Guide to Federal Employees Health Benefits Plans

For United States Postal Service Employees

Retirement and
Insurance Service

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

RI 70-2
Revised November 2002

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present the Federal Employees Health Benefits (FEHB) Program Guide for the FEHB Open Season. I would like to take this opportunity to encourage you to become informed about your health plan choices this year. In keeping with the President's health care agenda, we are committed to providing FEHB Program members with affordable, quality health care choices. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep this program a model of consumer choice and on the cutting edge of employer-provided health benefits. I reminded them of President Bush's principles for health care: patient-centered health care, preservation of choice, and excellent quality. I encouraged each plan to explore all reasonable options to hold down premium increases while maintaining a benefits package that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with the plans to provide health plan choices this year that maintain competitive benefit packages and yet keep health care affordable. We will continue on this path.

Now, it is your turn. This is the time to reevaluate your personal needs and to change plans, if necessary, based on those needs. The Guide provides a comparison of the plans, benefits, premiums, results of a customer satisfaction survey and quality information. If you review the Guide and the health plan brochures you will have the information you need to make an informed choice. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

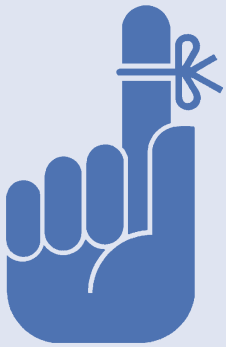
Table of Contents

Page:

Program Features 1
FEHB and You 2
- Overview 2
- Coverage 2
- FEHB Open Season 3
- Getting Information and Selecting a Health Plan 5
  - Quality 5
  - • Member Survey Results 5
  - • Accreditation 6
  - Benefits 6
  - Cost 6
  - How the Plan Works 7

Pre-Tax Payment of Premium Contributions 9
Patient Safety 12
Stop Health Care Fraud 13
Web Resources 14
Quality and Safety Links 15
Plan Comparisons
- Fee-For-Service Plans – Open to All 17
- Fee-For-Service Plans Open ONLY to Specific Groups 21
- Health Maintenance Organization Plans and Plans Offering a Point of Service 25

Things to Remember



- ☑ Note premiums changes for 2003
- ☑ Be aware of benefit changes for 2003.
- ☑ Make any new or change in election **NO LATER THAN DECEMBER 9, 2002**
- ☑ 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. Be sure to read the plan brochures before you make any final decisions about health plans.

Program Features

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

- **A Choice of Coverage.** Choose between self only or self and family.

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

- **A Government Contribution.** The US Postal Service pays 85 percent of the average premium toward the total cost of your premium, but not more than 88.75 percent of the total premium for any plan.

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

- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enrollment. This year Open Season runs from November 11, 2002 through December 9, 2002, and all Open Season enrollment changes become effective January 11, 2003. Other events allow for certain types of changes throughout the year; see your local personnel office for details.

- **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 regarding specific deadlines.

- **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 regarding specific deadlines.

FEHB and You

Overview

The United States Postal Service (USPS) provides health benefits to its career employees by participating in the Federal Employees Health Benefits (FEHB) Program, which is administered by the U.S. Office of Personnel Management (OPM), Office of Insurance Programs. FEHB began operation in July 1960 and almost 8.5 million people are in the program, including 2.2 million federal and postal employees, 1.85 million retirees and eligible family members. It is the largest employer-sponsored health insurance program in the world. OPM interprets health insurance laws and writes regulations for the FEHB Program. It gives advice and guidance to the USPS and other participating agencies to process your enrollment changes and to deduct your premiums. OPM also contracts with and monitors all of the plans participating in the FEHB Program.

The purpose of this 2003 Guide to Federal Employees Health Benefits (FEHB) Plans is to provide information about enrollment and premium features that USPS career employees must consider when selecting a health insurance plan under the FEHB Program. The Guide is a summary of FEHB plans -- the plan brochures give specific benefit information. You can get individual plan brochures directly from the health plans 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 17 through 20) and from Health Maintenance Organizations (HMOs) plans if you live (or sometimes if you work) within the area serviced by the plan (see pages 25 through 51). 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 2003 are the same for federal and USPS employees alike, the Postal Service pays a higher percentage contribution towards career postal employee premium rates than the rest of the federal government. All employee premium rates are calculated using the "Fair Share Formula."

Coverage

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

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

- During Open Season
- When certain life events occur (see pages 6 & 7 of SF 2809). ***These elections MUST be made within 60 days of the event.***

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 SF 2809, Health Benefits Election Form, (July 1999 edition).

Loss of Coverage - When an event occurs that causes you or your family member to lose coverage, the FEHB Program offers a continuation of coverage feature, either temporarily or by permanent conversion to a private sector policy. Such events include but are not limited to:

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

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

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

FEHB Open Season

Each year you have the opportunity to enroll or change enrollment during an open season. **The 2002 Open Season is from November 11 through close of business December 9.** 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 of this Guide)
- 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 9, 2002**. It is critical that this be done timely.

Your new enrollment or any changes that you make to your existing coverage will take effect on **January 11, 2003**, and the change in premium rate deductions will be seen in your January 31, 2003 earnings statement. If you decide NOT to change your enrollment, DO NOTHING, and your present enrollment will continue automatically unless your plan is not participating in 2003. If your plan is not participating in 2003, 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 2002 plan year.

If you decide to cancel your coverage during open season, you must submit a Standard Form 2809 that clearly reflects your acceptance of the consequences of cancellation. The cancellation will become effective on January 10, 2003.

If you pay premium contributions on a pre-tax basis (which most career employees do) you will not be able to cancel or reduce (change from Self and Family to Self Only) coverage unless you experience a qualified life status change and your election is in keeping with the change. See pages 9-11 of this Guide on Pre-tax Payment of Premium Contributions.

Should you cancel coverage, you may not enroll again until the next open season unless an event occurs that permits enrollment. See pages 6 and 7 of SF 2809.

Note to those considering retirement: To be eligible to carry your FEHB enrollment into retirement, you must have been continuously covered, either as an enrollee or as an eligible family member under another FEHB enrollment, for the 5 years immediately preceding retirement, or, if less than 5 years, for the entire period since your first opportunity to enroll.

FEHB and You

You, as an employee, are responsible for being informed about your health benefits. You should thoroughly read this Guide, the brochures of plans that interest you, and the bulletin board notices on health benefits topics. These include family member eligibility, the option to continue or terminate an enrollment during periods of non-pay status or insufficient pay, dual enrollment prohibition, coverage for former spouses, and discontinued health insurance plans. Be sure to read the section on the pre-tax payment of health insurance premium contributions, which specifies Internal Revenue Service (IRS) restrictions for reducing or canceling coverage (see pages 9-11 of this Guide).

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 specific brochures directly from the health plans or from your local personnel office. OPM's web site, www.opm.gov/insure, provides the Guides, 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 is how well health plans keep their members healthy or treat them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person -- and getting the best possible results. Health plan quality can be measured from the enrollees' viewpoint (member surveys) and by the independent evaluations (accreditation) in this Guide.

Member survey results in this Guide were collected, scored, and reported by an independent organization - not by the health plans. Here are the survey categories:

Getting Needed Care. Were you satisfied with the choices your health plan gave you to select a personal doctor? Were you satisfied with the time it takes to get a referral to a specialist?

Getting Care Quickly. Did you get the advice or help you needed when you called your doctor during regular office hours? Could you get an appointment for regular or routine care when you wanted?

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

Customer Service. Was your plan helpful when you called its customer service department? Did you have paperwork problems? Were the plan's written materials understandable?

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

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

Accreditation is an approval by a private, independent organization. This approval is given after a nationally recognized organization carefully reviews a health plan and decides if it meets the organization's quality standards. Reviews include on-site visits, assessments of the care and services plans are delivering in important areas of public concern, and records reviews.

The National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and URAC (URAC) are independent, private, not-for-profit organizations dedicated to measuring the quality of health care organizations.

(URAC) are independent, private, not-for-profit organizations dedicated to measuring the quality of health care organizations.

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

NCQA (www.ncqa.org):

1 = Excellent (HMO) or Full (PPO)

2 =Commendable (HMO only)

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

4 = Provisional (HMO and PPO)

6 = New Health Plan

JCAHO (www.jcaho.org):

1 = Accreditation with Full Compliance

2 = Accreditation with Requirements for Improvement

3 = Provisional

4 = Conditional

URAC (www.urac.org):

1 = Full Accreditation

2 = Conditional Accreditation

3 = Provisional Accreditation

Also, you should check your health plan's provider directory to see which provider networks are accredited or credentialed.

Benefits

What type of services do you think you and your family will need?

Are there limits on the number of visits for the services you want or the types of services you want?

All FEHB plans cover major medical benefits -- hospital costs, doctors' inpatient and outpatient visits -- but your share of the costs vary by plan. Don't assume benefits will be the same as they were last year.

- **Read plan brochures and the Change page carefully.**
- **Know what services are covered**
- **Know what services are not covered**

Cost

The premium you pay is an important consideration. 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 how much do you have to pay?

You also need to consider other costs: Check to see how you are protected by the plan's annual out-of-pocket maximum. If you need to go to the hospital, how much will you 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 your prescription?

Do you pay a deductible for the services you need? 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 pays for certain services, making you pay the rest?

- **Review the benefit summary 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. In the first approach, you 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 the specific doctor or hospital you want. Using PPO providers usually will save you money and reduce your paperwork. In the second approach, you choose any doctor and hospital. This may be more expensive for you and require extra 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 only benefit*. In a PPO-only option, you must use the PPO's providers to receive benefits.

Health Maintenance Organizations (HMOs) generally limit their networks of physicians and facilities. You must use their network to get covered services and follow their guidance for referrals, prior authorizations, and other services. HMOs limit your out-of-pocket costs to the relatively low amounts shown in the benefit brochures.

Some plans are **Point Of Service (POS) plans** and have features similar to both FFS plans and HMOs. In a POS, you don't have to use the plan's network of providers, but there are advantages if you do. POS plans are identified in the charts by lines for "In-Network" and "Out-of-Network."

Be sure to look at the primary care physicians, specialists, and hospitals with whom your health plan contracts (the provider network). Does it have the specialists to treat your chronic condition? Does it contract with primary doctors and hospitals that are convenient to you?

Consumer Driven Option – A fee-for-service option under the FEHB that offers you greater control over choices of your health care expenditures. You decide what health care services will be reimbursed under the health care funded Personal Care account. Unused funds from the account will roll over at the end of the year. If you spend the entire account fund before the end of the year, then you must satisfy a member responsibility/deductible **before** benefits are payable under the traditional type of insurance covered by your plan. You decide whether to use PPO or Non-PPO providers to reach the maximum fund allowed under your account.

If you are in a FFS plan and...

You 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

You do not use the PPO (or one is not available):

- You will generally pay more when you get care
- Fewer preventative health care services may be covered
- You will have to file your own claims for services you receive

NOTE: The Blue Cross and Blue Shield Basic Option generally does not pay for non-PPO providers

APWU's Consumer Driven Option differs from its FFS option in many important ways. Read the brochure for details.

If you are in a FFS plan's "PPO-only" option:

- You **must** use network providers to receive benefits.

FEHB and You

If you belong to an HMO:

- You will have limitations on the doctors, providers, and facilities 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...

You 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

You do not use the network providers or referral procedures:

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

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. Verify physician participation.
- 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. Most plans charge you a lower copay if you use generic drugs.
- 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, will probably be covered under non-PPO benefits.)
- **Ask questions.** You deserve a voice in your own health care.

Pre-Tax Payment of Premium Contributions

Pre-Tax Payment of Premium Contributions

The Postal Service has established the pre-tax payment of health insurance premium contributions as a tax-saving benefit feature for its employees. This feature has been sponsored by the Postal Service since 1994. Payment of premiums on a pre-tax basis prohibits enrollees from reducing coverage 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 of this Guide.

Reducing Coverage

When your premium contributions are withheld on a pre-tax basis, certain Internal Revenue Service (IRS) guidelines affect your ability to change coverage. You may elect to reduce your coverage, that is, to cancel your FEHB enrollment, or to go from Self and Family to Self Only coverage, only during an FEHB Open Season, unless one of the following qualified life status changes occur:

Pre-Tax Payment of Premium Contributions

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.

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

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

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

8. 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, or on account of, 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 option, only to reduce (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 documentation requested by your local personnel office. The effective date of a change from Self and Family to Self Only will be the first day of the pay period that follows the pay period in which your 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 (via SF 2809) 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.

Pre-Tax Payment of Premium Contributions

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

Retirement is NOT a qualified life status change that allows cancellation prior to 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 is retroactive to the end of the last pay period in which a premium contribution was withheld from pay. Contact your local personnel office for more information about how termination during periods of non-pay status or insufficient pay affects FEHB enrollment.

How to Waive Pre-Tax Payments

If you wish to pay your premiums with after-tax money, you must contact your local personnel office and ask for Postal Service (PS) Form 8201, Pre-tax Health Insurance Premium Waiver/Restoration Form. Complete the form and return it to your local personnel office by close of business December 9, 2002.

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 permitting event or 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

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.

Stop Health Care Fraud!

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

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

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

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

CALL -- THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

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

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

FEHB Web Resources

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

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

- An interactive tool that will allow you to find the health plans that service your area and will allow you to make side-by-side comparisons of the costs, benefits, and quality indicators of the plans that interest you.
- Electronic versions of all plan brochures.
- Information on enrolling, with the ability to enroll online for annuitants and employees of selected agencies.
- Information on how plans in the FEHB Program coordinate benefit payments with Medicare.
- A comprehensive set of Frequently Asked Questions and answers on all aspects of the Program.
- An online version of the FEHB Handbook for detailed guidance on FEHB policies and procedures.

You can also look at and download:

- All of the FEHB Guides including the Guide for United States Postal Service Employees.
- Plan Brochures that include the benefits, cost, and other major features of each health plan.

Quality and Safety Links

Want more information on health care quality and safety? The following web sites have information consumers can use when considering health plans, doctors and hospitals, medications, and more.

www.ihealthcoalition.org/content/tips.html
- This site offers tips on what to look for when searching for health information on the Internet.

www.ahrq.gov/consumer/pathqpack.htm
- The Agency for Healthcare Research and Quality has made available a wide-ranging list of topics to help consumers choose quality healthcare providers and improve the quality of care they receive.

www.npsf.org
- The National Patient Safety Foundation has information for patients on how to ensure safer healthcare for you and your family.

www.talkaboutrx.org/consumer.html
- The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

http://medlineplus.gov
- The world's largest medical library offering health information from the National Library of Medicine/National Institutes of Health.

www.leapfroggroup.com
- The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.org
- The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety and the quality of healthcare nationwide.

www.quic.gov/report
- Find out what Federal agencies are doing to identify threats to patient safety and help prevent mistakes in the Nation's healthcare delivery system.

www.nchc.org/releases/medical_error.pdf
- The National Coalition on Health Care and the Institute for Healthcare Improvement offer profiles on what institutions and organizations are doing to reduce medical errors and improve patient safety.

2003 Plan Year List of Health Plans with Biweekly Premium Rates for USPS Employees

Nationwide Fee-for-Service Plans Open to All

(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.

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

Consumer Driven Option offers three major benefit elements. (See page 7)

A) In-Network Preventive Care – you pay nothing for preventive services provided in PPO. Your in-network preventive care does not count against your Personal Care Account.

B) Personal Care Account – you pay nothing for the first $1,000 ($2,000 for self and family enrollment) in covered services by your FFS plan. A PPO or Non-PPO provider may provide your service. These services may include limited dental and vision care that you select.

C) Traditional Health Care – you pay stated coinsurance **after** spending the amount allowed in the Personal Care Account **and** satisfy the member responsibility/deductible. A PPO or Non-PPO provider may provide your service.

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	52.76	90.70
APWU Health Plan-High (APWU)	800/222-2798	471	472	32.35	59.45
APWU Health Plan-Consumer Driven (APWU)	800/222-2798	474	475	16.57	41.22
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	25.93	60.14
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	Local phone #	111	112	15.75	37.02
GEHA Benefit Plan-High (GEHA)	800/821-6136	311	312	47.44	89.36
GEHA Benefit Plan-Std (GEHA)	800/821-6136	314	315	12.37	28.12
Mail Handlers-High (MH)	800/410-7778	451	452	44.56	71.46
Mail Handlers-Std (MH)	800/410-7778	454	455	12.64	27.44
NALC	888/636-6252	321	322	28.71	42.37
PBP Health Plan-High (PBP)	800-544-7111	361	362	140.09	285.94
PBP Health Plan-Std (PBP)	800-544-7111	364	365	28.72	62.62

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 below. 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				
						Inpatient		Outpatient other	Generic	Brand Name	Non-formulary	Home Delivery	
		Calendar Year	Prescription Drug			R&B	Other					Generic	Brand Name
AHP	PPO Non-PPO	$200 $400	$200 $200	$150 $250	10% 30%	10% 30%	10% 30%	10% 30%	10%/50% 10%/50% +	15%/50% 15%/50%+	15%/50% 15%/50%+	20% 20%	25% 25%
APWU-High	PPO Non-PPO	$275 $350	None None	None $200	10% 30%	10% 30%	10% 30%	10% 30%	$7 45%	25% 45%	25% 45%	$10 $10	20% 20%
APWU	**See page 7 of this Guide for a benefit description, and carefully read the APWU brochure for details.**												
BCBS-Std	PPO Non-PPO	$250 $250	None None	$100 $300	10% 25%	Nothing 30%	Nothing 30%	10% 25%	25% 45%+	25% 45%+	25% 45%+	$10/25% 45%+	$35/25% 45%+
BCBS-Basic	PPO	None	None	$100/day x 5	$20/$30	Nothing	Nothing	$30	$10	$25	$35 or 50%	$10 *	$25 *
GEHA-High	PPO Non-PPO	$350 $350	None None	$100 $300	10% 25%	Nothing Nothing	10% 25%	10% 25%	$5/50% $5/50% +	$20/50% $20/50% +	$20/$35/50% $20/$35/50% +	$10 $10	$40/$55 $40/$55
GEHA-Std	PPO Non-PPO	$450 $450	None None	None None	15% 35%	15% 35%	15% 35%	15% 35%	$5 $5 +	50% 50% +	50% 50% +	$15 $15	50% 50%
MH-High	PPO Non-PPO	$250 $250	$250 $250	None $250	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%	$7 50%	$23 50%	$35 50%	$10 $10	$30/$45 $30/$45
MH-Std	PPO Non-PPO	$300 $300	$600 $600	$150 $300	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%	$8 50%	$28 50%	$40 50%	$10 $10	$40/$55 $40/$55
NALC	PPO Non-PPO	$250 $300	None $25 for Retail	None $100	15% 30%	10% 30%	10% 30%	15% 30%	25% 40%+	25% 40%+	25% 40%+	$10 $10	$30 $30
PBP-High	PPO Non-PPO	$200 $450	$90 $90	None $150	10% 15%-25%	10% 25%	10% 25%	10% 25%	$3 20%+	$25 or 20% 20%+	$40 or 20% 20%+	$6 $6	$25/ $40 or 20%
PBP-Std	PPO Non-PPO	$250 $500	$90 $90	None $250	9% 30%	9% 30%	9% 30%	9% 30%	$4 30%+	$30 or 20% 30%+	$40 or 20% 30%+	$8 $8	$30/ $40 or 20%

* Home delivery is available from Internet pharmacies and may be available from certain retail pharmacies. The Mail Service Program is not available under Basic Option.

Nationwide Fee-for-Service Plans Open to All

Enrollee Survey Results — See page 5 for a description.

Plan name	Plan code	Enrollee Survey Results ● above average, ◒ average, ○ below average					
		Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Alliance Health Plan	1R	◒	◒	●	●	◒	◒
APWU Health Plan-High	47	●	◒	◒	◒	●	●
APWU Health Plan-Consumer Driven	47						
Blue Cross and Blue Shield Service Benefit Plan-Std	10	○	◒	○	◒	◒	○
Blue Cross and Blue Shield Service Benefit Plan-Basic	11						
GEHA Benefit Plan-High	31	●	◒	○	○	●	●
GEHA Benefit Plan-Std	31	●	◒	○	○	●	●
Mail Handlers-High	45	○	○	○	◒	◒	○
Mail Handlers-Std	45	○	○	○	◒	◒	○
NALC	32	●	●	●	●	●	●
PBP Health Plan-High	36	○	◒	●	●	○	○
PBP Health Plan-Std	36	○	◒	●	●	○	○

2003 Plan Year
List of Health Plans with
Biweekly Premium Rates for USPS Employees

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

(Pages 22 through 24)

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	34.82	82.76
Foreign Service Benefit Plan (FS)	202/833-4910	401	402	19.53	66.11
Panama Canal Area Benefit Plan (PCA)*	800/548-8969	431	432	16.31	34.04
Rural Carrier Benefit Plan (Rural)	800/638-8432	381	382	50.95	71.90
SAMBA	800/638-6589	441	442	53.93	136.18
Secret Service (SS)	800/424-7474	Y71	Y72	17.42	52.38

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					
						Inpatient		Outpatient other	Generic	Brand Name	Non-formulary	Home Delivery	
		Calendar Year	Prescription Drug			R&B	Other					Generic	Brand Name
ABP	PPO Non-PPO	$300 $300	None None	$100 $200	10% 30%	Nothing 30%	Nothing 30%	10% 30%	$10 $10	$20 $20	$30/30% $30/30%	$20 $20	$40/ $45 or 30%
FS	PPO Non-PPO	$300 $300	None None	Nothing $200	10% 30%	Nothing 20%	Nothing 20%	10% 30%	$10/25% $10/25%	$20/25% $20/25%	$20/25% $20/25%	$20 $20	$40 $40
PCA	POS FFS	None None	$400 $400	$50 $125	Nothing 50%	Nothing 50%	Nothing 50%	Nothing 50%	50% 50%	50% 50%	50% 50%	N/A 50%	N/A N/A
Rural	PPO Non-PPO	$350 $350	CY Applies CY Applies	Nothing $200	10% 15%	Nothing 15%	Nothing 15%	15% 25%	25% 25%	25% 25%	25% 25%	$15 $15	$25 $25
SAMBA	PPO Non-PPO	$350 $350	None None	$200 $300	10% 30%	Nothing 30%	10% 30%	$100/10% $150/30%	$10 $10	$25 $25	$40 $40	$10 $10	$35/$50 $35/$50
SS	No PPO	$200	None	$100	20%	Nothing	Nothing	Nothing	$10	$20	$20	$20	$40

*The Panama Canal Area Plan provides a point-of-service product within the Republic of Panama.

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

Enrollee Survey Results — See page 5 for a description.

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

2003 Plan Year List of Health Plans with Biweekly Premium Rates for USPS Employees

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

(Pages 26 through 51)

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 inhospital care.
- Most HMOs ask you to choose a doctor or medical group to be your primary care physician (PCP). Your PCP provides your general medical care. In many HMOs, you must get authorization or a "referral" from your PCP to see other providers. The referral is a recommendation by your physician for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures that you see the right provider for the care most appropriate to your condition.
- Care 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 similar to an HMO and FFS plan.

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.

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
Alabama						
PrimeHealth of Alabama, Inc. - Southern Alabama and the Montgomery Area	800/236-9421	AA1	AA2	11.97	30.68	
The Oath - A Health Plan for Alabama, Inc. - Birmingham/Other areas	800/947-5093	DF1	DF2	25.14	99.97	
Arizona						
Aetna Health Inc. - Phoenix/Tucson areas	800/537-9384	WQ1	WQ2	11.75	32.28	NCQA 1
Health Net of Arizona, Inc. - Maricopa/Pima/Other AZ counties	800/289-2818	A71	A72	14.35	36.37	NCQA 2
PacifiCare Health Plans - Maricopa/Pima/parts of Apache Junction	800/531-3341	A31	A32	14.62	62.24	NCQA 1
California						
Aetna Health Inc. - Southern California area	800/537-9384	2X1	2X2	12.15	28.82	NCQA 2
Blue Cross- HMO - Most of California	800/235-8631	M51	M52	15.01	45.59	NCQA 2
Blue Shield of CA Access+ - Most of California	800/880-8086	SJ1	SJ2	14.73	36.54	NCQA 2
CIGNA HealthCare of California - Northern/Southern California	800/244-6224	9T1	9T2	15.07	33.15	NCQA 2
Health Net - Most of California	800/522-0088	LB1	LB2	14.16	33.53	NCQA 2
Kaiser Permanente - Northern California	800/464-4000	591	592	15.54	37.09	NCQA 1
Kaiser Permanente - Southern California	800/464-4000	621	622	14.55	33.63	NCQA 1
PacifiCare Health Plans - Most of California	800/531-3341	CY1	CY2	11.88	30.75	NCQA 1
UHP Healthcare - LA/Orange/San Bernardino Counties	800/544-0088	C41	C42	11.86	25.25	JCAHO 1
Universal Care - Southern California	800/257-3087	6Q1	6Q2	11.71	30.91	
Colorado						
Kaiser Permanente - Denver/Colorado Springs areas	800/632-9700	651	652	15.11	57.18	NCQA 1
PacifiCare of Colorado-High -Denver/Colorado Springs/Ft.Collins	800/877-9777	D61	D62	16.34	83.01	NCQA 1
PacifiCare of Colorado-Std - Denver/Colorado Springs/Ft.Collins	800/877-9777	D64	D65	11.68	30.35	NCQA 1

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Alabama												
PrimeHealth of Alabama, Inc.	$15	$25	$150/day x 4	$10	$20	$40	◒	◒	●	●	◒	◒
The Oath - A Health Plan for Alabama, Inc.	$20	$20	$100	$10	$20	$30	●	◒	●	●	◒	◒
Arizona												
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	◒	○	○	○	○	◒
Health Net of Arizona, Inc.	$10	$10	$100/day x 5	$10	$30	$45	○	○	○	○	○	○
PacifiCare Health Plans	$10	$20	None	$10	$20	$20	○	○	○	◒	◒	◒
California												
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	○	○	○	○	○	○
Blue Cross- HMO	$10	$10	None	$5	$10	50%	○	○	○	◒	◒	◒
Blue Shield of CA Access+	$10	$10	None	$5	$10	$25	◒	○	○	◒	◒	◒
CIGNA HealthCare of California	$15	$25	$250	$7	$15	$35	○	○	○	○	○	○
Health Net	$10	$10	$100	$10	$20	$35	○	○	○	○	○	○
Kaiser Permanente	$15	$15	None	$10	$25	$25	◒	◒	○	○	◒	◒
Kaiser Permanente	$10	$10	None	$10	$25	$25	◒	◒	○	○	●	◒
PacifiCare Health Plans	$10	$20	None	$10	$20	$20	◒	○	○	○	○	◒
UHP Healthcare	$10	$10	None	$10	$20	N/A						
NCQA 2Universal Care	$10	$10	$100/day x 3	$10	$20	$30	◒	○	○	◒	◒	◒
Colorado												
Kaiser Permanente	$10	$20	$100	$10	$20	$20	◒	◒	○	○	◒	◒
PacifiCare of Colorado-High	$10	$20	$100	$10	$20	$30	○	○	◒	◒	◒	◒
PacifiCare of Colorado-Std	$15	$30	$300	$10	$30	$40	○	○	◒	◒	◒	◒

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
Connecticut						
ConnectiCare - All of Connecticut	800/251-7722	TE1	TE2	15.15	57.97	NCQA 1
District of Columbia						
Aetna Health Inc.-High -Washington, DC area	800/537-9384	JN1	JN2	15.91	35.84	NCQA 1
Aetna Health Inc.-Std - Washington, DC area	800/537-9384	JN4	JN5	11.90	27.84	NCQA 1
CareFirst BlueChoice - Washington, D.C. Metro Area	866/520-6099	2G1	2G2	31.68	66.88	NCQA 1
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	13.86	33.00	NCQA 2
MD-IPA - Washington, DC area	800/251-0956	JP1	JP2	15.61	38.47	
Florida						
Av-Med Health Plan (North Florida) - Tampa	800/882-8633	EM1	EM2	15.97	95.60	NCQA 2
Av-Med Health Plan (South Florida) - Broward, Dade and Palm Beach	800/882-8633	ML1	ML2	14.12	50.42	NCQA 2
Capital Health Plan - Tallahassee area	850/383-3311	EA1	EA2	15.98	82.83	NCQA 1
Foundation Health - Southern Florida	800/441-5501	5E1	5E2	10.24	28.17	NCQA 2
Healthplan Southeast - Florida	850/668-3000	RK1	RK2	14.56	50.86	
Humana Medical Plan - South Florida	888/393-6765	EE1	EE2	13.37	33.43	URAC 1
JMH Health Plan - Broward-Dade counties	800/721-2993	J81	J82	10.90	26.82	
Total Health Choice - Broward/Dade/Palm Beach Counties	305/408-5823	4A1	4A2	13.14	32.74	
Vista Healthplan - South Florida	866/847-8235	3N1	3N2	15.50	89.69	NCQA 2
Georgia						
Aetna Health Inc. - Atlanta and Athens areas	800/537-9384	2U1	2U2	15.69	41.83	NCQA 1
Kaiser Permanente - Atlanta area	800/611-1811	F81	F82	12.96	32.89	NCQA 1

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Connecticut												
ConnectiCare	$10	$10	None	$10	$20	$35	●	●	●	◒	●	●
District of Columbia												
Aetna Health Inc.-High	$15	$20	$150/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
Aetna Health Inc.-Std	$20	$25	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
CareFirst BlueChoice	$20	$30	None	$10	$20	$35	◒	◒	○	○	○	○
Kaiser Permanente	$10	$20	$100	$10$20Net	$20$40Net	$20$40Net	◒	◒	◒	○	●	◒
NCQA 1MD-IPA	$10	$20	None	$8	$17	$33	●	●	◒	◒	●	◒
Florida												
Av-Med Health Plan (North Florida)	$20	$30	$100/day x 5	$15	$30	$50	◒	○	○	◒	◒	◒
Av-Med Health Plan (South Florida)	$15	$15	$100	$10	$20	$30	◒	○	○	◒	◒	◒
Capital Health Plan	$10	$10	$100	$7	$20	$35	●	●	◒	◒	●	●
Foundation Health	$10	$15	$200	$7	$14	$34	○	○	○	○	○	◒
Healthplan Southeast	$10	$10	Nothing	$7	$20	$35						
Humana Medical Plan	$10	$20	$100/day x 3	$5/$20	$20/$40	$100	◒	○	○	◒	◒	
JMH HEALTH PLAN	$10	$10	None	$5	50%	50%						
Total Health Choice	$10	$10	$100	$5	$15	$15						
Vista Healthplan	$10	$20	$250	$10	$20	$40	○	◒	○	◒	◒	◒
Georgia												
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	◒	○	○	◒	◒	◒
Kaiser Permanente	$10	$10	None	$10$16 Com	$10$16Com	$10$16Com	●	●	◒	◒	●	◒

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
Guam						
PacifiCare Asia Pacific-High -Guam/N. Mariana Islands/Palau	671/647-3526	JK1	JK2	13.33	35.03	
PacifiCare Asia Pacific-Std - Guam/N. Mariana Islands/Palau	671/647-3526	JK4	JK5	11.37	30.03	
Hawaii						
HMSA - All of Hawaii	808/948-6499	871	872	13.55	30.17	NCQA 1
Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu/Kauai	808/432-5955	631	632	16.11	34.63	NCQA 1
Kaiser Permanente-Std - Islands of Hawaii/Maui/Oahu/Kauai	808/432-5955	634	635	12.23	26.30	NCQA 1
Idaho						
Group Health Cooperative - Kootenai and Latah	888/901-4636	VR1	VR2	16.31	77.62	NCQA 1
Illinois						
BlueCHOICE - Madison and St. Clair counties	800/634-4395	9G1	9G2	15.71	34.00	NCQA 1
Group Health Plan - Southern/Metro East/Central	800/755-3901	MM1	MM2	37.11	64.16	URAC 1
Health Alliance HMO - Central/E.Central/N.West/South/West IL	800/851-3379	FX1	FX2	22.22	58.31	NCQA 1
Humana Health Plan Inc.-High -Chicago area	888/393-6765	751	752	15.13	36.30	
Humana Health Plan Inc.-Std - Chicago area	888/393-6765	754	755	11.49	27.55	
John Deere Health Plan - Bloomingtn/Joliet/Moline/Peoria/RockIsld	800/247-9110	YH1	YH2	13.97	34.22	NCQA 1
Mercy Health Plans/Premier Health Plans - Southwest Illinois	800/327-0763	7M1	7M2	45.21	110.59	
OSF HealthPlans - Central/Central-Northwestern Illinois	800/673-5222	9F1	9F2	12.78	33.60	NCQA 1
PersonalCare's HMO - Central Illinois	800/431-1211	GE1	GE2	13.25	34.09	NCQA 1
Unicare HMO - Chicagoland Area	888/234-8855	171	172	13.75	55.49	NCQA 1
Union Health Service - Chicago area	312/829-4224	761	762	12.07	29.93	

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Guam												
PacifiCare Asia Pacific-High	$10	$10	None	$5	$20	$20	◒	◒	○	●	◒	◒
PacifiCare Asia Pacific-Std	$15	$15	$150	$5	$20	$20	◒	◒	○	●	◒	◒
Hawaii												
HMSA -In-Network	20%	20%	None	$5	$15	$15 or 50%	●	●	●	●	●	●
HMSA - Out-of-Network	30%	30%	30%	$5+20%+	$15+20%+	$15 or 50%+						
Kaiser Permanente-High	$10	$10	None	$10	$10	$10	●	◒	◒	◒	●	◒
Kaiser Permanente-Std	$15	$15	None	$10	$10	$10	●	◒	◒	◒	●	◒
Idaho												
Group Health Cooperative	$15	$15	$200/day x 3	$15	$25	$50	◒	◒	●	◒	●	●
Illinois												
BlueCHOICE	$10	$10	None	$7	$12	$25						
Group Health Plan	$10	$20	$100	$8	$20	$35	◒	◒	●	◒	◒	◒
Health Alliance HMO	$15	$15	$100	$10	$20	$40	●	◒	●	●	●	●
Humana Health Plan Inc.-High	$10	$20	$100/day x 3	$5/$15	$15/$35	25%	○	◒	○	◒	○	○
Humana Health Plan Inc.-Std	$15	$25	$250/day x 3	$10/$25	$25/$45	25%	○	◒	○	◒	○	○
John Deere Health Plan	$15	$15	$100	$10	$20	$35	●	●	●	●	●	●
Mercy Health Plans/ Premier Health Plans - In-Network	$10	$20	None	$10	$20	$35	●	◒	●	●	●	●
Mercy Health Plans/ Premier Health Plans - Out-of-Network	30%	30%	30%	N/A	N/A	N/A						
OSF HealthPlans	$20	$20	$500	$10	$20	$40	●	●	●	●	◒	●
PersonalCare's HMO	$20	$20	$100/day X 5	$10	$20	$50	●	●	●	◒	●	◒
Unicare HMO	$15	$15	None	$5	$15	$25	○	○	◒	◒	○	○
Union Health Service	$10	$10	None	$15	$15	N/A						

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
Indiana						
Advantage Health Plan, Inc. - Most of Indiana	800/553-8933	6Y1	6Y2	16.99	48.15	NCQA 6
Aetna Health Inc. - Southeastern Indiana	800/537-9384	RD1	RD2	15.75	49.29	NCQA 1
Arnett HMO - Lafayette area	765/448-7440	G21	G22	15.73	68.87	NCQA 1
Health Alliance HMO - Fountain/Vermillion/Warren Counties	800/851-3379	FX1	FX2	22.22	58.31	NCQA 1
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	17.66	72.08	URAC 1
Humana Health Plan Inc.-High -Lake/Porter/LaPorte Counties	888/393-6765	751	752	15.13	36.30	
Humana Health Plan Inc.-Std - Lake/Porter/LaPorte Counties	888/393-6765	754	755	11.49	27.55	
M*Plan - Indiana Metropolitan areas	317/571-5320	IN1	IN2	40.51	94.41	NCQA 1
Physicians Health Plan of Northern Indiana - Northeast Indiana	260/432-6690	DQ1	DQ2	14.57	32.75	
Unicare HMO - Lake/Porter Counties	888/234-8855	171	172	13.75	55.49	NCQA 1
Iowa						
Avera Health Plans - Northwestern Iowa	888/322-2115	AV1	AV2	13.30	31.05	
Coventry Health Care of Iowa - Central Iowa/Cedar Rapids/Sioux City	800/257-4692	SV1	SV2	13.12	35.44	
Health Alliance HMO - Central and Eastern Iowa	800/851-3379	FX1	FX2	22.22	58.31	NCQA 1
John Deere Health Plan - Central/Eastern Iowa	800/247-9110	YH1	YH2	13.97	34.22	NCQA 1
Kansas						
Coventry Health Care of Kansas - Wichita/Salina areas	800/664-9251	7W1	7W2	27.46	104.34	
Coventry Health Care of Kansas - Kansas City - Kansas City area	800/969-3343	HA1	HA2	12.82	33.08	
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	15.84	43.12	URAC 1
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	9.21	22.10	URAC 1
Preferred Plus of Kansas - S. Central Area	800/660-8114	VA1	VA2	17.13	94.09	JCAHO 2
Kentucky						
Humana Health Plan - Louisville area	888/393-6765	D21	D22	17.66	72.08	URAC 1
United Healthcare of Ohio, Inc. - Northern Kentucky	800/231-2918	3U1	3U2	48.79	114.30	NCQA 1

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Indiana												
Advantage Health Plan, Inc.	$15	$30	$400	$10	$30	$50	○	◒	◒	◒	○	○
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
Arnett HMO	$10	$10	None	$5	$15	$30	●	●	●	◒	●	●
Health Alliance HMO	$15	$15	$100	$10	$20	$40	●	◒	●	●	●	●
Humana Health Plan	$15	$25	$250/day x 3	$10/$25	$25/$45	25%	◒	○	○	○	◒	○
Humana Health Plan Inc.-High	$10	$20	$100/day x 3	$5/$15	$15/$35	25%	○	◒	○	◒	○	○
Humana Health Plan Inc.-Std	$15	$25	$250/day x 3	$10/$25	$25/$45	25%	○	◒	○	◒	○	○
M*Plan	$10	$15	$250	$5/$10	$15	$50	◒	◒	●	●	◒	◒
Physicians Health Plan of Northern Indiana	$10	$10	20%of$2500	$5	$15	$40	●	●	●	●	●	●
Unicare HMO	$15	$15	None	$5	$15	$25	○	○	◒	◒	○	○
Iowa												
Avera Health Plans	$10	$15	$100/dayx3	$10	$20	$35 or 50%						
Coventry Health Care of Iowa	$10	$10	None	$5	$15	$30	○	●	●	◒	○	◒
Health Alliance HMO	$15	$15	$100	$10	$20	$40	●	◒	●	●	●	●
John Deere Health Plan	$15	$15	$100	$10	$20	$35	●	●	●	●	●	●
Kansas												
Coventry Health Care of Kansas	$15	$15	$100/day x 3	$5	$15	$45						
Coventry Health Care of Kansas - Kansas City	$15	$15	$100/day x 3	$10	$20	$50	○	◒	◒	◒	○	○
Humana Health Plan, Inc.-High	$10	$20	$100/day x 3	$5/$20	$20/$40	25%	○	◒	◒	○	○	○
Humana Health Plan, Inc.-Std	$15	$25	$250/day x 3	$10/$25	$25/$45	25%	○	◒	◒	○	○	○
Preferred Plus of Kansas	$10	$10	$50/day x 10	$5	$15	$15						
Kentucky												
Humana Health Plan	$15	$25	$250/day x 3	$10/$25	$25/$45	25%	◒	○	○	○	◒	○
United Healthcare of Ohio, Inc.	$15	$15	$250	$10	$15	$30	◒	●	●	◒	◒	◒

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
Louisiana						
Coventry Healthcare Louisiana - New Orleans area	800/341-6613	BJ1	BJ2	14.61	33.94	
Coventry Healthcare Louisiana - Baton Rouge area	800/341-6613	JA1	JA2	15.40	35.77	
Vantage Health Plan - Monroe area	888/823-1910	AQ1	AQ2	24.15	116.26	
Vantage Health Plan - Shreveport/Alexandria areas	888/823-1910	MV1	MV2	33.32	140.89	
Maryland						
Aetna Health Inc.-High -North/Central/Southern Maryland	800/537-9384	JN1	JN2	15.91	35.84	NCQA 1
Aetna Health Inc.-Std - North/Central/Southern Maryland	800/537-9384	JN4	JN5	11.90	27.84	NCQA 1
CareFirst BlueChoice - All of Maryland	866/520-6099	2G1	2G2	31.68	66.88	NCQA 1
Kaiser Permanente - Baltimore/Washington, DC areas	301/468-6000	E31	E32	13.86	33.00	NCQA 2
MD-IPA - All of Maryland	800/251-0956	JP1	JP2	15.61	38.47	NCQA 1
Massachusetts						
Blue Chip, Coord Hlth Partners - Southeastern Massachusetts	401/459-5500	DA1	DA2	33.36	121.08	NCQA 1
ConnectiCare - Counties Hampden, Hampshire, Franklin	800/251-7722	TE1	TE2	15.15	57.97	NCQA 1
Fallon Community Health Plan - Central/Eastern Massachusetts	800/868-5200	JV1	JV2	15.90	68.45	NCQA 1

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Louisiana												
Coventry Healthcare Louisiana	$15	$15	$100/day x 3	$10	$20	$45	○	○	○	◒	○	○
Coventry Healthcare Louisiana	$15	$15	$100/day x 3	$10	$20	$45	○	○	○	◒	○	○
Vantage Health Plan	$15	$15	$250	$10	$20	$35						
Vantage Health Plan	$15	$15	$250	$10	$20	$35						
Maryland												
Aetna Health Inc.-High	$15	$20	$150/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
Aetna Health Inc.-Std	$20	$25	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
CareFirst BlueChoice	$20	$30	None	$10	$20	$35	◒	◒	○	○	○	○
Kaiser Permanente	$10	$20	$100	$10$20Net	$20$40Net	$20$40Net	◒	◒	◒	○	●	◒
MD-IPA	$10	$20	None	$8	$17	$33	●	●	◒	◒	●	◒
Massachusetts												
Blue Chip, Coord Hlth Partners - In-Network	$15	$25	$500	$7	$25	$40	◒	●	●	◒	◒	◒
- Out-of-Network	30%	30%	None	$40 + 20%	$40 + 20%	$40 + 20%						
ConnectiCare	$10	$10	None	$10	$20	$35						
Fallon Community Health Plan	$10	$10	None	$5	$15	$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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
Michigan						
Bluecare Network of MI - Cheboygan and Roscommon Counties Area	800/662-6667	G71	G72	113.05	317.44	NCQA 1
Bluecare Network of MI - Midland County Area	800/662-6667	K51	K52	14.88	75.13	NCQA 1
Bluecare Network of MI - Kalamazoo County Area	800/662-6667	KF1	KF2	45.32	185.31	NCQA 1
Bluecare Network of MI - Genesee County Area	800/662-6667	KN1	KN2	15.92	100.77	NCQA 1
Bluecare Network of MI - Kent County Area	800/662-6667	KR1	KR2	16.98	127.02	NCQA 1
Bluecare Network of MI - Mid Michigan	800/662-6667	LN1	LN2	48.66	133.16	NCQA 1
Bluecare Network of MI - Southeast MI	800/662-6667	LX1	LX2	11.55	34.54	NCQA 1
Grand Valley Health Plan - Grand Rapids area	616/949-2410	RL1	RL2	15.14	83.28	NCQA 1
Health Alliance Plan - Southeastern Michigan/Flint area	800/422-4641	521	522	13.89	36.82	NCQA 1
HealthPlus MI - Flint/Saginaw areas	800/332-9161	X51	X52	21.04	73.21	NCQA 1
M-Care - Mid and Southeastern Michigan	800/658-8878	EG1	EG2	13.41	35.53	NCQA 1
OmniCare - Southeastern Michigan	800/477-6664	KA1	KA2	13.52	33.25	NCQA 4
The Wellness Plan - Detroit/Flint Areas	800/875-9355	K31	K32	11.10	30.00	
Total Health Care - Greater Detroit/Flint Areas	800/826-2862	N21	N22	13.33	33.91	
Minnesota						
Avera Health Plans - Southwestern Minnesota	888/322-2115	AV1	AV2	13.30	31.05	
HealthPartners Classic - Minneapolis/St. Paul/St. Cloud Areas	952/883-5000	531	532	34.10	96.81	NCQA 1
HealthPartners Primary Clinic Plan - Minneapolis/St. Paul/St. Cloud Areas	952/883-5000	HQ1	HQ2	74.02	192.61	

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Michigan												
Bluecare Network of MI	$15	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒
Bluecare Network of MI	$15	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒
Bluecare Network of MI	$15	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒
Bluecare Network of MI	$15	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒
Bluecare Network of MI	$15	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒
Bluecare Network of MI	$15	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒
Bluecare Network of MI	$15	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒
Grand Valley Health Plan	$10	$10	None	$5	$5	$5	●	◒	●	◒	●	◒
Health Alliance Plan	$10	$10	None	$10	$20	$30	◒	◒	◒	●	◒	◒
HealthPlus MI	$10	$10	None	$5	$10	$10	●	●	●	●	●	●
M-Care	$10	$10	None	$10	$20	$30	●	◒	◒	◒	●	●
OmniCare	$10	$10	None	$2	$2	$2	○	○	○	◒	◒	○
The Wellness Plan	$10	$10	None	$5	$5	$5	○	○	○	○	○	○
Total Health Care	$10	Nothing	None	Nothing	Nothing	Nothing	○	○	○	○	○	◒
Minnesota												
Avera Health Plans	$10	$15	$100/dayx3	$10	$20	$35 or 50%						
HealthPartners Classic	$15	$15	$100	$12	$12	$24	◒	◒	◒	◒	◒	◒
HealthPartners Primary	$20	$20	$200	$12	$12	$24	◒	◒	◒	◒	◒	◒

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
Missouri						
BlueCHOICE - StLouis/Central/SW Areas	800/634-4395	9G1	9G2	15.71	34.00	NCQA 1
Coventry Health Care of Kansas - Kansas City - Kansas City Area	800/969-3343	HA1	HA2	12.82	33.08	
Group Health Plan - St. Louis Area	800/755-3901	MM1	MM2	37.11	64.16	URAC 1
Humana Health Plan, Inc.-High -Kansas City Area	888/393-6765	MS1	MS2	15.84	43.12	URAC 1
Humana Health Plan, Inc.-Std - Kansas City Area	888/393-6765	MS4	MS5	9.21	22.10	URAC 1
Mercy Health Plans/Premier Health Plans - East/Central;Southwest Missouri	800/327-0763; 800/836-0402	7M1	7M2	45.21	110.59	
Montana						
New West Health Plan - Most of Montana	800/290-3657	NV1	NV2	14.98	33.34	
Nevada						
Health Plan of Nevada - Las Vegas/Reno Areas	800/777/1840	NM1	NM2	11.00	28.18	NCQA 3
PacifiCare Health Plans - Clark County	800/531-3341	K91	K92	14.01	39.54	NCQA 2
New Jersey						
Aetna Health Inc. - All of New Jersey	800/537-9384	P31	P32	19.48	63.64	NCQA 1
AmeriHealth HMO - All of New Jersey	800/454-7651	FK1	FK2	18.24	56.30	NCQA 1
GHI Health Plan - Northern New Jersey	212/501-4444	801	802	39.62	126.90	URAC 1
New Mexico						
Cimarron Health Plan - All of New Mexico	800/473-0391	PX1	PX2	14.68	48.36	NCQA 2
Lovelace Health Plan - All of New Mexico	800/244-6224	Q11	Q12	15.06	53.28	NCQA 2 JCAHO 1
Presbyterian Health Plan - All NM counties except Otero & S. Eddy	505/923-5678	P21	P22	13.96	36.41	NCQA 2

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Missouri												
BlueCHOICE	$10	$10	None	$7	$12	$25	◒	◒	●	●	◒	◒
Coventry Health Care of Kansas - Kansas City	$15	$15	$100/day x 3	$10	$20	$50	○	◒	◒	◒	○	○
Group Health Plan	$10	$20	$100	$8	$20	$35	◒	◒	●	◒	◒	◒
Humana Health Plan, Inc.-High	$10	$20	$100/day x 3	$5/$20	$20/$40	25%	○	◒	◒	○	○	○
Humana Health Plan, Inc.-Std	$15	$25	$250/day x 3	$10/$25	$25/$45	25%	○	◒	◒	○	○	○
Mercy Health Plans/ Premier Health Plans - In-Network	$10	$20	None	$10	$20	$35	●	◒	◒	◒	●	●
Premier Health Plans - Out-of-Network	30%	30%	30%	N/A	N/A	N/A						
Montana												
New West Health Plan	$15	$15	$100	$10	$20	$20						
Nevada												
Health Plan of Nevada	$10	$10	$100	$5	$20	$35	○	○	○	○	○	◒
PacifiCare Health Plans	$10	$20	None	$10	$20	$20	○	○	○	○	○	◒
New Jersey												
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
AmeriHealth HMO	$30	$35	$200/day x 3	$20	$40	50%	○	●	◒	◒	◒	○
GHI Health Plan - In-Network	$15	$15	None	$10	$20	$50	◒	●	◒	◒	◒	◒
GHI Health Plan - Out-of-Network	50% of sch.	50% of sch.	None	N/A	N/A	N/A						
New Mexico												
Cimarron Health Plan	$10	$10	None	$5	$10	$25	◒	○	○	◒	◒	◒
Lovelace Health Plan	$15	$25	$250	$7	$15	$35	◒	◒	◒	◒	◒	◒
Presbyterian Health Plan	$10	$10	None	$5	$15	$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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
New York						
Aetna Health Inc. - NYC Area and Dutchess/Sullivan/Ulster	800/537-9384	JC1	JC2	14.89	37.27	NCQA 1
Blue Choice - Rochester Area	800/462-0108	MK1	MK2	15.21	44.02	NCQA 2
Capital District Physicians Health Plan - Albany/Cooperstown Areas	518/641-3700	PW1	PW2	15.48	57.22	NCQA 1
Capital District Physicians Health Plan - Hudson Valley Area	518/641-3700	QB1	QB2	14.88	45.23	NCQA 1
Capital District Physicians Health Plan - Capital District Area	518/641-3700	SG1	SG2	14.48	37.07	NCQA 1
GHI Health Plan - All of New York	212/501-4444	801	802	39.62	126.90	URAC 1
GHI HMO Select - Brnx/Brklyn/Manhat/Queen/Richmon/Westche	877/244-4466	6V1	6V2	25.13	99.69	NCQA 6
GHI HMO Select - Capital/Hudson Valley Regions	877/244-4466	X41	X42	15.76	38.97	NCQA 6
HIP of Greater New York-High -New York City Area	800/HIP-TALK	511	512	15.12	82.29	NCQA 2
HIP of Greater New York-Std - New York City Area	800/HIP-TALK	514	515	12.09	33.86	NCQA 2
HMO Blue - Utica/Rome/Central New York Areas	800/722-7884	AH1	AH2	28.60	106.94	NCQA 1
HMO-CNY - Syracuse/Binghamton/Elmira Areas	800/828-2887	EB1	EB2	29.64	125.75	NCQA 1
Independent Health Assoc - Western New York	800/453-1910	QA1	QA2	11.40	31.61	NCQA 1
MVP Health Care - Eastern Region	888/687-6277	GA1	GA2	13.36	34.52	NCQA 2
MVP Health Care - Central Region	888/687-6277	M91	M92	14.41	37.21	NCQA 2
MVP Health Care - Mid-Hudson Region	888/687-6277	MX1	MX2	15.38	58.29	NCQA 2
Preferred Care - Rochester Area	800/950-3224	GV1	GV2	12.25	32.70	NCQA 1
Univera Healthcare - Western New York (Southern Counties)	716/847-0881	KQ1	KQ2	14.84	55.10	
Univera Healthcare - Western New York	716/847-0881	Q81	Q82	12.49	35.42	NCQA 1
Vytra Health Plans - Queens/Nassau/Suffolk Counties	800/406-0806	J61	J62	15.70	71.16	

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
New York												
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	◒	◒	◒	○	◒	◒
Blue Choice	$10	$10	None	$5	$15	$30	●	●	●	●	◒	●
Capital District Physicians Health Plan	$10	$10	$100	$5	$20	$20	●	●	●	●	●	●
Capital District Physicians Health Plan	$10	$10	$100	$5	$20	$20	●	●	●	●	●	●
Capital District Physicians Health Plan	$10	$10	$100	$5	$20	$20	●	●	●	●	●	●
GHI Health Plan - In-Network	$15	$15	None	$10	$20	$50	◒	●	◒	◒	◒	◒
GHI Health Plan - Out-of-Network	50% of sch.	50% of sch.	None	N/A	N/A	N/A						
GHI HMO Select	$10	$10	None	$10	$20	$30	○	○	○	○	○	○
GHI HMO Select	$10	$10	None	$10	$20	$30	○	○	○	○	○	○
HIP of Greater New York-High	$10	$10	None	$10	$15	$40	◒	◒	○	◒	◒	○
HIP of Greater New York-Std	$10	$20	$500	$10	$20	$40	◒	◒	○	◒	◒	○
HMO Blue	$15	$15	$240	$10	$25	$40	◒	●	●	●	◒	◒
HMO-CNY	$10	$10	None	$5	$20	$35	○	●	●	◒	○	◒
Independent Health Assoc	$15	$15	None	$10	$20	$35	●	●	●	●	●	●
MVP Health Care	$15	$15	$240	$5	$20	$40	●	●	●	●	●	●
MVP Health Care	$15	$15	$240	$5	$20	$40	●	●	●	●	●	●
MVP Health Care	$15	$15	$240	$5	$20	$40	●	●	●	●	●	●
Preferred Care	$15	$15	None	$10	$20	$35	●	●	●	●	●	●
Univera Healthcare	$15	$15	$250	$5	$15	$35						
Univera Healthcare	$15	$15	$250	$5	$15	$35	◒	●	●	●	◒	●
Vytra Health Plans	$10	$10	None	$5	$10	$10	●	●	◒	◒	●	◒

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
North Dakota						
Heart of America HMO - Northcentral North Dakota	701/776-5848	RU1	RU2	13.12	32.42	
Ohio						
Aetna Health Inc. - Cleveland Area	800/537-9384	7D1	7D2	15.72	41.85	NCQA 1
Aetna Health Inc. - Greater Cincinnati Area	800/537-9384	RD1	RD2	15.75	49.29	NCQA 1
AultCare HMO - Stark/Carroll/Holmes/Tuscarawas/Wayne Co	330/438-6360	3A1	3A2	21.39	86.25	
Blue HMO - Most of Ohio	800/228-4375	R51	R52	20.07	75.63	NCQA 1
Health Plan of the Upper Ohio Valley-High -Eastern Ohio	800/624-6961	U41	U42	20.36	116.13	NCQA 1
Health Plan of the Upper Ohio Valley-Std - Eastern Ohio	800/624-6961	U44	U45	15.62	87.06	NCQA 1
HMO Health Ohio - Northeast Ohio	800/522-2066	L41	L42	15.04	47.26	NCQA 1
Kaiser Permanente - Cleveland/Akron Areas	800/686-7100	641	642	15.41	41.48	NCQA 1
Paramount Health Care - Northwest/North Central Ohio	800/462-3589	U21	U22	15.77	76.49	NCQA 2
SummaCare Health Plan - Cleveland, Akron Areas	330/996-8700	5W1	5W2	14.92	69.96	NCQA 1
SuperMed HMO - Northeast Ohio	800/522-2066	5M1	5M2	25.57	100.75	NCQA 1
United Healthcare of Ohio, Inc. - Cincinnati/Dayton/Springfield Areas	800/231-2918	3U1	3U2	48.79	114.30	NCQA 1
Oklahoma						
PacifiCare Health Plans - Central/Northeastern Oklahoma	800/531-3341	2N1	2N2	19.25	79.94	NCQA 1
Oregon						
Kaiser Permanente-High -Portland/Salem Areas	800/813-2000	571	572	24.27	57.11	NCQA 1
Kaiser Permanente-Std - Portland/Salem Areas	800/813-2000	574	575	15.42	35.39	NCQA 1
PacifiCare Health Plans - Metro Portland/Salem/Corvalis/Eugene	800/531-3341	7Z1	7Z2	33.05	64.40	NCQA 1

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
North Dakota												
Heart of America HMO	$10	Nothing	None	50%	50%	50%						
Ohio												
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
AultCare HMO	$10	$10	None	$5	$10	$10	●	●	●	●	●	●
Blue HMO	$10	$10	None	$10	$20	$30	◒	◒	●	◒	◒	◒
Health Plan of the Upper Ohio Valley-High	$10	$10	None	$10	$20	$35	●	●	●	●	●	●
Health Plan of the Upper Ohio Valley-Std	$10	$20	None	$15	$30	$50	●	●	●	●	●	●
HMO Health Ohio	$10	$10	None	$10	$20	$20	◒	◒	◒	◒	○	○
Kaiser Permanente	$10	$10	None	$5	$15	$15	●	●	◒	◒	●	◒
Paramount Health Care	$10	$20	$300	$5	$15	$25	●	●	◒	◒	●	●
SummaCare Health Plan	$10	$10	None	$8	$15	$30	●	●	●	●	●	○
SuperMed HMO	$10	$10	None	$10	$20	$20	◒	◒	◒	◒	○	○
United Healthcare of Ohio, Inc.	$15	$15	$250	$10	$15	$30	◒	●	●	◒	◒	◒
Oklahoma												
PacifiCare Health Plans	$10	$20	None	$10	$20	$20	◒	○	○	◒	○	●
Oregon												
Kaiser Permanente-High	$10	$10	None	$10	$20	$20	◒	◒	○	○	●	◒
Kaiser Permanente-Std	$15	$15	None	$15	$30	$30	◒	◒	○	○	●	◒
PacifiCare Health Plans	$10	$20	None	$10	$20	$20	○	○	◒	◒	○	◒

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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				Accredited
		Self only	Self & family	Self only		Self & family		
Pennsylvania								
Aetna Health Inc. - Philadelphia and Southeastern PA	800/537-9384	P31	P32	84.95	235.56	39.21	108.72	NCQA 1
Health Net of Pennsylvania - Scranton/Wilkes Barre Areas	877/747-9585	2K1	2K2	80.58	238.08	37.19	109.88	
HealthAmerica Pennsylvania - Greater Pittsburgh Area	800/735-4404	261	262	74.22	231.10	34.26	106.66	NCQA 1
HealthAmerica Pennsylvania - Central Pennsylvania	800/788-8445	SW1	SW2	76.82	258.12	35.45	119.13	NCQA 1
HealthGuard - Berks/Cmbrlnd/Dauphine/Lanc/Lebanon/York	800/822-0350	NQ1	NQ2	65.43	170.43	30.20	78.66	NCQA 1
Keystone Health Plan Central - Harrisburg/Northern Region/Lehigh Valley	800/622-2843	S41	S42	101.64	278.94	46.91	128.74	NCQA 1
Keystone Health Plan East - Philadelphia Area	800/227-3115	ED1	ED2	80.88	296.99	37.33	137.07	NCQA 1
UPMC Health Plan - Western Pennsylvania Area	888/876-2756	8W1	8W2	75.24	226.79	34.72	104.67	
Puerto Rico								
Humana Health Plans of Puerto Rico - Puerto Rico	800/314-3121	ZJ1	ZJ2	41.12	94.57	18.98	43.65	
Triple-S - All of Puerto Rico	787/749-4777	891	892	51.84	111.34	23.92	51.39	
Rhode Island								
Blue Chip, Coord Hlth Partners - All of Rhode Island	401/459-5500	DA1	DA2	115.03	360.02	53.09	166.16	NCQA 1
South Dakota								
Avera Health Plans - Eastern and Central South Dakota	888/322-2115	AV1	AV2	64.01	149.49	29.54	68.99	
Sioux Valley Health Plan - Eastern/Central/Rapid City Areas	800/752-5863	AU1	AU2	125.21	288.21	57.79	133.02	NCQA 6 JCAHO 1

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Pennsylvania												
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	◒	●	●	◒	◒	◒
Health Net of Pennsylvania	$10	$10	None	$10	$20	$35	○	◒	●	●	○	○
HealthAmerica Pennsylvania	$10	$15	None	$8	$14	$35	●	●	●	●	◒	●
HealthAmerica Pennsylvania	$10	$15	None	$8	$14	$35	●	●	●	●	◒	●
HealthGuard	$10	$20	None	$10	$25	$40	●	●	●	◒	◒	●
Keystone Health Plan Central	$10	$10	None	$10	$25	$40	●	●	●	●	●	●
Keystone Health Plan East	$10	$15	None	$5	$15	$25	○	●	◒	◒	◒	◒
UPMC Health Plan	$10	$10	None	$5	$15	$35	◒	●	◒	◒	◒	◒
Puerto Rico												
Humana Health Plans of Puerto Rico	- In-Network - Out-of-Network	$5 $8	$5 $8	None $50	$2.50 N/A	$5 N/A	$5 N/A					
Triple-S	- In-Network - Out-of-Network	$7.50 $7.50 + 10%	$10 $10 + 10%	None None	$2 25%	$5/$10 25%	$10 or 20% 25%	●	●	○	●	◒	◒
Rhode Island												
Blue Chip, Coord Hlth Partners	- In-Network - Out-of-Network	$15 30%	$25 30%	$500 None	$7 $40 + 20%	$25 $40 + 20%	$40 $40 + 20%	◒	●	●	◒	◒	◒
South Dakota												
Avera Health Plans		$10	$15	$100/dayx3	$10	$20	$35 or 50%						
Sioux Valley Health Plan	- In-Network - Out-of-Network	$20 40%	$20 40%	$100 40%	$10 N/A	$20 N/A	$35 N/A	○	●	●	●	◒	◒

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
Tennessee						
Aetna Health Inc. - Nashville/Middle Tennessee Areas	800/537-9384	6J1	6J2	13.31	36.04	NCQA 1
Aetna Health Inc. - Memphis Area	800/537-9384	UB1	UB2	14.49	49.86	NCQA 1
HealthSpring-High -Nashville/Middle Tennessee Area	615/291-5030	6K1	6K2	19.26	118.55	
HealthSpring-Std - Nashville/Middle Tennessee Area	615/291-5030	6K4	6K5	13.93	50.26	
Texas						
FIRSTCARE - Waco Area	800/884-4901	6U1	6U2	13.90	29.86	
FIRSTCARE - West Texas	800/884-4901	CK1	CK2	47.48	84.43	
HMO Blue Texas - Houston	800/833-5318	YM1	YM2	15.58	44.30	NCQA 2
Humana Health Plan of Texas-High -San Antonio Area	888/393-6765	UR1	UR2	15.05	49.16	
Humana Health Plan of Texas-Std - San Antonio Area	888/393-6765	UR4	UR5	12.10	31.10	
Mercy Health Plans/Premier Health Plans - Webb/Zapata/Duval/Jim Hogg Counties	800/617-3433	HM1	HM2	45.08	140.59	
PacifiCare Health Plans - San Antonio/Dallas/Ft Worth	800/531-3341	GF1	GF2	16.10	77.13	NCQA 2
Utah						
Altius Health Plans - Wasatch Front	800/377-4161	9K1	9K2	33.93	63.82	

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Tennessee												
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	○	○	◒	◒	◒	○
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	○	○	◒	◒	◒	○
HealthSpring-High	$15	$25	$250	$10	$20	$35						
HealthSpring-Std	$20	$20	$250	$10	$20	50%						
Texas												
FIRSTCARE	$15	$25	$100	$10	$20	$40	◒	◒	◒	●	●	◒
FIRSTCARE	$15	$25	$100	$10	$20	$40	◒	●	◒	●	●	●
HMO Blue Texas	$20	$20	$100/dayx4	$10	$25	$40	○	○	○	○	○	○
Humana Health Plan of Texas-High	$10	$20	$100/day x 3	$5/$20	$20/$40	25%	◒	○	○	○	◒	◒
Humana Health Plan of Texas-Std	$15	$25	$250/day x 3	$10/$25	$25/$45	25%	◒	○	○	○	◒	◒
Mercy Health Plans/Premier - In-Network - Out-of-Network	$10 40%	$10 40%	None 40%	$7 N/A	$12 N/A	$25 N/A	●	◒	○	●	◒	◒
PacifiCare Health Plans	$10	$20	None	$10	$20	$20	○	○	○	◒	○	○
Utah												
Altius Health Plans	$10	$15	None	$10	$20	$40	◒	◒	◒	◒	○	○

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
Vermont						
MVP Health Care - All of Vermont	888/687-6277	VW1	VW2	47.33	160.79	NCQA 2
Virginia						
Aetna Health Inc.-High -N.VA/Fredericksburg Areas	800/537-9384	JN1	JN2	15.91	35.84	NCQA 1
Aetna Health Inc.-Std - N.VA/Fredericksburg Areas	800/537-9384	JN4	JN5	11.90	27.84	NCQA 1
CareFirst BlueChoice - Northern Virginia	866/520-6099	2G1	2G2	31.68	66.88	NCQA 1
Kaiser Permanente - Washington, DC Area	301/468-6000	E31	E32	13.86	33.00	NCQA 2
MD-IPA - N.VA/Cntrl VA/Richmond/Tidewater/Roanoke	800/251-0956	JP1	JP2	15.61	38.47	NCQA 1
Optima Health Plan - Peninsula/Southside Hampton Roads	800/206-1060	9R1	9R2	32.87	88.38	NCQA 1
Piedmont Community Healthcare - Lynchburg Area	888/674-3368	2C1	2C2	31.83	73.66	
Washington						
Aetna Health Inc. - Western/Southeast Washington	800/537-9384	8J1	8J2	14.17	36.03	
Group Health Cooperative - Most of Western Washington	888/901-4636	541	542	24.46	51.82	NCQA 1
Group Health Cooperative - Central WA/Spokane/Pullman	888/901-4636	VR1	VR2	16.31	77.62	NCQA 1
Kaiser Permanente-High -Vancouver/Longview	800/813-2000	571	572	24.27	57.11	NCQA 1
Kaiser Permanente-Std - Vancouver/Longview	800/813-2000	574	575	15.42	35.39	NCQA 1
KPS Health Plans-High -Most of Western Washington	800/552-7114	VT1	VT2	93.61	181.53	
KPS Health Plans-Std - Most of Western Washington	800/552-7114	VT4	VT5	27.46	47.24	
PacifiCare Health Plans - Clark County	800/531-3341	7Z1	7Z2	33.05	64.40	NCQA 1
PacifiCare Health Plans - Puget Sound/Most West WA	800/531-3341	WB1	WB2	18.28	56.19	NCQA 1

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
Vermont												
MVP Health Care	$15	$15	$240	$5	$20	$40	●	●	●	●	●	●
Virginia												
Aetna Health Inc.-High	$15	$20	$150/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
Aetna Health Inc.-Std	$20	$25	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒
CareFirst BlueChoice	$20	$30	None	$10	$20	$35	◒	◒	○	○	○	○
Kaiser Permanente	$10	$20	$100	$10$20Net	$20$40Net	$20$40Net	◒	◒	◒	○	●	◒
MD-IPA	$10	$20	None	$8	$17	$33	●	●	◒	◒	●	◒
Optima Health Plan	$10	$20	$250	$10	$20	$40	◒	●	◒	◒	●	●
Piedmont Community - In-Network	$20	$20	None	$10	$20	$20						
Healthcare - Out-of-Network	40%	30%	None	$10	$20	$20						
Washington												
Aetna Health Inc.	$20	$25	$250/day x 3	$10	$25	$40	○	○	◒	◒	○	◒
Group Health Cooperative	$15	$15	$200/day x 3	$15	$25	$50	◒	◒	●	◒	●	●
Group Health Cooperative	$15	$15	$200/day x 3	$15	$25	$50	◒	◒	●	◒	●	●
Kaiser Permanente-High	$10	$10	None	$10	$20	$20	◒	◒	○	○	●	◒
Kaiser Permanente-Std	$15	$15	None	$15	$30	$30	◒	◒	○	○	●	◒
KPS Health Plans-High	$10	$10	$100/day x 10	$5	50%	50%	●	●	●	●	●	●
KPS Health Plans-Std	$20	$20	None	$5	$20	$100 or 50%	●	●	●	●	●	●
PacifiCare Health Plans	$10	$20	None	$10	$20	$20	◒	○	◒	◒	◒	◒
PacifiCare Health Plans	$10	$20	None	$10	$20	$20	◒	○	◒	◒	◒	◒

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.

The **Premium** shown is not for part-time employees. See your Human Resources office for details.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.
Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.
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		Accredited
		Self only	Self & family	Self only	Self & family	
West Virginia						
Health Plan of the Upper Ohio Valley-High -Northern/Central West Virginia	800/624-6961	U41	U42	20.36	116.13	NCQA 1
Health Plan of the Upper Ohio Valley-Std - Northern/Central West Virginia	800/624-6961	U44	U45	15.62	87.06	NCQA 1
Wisconsin						
Dean Health Plan - South Central Wisconsin	800/279-1301	WD1	WD2	14.31	48.66	NCQA 1
Group Health Cooperative - South Central Wisconsin	608/251-3356	WJ1	WJ2	14.66	54.72	NCQA 1
Group Health Cooperative/Eau Claire - West Central Wisconsin	715/552-4300	WT1	WT2	54.94	179.72	
HealthPartners Classic - West Central Wisconsin	952/883-5000	531	532	34.10	96.81	NCQA 1
HealthPartners Primary Clinic Plan - West Central Wisconsin	952/883-5000	HQ1	HQ2	74.02	192.61	
Wyoming						
WINhealth Partners - Wyoming	307/638-7700	PV1	PV2	13.91	41.81	

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.

Member Survey Results — See page 5 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See page 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member 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
West Virginia												
Health Plan of the Upper Ohio Valley-High	$10	$10	None	$10	$20	$35	●	●	●	●	●	●
Health Plan of the Upper Ohio Valley-Std	$10	$20	None	$15	$30	$50	●	●	●	●	●	●
Wisconsin												
Dean Health Plan	$10	$10	None	$10	30% to 1500	N/A	●	●	●	◒	●	●
Group Health Cooperative	$20	$20	None	$6	$12	$12	●	●	●	◒	●	●
Group Health Cooperative/Eau Claire	$10	$10	None	$10	$20	$20	●	●	●	●	●	●
HealthPartners Classic	$15	$15	$100	$12	$12	$24	◒	◒	◒	◒	◒	◒
HealthPartners Primary	$20	$20	$200	$12	$12	$24	◒	◒	◒	◒	◒	◒
Wyoming												
WINhealth Partners	$10	$10	None	$10	$15	$40						