | ○ | ○ | ● | ○ | |
| Mercy Health Plans/Premier - In-Network | \$10 | None | \$7 | \$12 | \$25 | ● | ● | ● | ● | ● | ● | |
| - Out-of-Network | 30% | 30% | N/A | N/A | N/A | | | | | | | |
| PacifiCare Health Plans | \$10 | None | \$5 | \$15 | \$15 | ○ | ○ | ○ | ● | ○ | ○ | N2 |
| Utah | | | | | | | | | | | | |
| Altius Health Plans | \$10 | None | \$10 | \$15 | \$30 | ○ | ● | ○ | ● | ○ | ○ | |
| Vermont | | | | | | | | | | | | |
| MVP Health Plan | \$10 | None | \$5 | \$20 | \$20 | ● | ● | ● | ● | ● | ● | N2 |

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

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Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|--|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| Virginia | | | | | |
| Aetna U. S. Healthcare, Inc.-High -N.VA/Fredericksburg areas | 800/537-9384 | JN1 | JN2 | 22.50 | 69.55 |
| Aetna U. S. Healthcare, Inc.-Std - N.VA/Fredericksburg areas | 800/537-9384 | JN4 | JN5 | 10.79 | 25.24 |
| CareFirst BlueChoice - Northern Virginia | 800/680-9495 | 2G1 | 2G2 | 18.34 | 51.85 |
| HealthKeepers - Eastern,Central,F'burg,Western,SW areas | 800/421-1880 | X81 | X82 | 12.73 | 52.12 |
| Kaiser Permanente - Washington, DC area | 301/468-6000 | E31 | E32 | 12.04 | 29.75 |
| MD-IPA - N.VA/Cntrl VA/Richmond/Tidewater/Roanoke | 800/251-0956 | JP1 | JP2 | 13.56 | 54.22 |
| OPTIMA Health Plan - Peninsula/Southside Hampton Roads | 800/206-1060 | 9R1 | 9R2 | 28.01 | 89.61 |
| Piedmont Community Healthcare - Lynchburg area | 888/674-3368 | 2C1 | 2C2 | 25.36 | 73.05 |
| Washington | | | | | |
| Aetna U. S. Healthcare, Inc. - Western/Southeast Washington | 800/537-9384 | 8J1 | 8J2 | 12.46 | 52.77 |
| Group Health Cooperative - Most of Western Washington | 206/448-4140 | 541 | 542 | 19.72 | 55.83 |
| Group Health Cooperative - Central WA/Spokane/Colville/Pullman | 800/497-2210 | VR1 | VR2 | 13.42 | 71.48 |
| Kaiser Permanente-High -Vancouver/Longview | 800/813-2000 | 571 | 572 | 24.87 | 72.61 |
| Kaiser Permanente-Std - Vancouver/Longview | 800/813-2000 | 574 | 575 | 13.50 | 40.26 |
| Kitsap Physicians Service-High -Most of Western Washington | 800/552-7114 | VT1 | VT2 | 69.10 | 146.30 |
| Kitsap Physicians Service-Std - Most of Western Washington | 800/552-7114 | VT4 | VT5 | 24.82 | 57.77 |
| PacifiCare Health Plans - Clark County | 800/531-3341 | 7Z1 | 7Z2 | 57.68 | 134.67 |
| PacifiCare Health Plans - Puget Sound/Most West WA | 800/531-3341 | WB1 | WB2 | 21.64 | 107.95 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ◐ average, ○ below average | | | | | | |
|---|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| | | | | | | | | | | | | |
| Virginia | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc.-High | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ○ | ○ | ○ | ◐ | ○ | ○ | N2 |
| Aetna U. S. Healthcare, Inc.-Std | \$20 | \$200-\$600 | \$10 | \$20 | 50% | ○ | ○ | ○ | ◐ | ○ | ○ | N2 |
| CareFirst BlueChoice* | \$10 | None | \$10 | \$20 | \$35 | ◐ | ◐ | ◐ | ◐ | ○ | ○ | N2 |
| HealthKeepers | \$10 | \$100 | \$5 | \$10 | \$25 | ◐ | ◐ | ○ | ◐ | ◐ | ● | N1 |
| Kaiser Permanente | \$10 | \$100 | \$10 | \$20 | \$20 | ◐ | ○ | ◐ | ○ | ● | ○ | N2 |
| MD-IPA | \$10 | None | \$5 | \$15 | \$30 | ● | ● | ◐ | ◐ | ● | ◐ | N1 |
| OPTIMA Health Plan | \$10 | None | \$10 | \$20 | \$40 | ● | ● | ● | ● | ● | ● | N1 |
| Piedmont Community Healthcare - In-Network | \$10 | None | \$5 | \$15 | \$15 | | | | | | | |
| | 30% | None | \$5 | \$15 | \$15 | | | | | | | |
| Washington | | | | | | | | | | | | |
| Aetna U. S. Healthcare, Inc. | \$15 | \$100-\$300 | \$10 | \$20 | 50% | ○ | ○ | ◐ | ◐ | ○ | ○ | |
| Group Health Cooperative | \$10 | \$100-\$300 | \$10 | \$20 | \$20 | ◐ | ◐ | ◐ | ◐ | ◐ | ◐ | N1 |
| Group Health Cooperative | \$10 | \$100-\$300 | \$10 | \$20 | \$20 | ◐ | ◐ | ◐ | ◐ | ◐ | ◐ | N1 |
| Kaiser Permanente-High | \$10 | None | \$10 | \$20 | \$20 | ◐ | ● | ○ | ○ | ● | ● | N1 |
| Kaiser Permanente-Std | \$15 | None | \$15 | \$30 | \$30 | ◐ | ● | ○ | ○ | ● | ● | N1 |
| Kitsap Physicians Service-High | \$10 | \$200 | 50% | 50% | 50% | ● | ● | ● | ● | ● | ● | |
| Kitsap Physicians Service-Std | 20% | None | \$5 | \$15 | \$100 or 50% | ● | ● | ● | ● | ● | ● | |
| PacifiCare Health Plans | \$10 | None | \$5 | \$15 | \$15 | ○ | ○ | ● | ◐ | ○ | ○ | N1 |
| PacifiCare Health Plans | \$10 | None | \$5 | \$15 | \$15 | ○ | ○ | ● | ◐ | ○ | ○ | N1 |

* Previously CapitalCare, which had Commendable NCQA accreditation.

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 Doctor Office shows what you pay for each office visit to your primary care doctor. **Hospital per Stay Deductible/Copay** is the amount you pay when you are admitted into a hospital.

| Plan name – location | Telephone number | Enrollment code | | Biweekly Premium Your Share | |
|--|------------------|-----------------|---------------|-----------------------------|---------------|
| | | Self only | Self & family | Self only | Self & family |
| West Virginia | | | | | |
| Health Plan Upper OH Valley - Northern/Central West Virginia | 800/624-6961 | U41 | U42 | 13.20 | 87.52 |
| Wisconsin | | | | | |
| Dean Health Plan - South Central Wisconsin | 800/279-1301 | WD1 | WD2 | 13.31 | 84.42 |
| Group Health Coop - South Central Wisconsin | 608/251-3356 | WJ1 | WJ2 | 13.07 | 76.65 |
| Group Hlth Coop/Eau Claire - West Central Wisconsin | 715/552-4300 | WT1 | WT2 | 66.29 | 217.77 |
| HealthPartners Classic-High -Pierce/St. Croix Counties | 952/883-5000 | 531 | 532 | 34.50 | 109.78 |
| HealthPartners Classic-Std - Pierce/St. Croix Counties | 952/883-5000 | 534 | 535 | 29.11 | 96.88 |
| HealthPartners Primary Clinic - West Central Wisconsin | 952/883-5000 | HQ1 | HQ2 | 56.73 | 163.17 |
| Unity Health Plans - Southern/Central Wisconsin | 800/362-3310 | W41 | W42 | 28.10 | 128.80 |
| Wyoming | | | | | |
| WINhealth Partners - Wyoming | 307/638-7700 | PV1 | PV2 | 12.96 | 76.72 |

Prescription drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. Non-formulary refers to prescriptions that are not on the plan's preferred list. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See pages 4-5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See page 5 for details. A lower number means a better accreditation.

| Plan name | Primary care doctor office copay | Hospital per stay deductible/copay | Prescription drugs | | | Enrollee Survey Results ● above average, ● average, ○ below average | | | | | | |
|-------------------------------|----------------------------------|------------------------------------|--------------------|------------|---------------|--|---------------------|----------------------|------------------------------|------------------|-------------------|------------|
| | | | Generic | Brand Name | Non-formulary | Overall plan satisfaction | Getting needed care | Getting care quickly | How well doctors communicate | Customer service | Claims processing | Accredited |
| West Virginia | | | | | | | | | | | | |
| Health Plan Upper OH Valley | \$10 | None | \$10 | \$20 | \$35 | ● | ● | ● | ● | ● | ● | N1 |
| Wisconsin | | | | | | | | | | | | |
| Dean Health Plan | \$10 | None | \$10 | \$15 | \$15 | ● | ● | ● | ● | ● | ● | N1 |
| Group Health Coop | \$10 | None | \$6 | \$12 | \$12 | ● | ● | ● | ● | ● | ● | N1 |
| Group Hlth Coop/Eau Claire | \$10 | None | \$10 | \$10 | \$10 | ● | ● | ● | ● | ● | ● | |
| HealthPartners Classic-High | \$15 | None | \$10 | \$20 | \$20 | ● | ● | ● | ● | ● | ● | N1 |
| HealthPartners Classic-Std | \$20 | \$200 | \$11 | \$22 | \$22 | ● | ● | ● | ● | ● | ● | N1 |
| HealthPartners Primary Clinic | \$15 | None | \$10 | \$10 | \$10 | ● | ● | ● | ● | ● | ● | N1 |
| Unity Health Plans | \$10 | None | \$6 | \$12 | \$24 | ● | ● | ● | ● | ● | ● | |
| Wyoming | | | | | | | | | | | | |
| WINhealth Partners | \$10 | None | \$10 | \$40 | \$40 | | | | | | | |

Notes

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