THE 2000 GUIDE TO

Federal Employees Health Benefits Plans

PARTICIPATING IN THE DoD/FEHBP DEMONSTRATION PROJECT

Be sure to visit our web site at www.opm.gov/insure

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

RETIREMENT AND INSURANCE SERVICE

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Our Commitment to Our Customers

The U.S. Office of Personnel Management (OPM) administers the Federal Employees Health Benefits (FEHB) Program, the largest employer-sponsored health insurance program in the world. We interpret the health insurance laws and write regulations for the FEHB Program. We give advice and help to agencies and retirement systems so they can process your enrollment changes and deduct your premium. We also contract with and monitor your plan — and all the other health plans — that pay claims or provide care to covered members.

This is our commitment to you:

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

FEHB
Federal Employees
Health Benefits Program

Better Information
Better Choices
Better Health

Table of Contents

The information in the 2000 Guide to Federal Employees Health Benefits (FEHB) Plans gives you an overview of the FEHB Program and its participating plans. Do not make any final decisions about health plans without first reading the plans' brochures.

Eligibility Requirements

The Department of Defense (DoD) and FEHB Program Demonstration Project

The National Defense Authorization Act for 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000.

DoD determines who is eligible to enroll in FEHB. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare,
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare,
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried, or
- You are a survivor dependent of a deceased active or retired uniformed service member, and
- You live in one of the eight geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The Demonstration Areas

- Dover AFB, DE, including most of Delaware and parts of Maryland
- Commonwealth of Puerto Rico
- Fort Knox, KY, including parts of Indiana bordering Kentucky
- Greensboro/Winston Salem/High Point, NC
- Dallas, TX
- Humboldt County, CA
- Naval Hospital, Camp Pendleton, CA
- New Orleans, LA

Using Military Treatment Facilities – If you elect to enroll in the DoD/FEHBP Demonstration Project, you will not be eligible to receive care at any military treatment facilities, including pharmacies at military treatment facilities. All your care will be through the health plan you select.

Opportunities to Enroll - Your first opportunity to enroll is during the 1999 Open Season, November 8, 1999, through December 13, 1999. You may select coverage for yourself (self-only) or for you and your family (self and family). Your coverage will begin January 1, 2000. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

Eligibility Requirements

The Department of Defense (DoD) and FEHB Program Demonstration Project

If you elect a self and family enrollment, and later add another dependent, e.g., a new child, you do not need to re-enroll. However, you should contact your plan to add the new dependent to their records.

Open Seasons will also be held in 2000 and 2001, during which you may enroll if you are eligible and not already enrolled, change plans or options or change from self only to self and family. (You may change from self and family to self only at any time.) Your coverage will begin January 1 of the year following the Open Season that you enrolled. For more information about features you will find in the FEHB Program, see Program Features on page 5.

If you become eligible for the DoD/FEHBP Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

If you move to somewhere not in a demonstration area, your entitlement will end. However, if you move from one demonstration area to another demonstration area, you may continue to participate in the demonstration project. If you were in an HMO or POS plan, you will be permitted to change your FEHBP plan.

Web sites - DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at **www.tricare.osd.mil/fehbp.** You can also view information about the FEHB Program and the demonstration project on the OPM web site at **www.opm.gov.**

Your enrollment will continue for up to 3 years, to the end of the demonstration project, unless you change plans, lose eligibility, e.g., move out of the demonstration sites, or voluntarily cancel your enrollment. You may cancel your enrollment at any time. However, you will **not** be able to enroll again and neither you nor your family members will be entitled to temporarily continue coverage (see below).

Eligibility for Temporary Continuation of Coverage (TCC) - Under this Demonstration Project, the only individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code.

31-Day Extension and Right To Convert - These provisions do not apply to the DoD/FEHBP Demonstration Project.

FEHB and You

The Federal Employees Health Benefits (FEHB) Program can help you meet your health care needs. FEHB members enjoy the widest selection of health plans in the country. You can choose from any Fee-for-Service (FFS) plans, or Plans offering a Point of Service (POS) product and Health Maintenance Organizations (HMO) if you live within the area serviced by the plan (see page 17).

Some FFS plans participating in the DoD/FEHBP Demonstration Project require that you join the organization that sponsors the plan. Membership requirements and/or limitations also apply to any POS product the FFS plan offers.

Managed care is an important part of the FEHB Program. You will find managed care features in all the plans described in this Guide. Common features of managed care are pre-approval of hospital stays, the use of primary care providers as "gatekeepers" to coordinate your medical care, and networks of physicians and other providers.

You are fortunate to be able to choose from among many different health plans competing for your business. Use this Guide to compare the costs, benefits, and features of different plans. This Guide shows comparative benefit information for all plans participating in the DoD/FEHBP Demonstration Project. The benefit categories we list were chosen based on enrollee requests, differences among plans, and simplicity. However, we urge you to consider the total benefit package, in addition to service and cost, when choosing a health plan.

The plan brochures tell you what services and supplies are covered and the level of coverage. Look over the brochures carefully. The brochures reflect the efforts of OPM and health plan representatives to eliminate jargon and use plain language. We also formatted the brochures to ensure they are all organized alike. You can get brochures from DoD's Information Processing Center (IPC) by calling toll free 1-877-DOD-FEHB (1-877-363-3342). They are also available on our web site at **www.opm.gov/insure.** When the IPC sends you the brochures you request, it will also send you an enrollment form for you to complete and return to the IPC. The IPC will verify your eligibility and confirm your enrollment.

Choosing a plan

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

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

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

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

How the plan works — if predictable cost, comprehensive benefits, no paperwork, and a coordinated approach to health care are high priorities, consider a Health Maintenance Organization (HMO). Most HMOs require you to select a doc-

tor to act as your primary care physician, or PCP, who refers you to specialists. If you don't use a plan doctor, the plan usually will not pay for the services, unless it is an emergency.

A plan offering a Point of Service (POS) product also has rules about what benefits are covered and doctor choice and access to specialists, but you can choose any doctor you like and see specialists without referrals if you agree to pay more.

If you are willing to pay a little more in total costs for the widest choice of doctors, a Fee-for-Service (FFS) plan might be for you. FFS plans let you choose your own doctor and allow you to see specialists without a referral. Most FFS plans have Preferred Provider Organizations (PPO) that save you money if you use these providers.

Some plans offer 24-hour medical advice lines to help you make health decisions. These programs try to keep you healthy and avoid unnecessary – and potentially costly and time-consuming – medical treatment.

Satisfaction — the experience of health plan members form the satisfaction ratings in this Guide. If you are considering joining a FFS plan, chances are you will file a claim. How quickly does the plan process claims? Will the plan be responsive to your questions? As an HMO enrollee, you might be most interested in how the plan is rated in access to care and choice of doctors. Also ask your doctor's office about experiences with different health plans.

Accreditations — HMO accreditations reflect the evaluations of independent, nationally-recognized organizations. Plans willing to go through an accreditation review show a commitment to continuous quality improvement and accountability.

Getting the most from a plan

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

Cost — here are some ideas for getting the best value for your premium dollar:

- An easy way to save money is to use your plan's mail order drug program, if it has one.
- Request generic drugs instead of brand name drugs.
- Almost all FFS Plans have Preferred Provider Organizations (PPO, see page 13). Using a PPO will reduce your out-of-pocket expenses. If you do not use a PPO provider, your plan will base its payment on an allowance that probably will be less than the actual billed charge. This means you have to pay the difference, which may be more than the coinsurance amounts stated in this Guide and the plan brochure. You can reduce the chance of this happening by discussing fees in advance with your provider. Remember that plans set their own allowances.

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

Quality — talk openly with your health plan and providers about the kind of quality you want. Is your HMO rated by a national accrediting organization? Ask your surgeon how frequently he or she performs the procedure you are considering. If you are pregnant, ask your obstetrician the percentage of cases in which he or she performs a caesarean section and how that compares with the local average. Is your doctor proposing an invasive approach to treatment when a more conservative one is just as effective? Does your doctor discuss possible drug interactions when prescribing a new medication for you?

No one has a greater stake in your health than you. Understand how your plan works and don't be shy about asking questions. An informed consumer is a better decision maker.

Program Features

Some of our important Program features are:

No waiting periods. Your retirement system sets the effective date of your coverage. You can use your FEHB benefits as soon as your coverage is effective — there are no waiting periods, required medical examinations or restrictions because of age or physical condition.

A choice of coverage. You can choose self only coverage just for you, or self and family coverage for you, your spouse, and unmarried dependent children under age 22. Under certain circumstances, your FEHB enrollment may cover your disabled child 22 years old or older who is incapable of self-support. Contact DoD's Information Processing Center for more information.

A choice of plans and options.

- Fee-for-Service plans
- Plans offering a Point of Service product
- Health Maintenance Organizations

A Government Contribution. The Government contributes toward the total cost of your premium. In 2000, the Government will pay up to $2,049.60 for each self only enrollment and $4,575.24 for each self and family enrollment, but not more than 75% of the total premium for any plan.

Deduction from your Monthly Annuity for your share. After the Government pays its share toward the total premium, you pay the rest. Each plan's premium in this Guide is the amount that will be withheld in 2000. Premiums take effect January 1, 2000 and are reflected in monthly annuities beginning in February, 2000.

If the premium is more than your monthly annuity, you may pay the amount directly to DoD's Information Processing Center (IPC), either by Electronic Funds Transfer (EFT) from your bank account or by check or money order. The IPC will tell you about these options.

Annual enrollment Opportunities. Each year during the 3-year demonstration project you will have the opportunity to enroll or change plans. The 1999 Open Season is from November 8 through December 13, during which you may enroll if you are eligible.

Your new plan will mail you an identification card. If you need services before you receive your new card, contact your new plan at the member services number in their brochure.

Continued group coverage. The FEHB Program offers continued FEHB coverage:

- for your former spouse if you divorce and he or she has a qualifying court order (contact the Information Processing Center for more information), or
- for your family if you die while you covered them.

Coverage after FEHB ends. The FEHB Program offers temporary continuation of FEHB coverage (TCC):

- for your covered dependent child if he or she marries or turns age 22, or
- for your former spouse if you divorce and he or she does not qualify to enroll as an unremarried former spouse under title 10, United States Code.

TCC begins the day after their enrollment in the DoD/FEHBP Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHBP Demonstration Project.

TCC is not available if you move out of a DoD/FEHBP Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

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.

Patients' Bill of Rights and Responsibilities

The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has recommended a Patients' Bill of Rights and Responsibilities that are a mainstay of the FEHB Program. The following are consumer protections and quality initiatives you can count on from your FEHB plan.

- Transitional care. If you have a chronic or disabling condition and your health plan terminates your provider's contract (unless the termination is for cause), you may be able to continue seeing your provider for up to 90 days after the notice of termination. If you are in the second or third trimester of pregnancy, you may continue seeing your OB/GYN until the end of your postpartum care.

  If you have a chronic or disabling condition or are in your second or third trimester of pregnancy and your health plan drops out of the FEHB Program, you may be able to continue seeing your provider if you enroll in a new FEHB plan. You may continue to see your current specialist after your old enrollment ends, even if he or she is not associated with your new plan, for up to 90 days after you receive the termination notice or through the end of postpartum care, and pay no greater cost than if your old enrollment had not ended.

- Medical records. You are allowed to review and obtain copies of your medical records on request. You may ask that a physician amend a record that is not accurate, relevant, or complete. If the physician does not amend your record, you may add a brief statement to the record.

- Direct access to women's health care providers for routine and preventive health care services.

- Coverage of emergency department services for screening and stabilization without authorization if you have reason to believe serious injury or disability would otherwise result.

- Direct access to a qualified specialist within your network of providers if you have complex or serious medical conditions that need frequent specialty care. Authorizations, when required by a plan, will be for an adequate number of direct access visits under an approved treatment plan.

- The elimination of "gag rules" in provider contracts that could limit communication about medically necessary treatment.

- Extensive information about plan characteristics and performance, provider network characteristics, physician and health care facility characteristics, and care management.

OPM's web site at **www.opm.gov/insure** lists the specific types of information that your health plan must make available to you. You may also contact your health plan directly for this information.

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

- Read and understand your health benefits coverage, limitations, and exclusions, health plan processes, and procedures to follow when seeking care.

- Work with your physician in developing and carrying out a treatment plan.

- Practice healthy habits.

Your Links to Information

2000 Web Site -- www.opm.gov/insure

Our 2000 FEHB web site gives current and valuable information to help you choose a health plan. Visit us at **www.opm.gov/insure.**

You will find our site even more informative and easier to use than last year. You can link to most of our topics directly from the home page this year. We still have our Health Plan Profiler (HPP) that lets you view and print summary information about health plans. This year, enrollees in all states can use our interactive decision tool to narrow their health plan search.

You can download and print plan brochures and other materials, access definitions by clicking hyperlinks, and use automated links to navigate to other sites where you can find information about the Patients' Bill of Rights, mental health, health care quality and general health care information. When you visit **www.opm.gov/insure** you will see these choices and more:

- **2000 Plan Information –** gives you access to general information about plans, plan quality indicators (including detailed survey results that are not printed in this Guide), plan brochures, and information about how to choose a plan. You can link to other web sites with valuable information about health plans, including those plans participating in the FEHB Program. You can also view, download and print the Guides to Federal Employees Health Benefits Plans.

- **Health Plan Profiler** is an easy-to-use web tool that lets you create plan profiles and summaries. You also can link to FEHB plan web sites from the Health Plan Profiler. Since most plans have web sites, we have deleted the web site column in this Guide.

- **PlanSmartChoice** is a link to an interactive survey tool for help in selecting a plan. Based on individual preferences that you enter, PlanSmartChoice will rank specific health plans.

- **DoD/FEHBP Demonstration Project** gives you special information about the demonstration and links you to DoD's TRICARE web site.

- **Patients' Bill of Rights –** gives you information about the Patients' Bill of Rights and the principle areas of rights and responsibilities. You can also link to the full text of the Patients' Bill of Rights and related background information.

- **Rate Us –** is a new feature where you can answer specific questions about our site. We still have our section for your comments and suggestions. Let us know what you think.

Your Links to Information

We're Y2K OK

The United States Office of Personnel Management is prepared for the year 2000 (Y2K). Our systems are updated, tested, and ready. We have also worked hard with our participating plans to help them get ready. We want you to be ready, too. If you would like more information, we can help! Here are three ways you can get free help:

1. Call the Federal Year 2000 Information Center toll free at **1-888-USA4-Y2K (1-888-872-4925)**
2. Call OPM's toll-free Fax-Back Line at **1-877-750-0177** (Select a topic from the menu and received faxed information immediately)
3. Visit our Y2K HELP site on the Internet at **www.opm.gov/Y2K/help**

Additionally, Government agencies and organizations within the pharmaceutical industry supply system have worked closely together to prepare for Y2K and its potential impact on the supply of medications. Y2K should not affect your ability to receive your normal supply of medications. To receive the medications you need, continue to get a normal refill of your medication when you have a 5 to 7 day supply remaining, and be sure to carry your FEHB insurance card with you.

Call the FEHB Fraud Hot Line
(202) 418-3300
if a provider has billed you for services you did not receive.

Quality Indicators

Satisfaction Survey

OPM and FEHB plans and enrollees participated this year in a broad-based survey effort with other public and private employers by using the Consumer Assessment of Health Plans Survey. This survey is a widely accepted tool for obtaining customer feedback on their experiences with their health plans. Before you join a plan, it may help to know what people who use the plan say about it. *The survey results are not provided or influenced by the health plans; they are solely based on the responses of enrolled individuals like yourself.* The complete questionnaire (59 questions) is on our web site at **www.opm.gov/insure**, but for ease of presentation in this Guide we have summarized findings in the following key areas:

What the survey asked health plan enrollees:

- **Getting Needed Care.** Did you have problems getting a referral to a specialist? Did you experience delays in obtaining care? Did you have problems getting the care you and your doctor believed necessary?
- **Getting Care Quickly.** When you called during regular office hours, did you get the advice or help you needed? Could you get an appointment for regular or routine health care as soon as you wanted?
- **How Well Doctors Communicate.** Did the doctors or other health providers listen carefully to you? Did they explain things in a way you could understand? Did they spend enough time with you?
- **Courteous and Helpful Office Staff.** Did the doctor or some other provider's staff treat you with courtesy and respect? Was the staff as helpful as you thought they should be?
- **Customer Service.** Were you helped when you called your plan's customer service department? Did you have problems with paperwork for your plan? Was it hard to find and understand information in the plan's written materials?
- **Claims Processing.** Did your plan handle your claims in a reasonable time? Did they handle your claims correctly?
- **Overall Plan Satisfaction.** How would you rate your overall experience with your health plan?

A plan may not be rated for one of three reasons: 1) it is new to the FEHB Program, 2) the plan has fewer than 500 Federal subscribers, or 3) the plan failed to administer the survey as we asked. We have identified the plans in this last category with an X.

FEHB plans also participated in a separate child's survey, but this data was not available for publication at the time this Guide went to print.

The Ratings. A plan's numbers show how well the plan scored for each question. For overall satisfaction the highest value is a 1. The other scores are on a scale of 3 (highest) to 1 (lowest). The numbers atop each category show the national average for the plan type (i.e., fee-for-service compared to fee-for-service and HMO/POS compared to HMO/POS). For more information about individual plan ratings, visit our web site at **www.opm.gov/insure.**

Quality Indicators

Accreditation

Accreditation is a rigorous and comprehensive evaluation process where independent organizations assess the quality of the key systems and processes that managed care organizations (specifically, an HMO or POS plan) use. Accreditation also includes an assessment of the care and service plans are delivering in important areas of public concern such as immunization rates, mammography rates, and member satisfaction.

The National Committee for Quality Assurance (NCQA) and the **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** are independent, private, not-for-profit organizations dedicated to assessing and reporting on the quality of health care organizations. These organizations are completely independent of the health plans and issue their accreditation results without the approval of the health plans they review. We encourage all FEHB plans to get accreditation from a national accrediting organization, that will evaluate their systems and processes and confer accreditation much like educational accrediting institutions confer accreditation to schools.

Quality includes 1) the perception of the quality of care received and 2) the quality of medical care provided. The first is measured by annual satisfaction surveys. The second is measured in part by accreditation. As an employer, accreditation to us means accountability to a customer and validation of selected measures of a health plan's operations. Enrollees can be assured that an independent organization has performed an unbiased assessment of a health plan's systems and found them to be of a particular quality. We think an accredited plan offers value to your health plan decision making.

Note: There are various reasons why a plan is not accredited; check with the plan for an explanation.

Both NCQA and JCAHO have multiple levels of accreditation. To find a plan's specific level of accreditation, visit our web site at www.opm.gov/insure.

Learning about today's Medicare can be beneficial to your health.

Today's Medicare offers more.
More preventive benefits. More information.
More help with your questions.

To learn more, call:

(1-800-MEDICARE)
(1-800-633-4227)

An education program of the Department of Health and Human Services
and the Health Care Financing Administration

www.medicare.gov

Census 2000 Will Help Our Government Allocate Resources and Make Better Decisions

An accurate census is important to your agency —and it's important to YOU!

Census 2000…

- Providing vital information for planning schools, hospitals, roads, and more
- Alerting rescuers to how many people will need their help in disaster areas
- Informing government leaders about who we are and what we need
- Apportioning Congress and determining representative voting districts

Part-Time Job Opportunities

New Office of Personnel Management regulations allow federal workers in participating agencies to moonlight on Census 2000. Federal and military annuitants also can apply for a waiver to work on the census. Visit our website at www.census.gov or call 1-888-325-7733 toll free for information on testing and hiring in your area. The U.S. Census Bureau is an equal opportunity employer.

United States Census 2000

By law, the Census Bureau cannot share your answers with others, including welfare agencies, the Immigration and Naturalization Service, the Internal Revenue Service, courts, police, and the military. All census workers are sworn to secrecy. Individual answers are combined with others to produce statistical summaries. No one can connect your answers with your name and address.

Nationwide Fee-for Service Plans Open to All

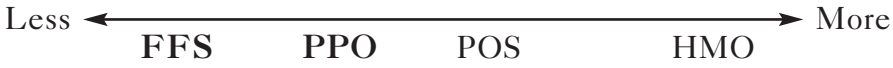
(Pages 14 through 16)

Fee-for-Service (FFS) with a Preferred Provider Organization (PPO) — A FFS option that allows you to see independent medical providers who reduce their charges to the plan, which means you pay less money out-of-pocket than when you use a non-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, but room and board would be.*

Fee-for-Service (FFS) Plan (non-PPO) — A traditional type of insurance in which the health plan will either reimburse you or pay the medical provider directly for each covered medical expense after you receive the service. When you need medical attention, you visit the doctor or hospital of your choice. After receiving medical treatment, you file a claim to your health plan and it pays a benefit, but you usually must first pay a deductible and coinsurance or a copayment. These plans use some managed care features such as a precertification and utilization review to control costs.

Managed care is an important force in today's health care. Generally speaking, managed care is a system of health care delivery that tries to manage the quality of health care, access to health care, and the cost of that care. The following graph compares the extent to which different plan types use managed care.

Use of Managed Care Techniques and Concepts



Important: Some FFS plans also offer a Point of Service product. Check pages 18-21 for details.

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. An (*) in any column means an exception to the general rule for that particular plan and we have tried to explain those exceptions here under the applicable column heading.

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 usually several times the amount shown for individuals and the entire family collectively contributes towards that amount. However, some plans require 3 family members to meet the per person deductible before the family deductible is considered met (*).

Some plans apply **Prescription Drug** purchases to the Calendar Year deductible (CY). Some plans apply a separate deductible to the combined purchase of mail order drugs and drugs from local pharmacies (C), while others apply it to drugs purchased from local pharmacies only (L). 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.

Plan name	Telephone number	Enrollment code		Monthly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Alliance Health Plan	202/939-6325	1R1	1R2	207.83	421.39
APWU Health Plan◊	800/222-2798	471	472	129.65	278.07
Blue Cross and Blue Shield-High	local phone #	101	102	143.63	291.09
Blue Cross and Blue Shield-Std◊	local phone #	104	105	65.09	144.69
GEHA Benefit Plan	800/821-6136	311	312	99.06	200.78
Mail Handlers-High	800/410-7778	451	452	95.98	234.32
Mail Handlers-Std	800/410-7778	454	455	70.63	175.85
NALC	703/729-4677	321	322	128.81	258.98
Postmasters-High	703/683-5585	361	362	286.43	605.26
Postmasters-Std	703/683-5585	364	365	174.07	364.74

◊ Offers a Point of Service product.

The **Catastrophic Limit** is the maximum amount of certain covered charges the plan will require you to pay during the year. Some plans (*) require each family member to meet the limit.

What you pay for **Doctors** inpatient visits and for surgical services is shown.

Your share of **Outpatient Tests** — provided, or ordered, and billed by a physician or physicians' group — is shown.

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

Finally, what you pay for **Generic** and **Brand** name drugs purchased through **Mail Order** is shown.

Taken together, you can use the highlighted features to compare the richness of plan benefits, but always consult plan brochures before making your final decision.

Plan name	Benefit type	Medical-Surgical – You pay										
		Deductible			Catastrophic Limit	Coinsurance (%)/Copay ($)						
		Per Person		Per Stay Hospital Inpatient				Hospital			Mail Order Prescription Drugs	
		Calendar Year	Prescription Drug			Doctors	Outpatient Tests	Inpatient R&B	Inpatient Other	Outpatient Other	Generic	Brand
Alliance Health Plan	PPO Non-PPO	$100* $300*	$200C* $200C*	$150 $250	$2,000* $3,000*	10% 30%	10% 30%	10% 30%	10% 30%	10% 30%	20% 20%	20% 20%
APWU Health Plan	PPO Non-PPO	$250 $250	$50L $50L	None $200	$2,000 $3,500	10% 30%	10% 30%	10% 30%	10% 30%	10% 30%	$7 $7	$25 $25
Blue Cross and Blue Shield-High	PPO Non-PPO	$150 $150	None None	None $100	$1,000 $2,700	5% 20%	5% 20%	Nothing 30%	Nothing 30%	$10 $100/d	$8 $8	$14 $14
Blue Cross and Blue Shield-Std	PPO Non-PPO	$200 $200	None None	None $250	$2,000 $3,750	10% 25%	10% 25%	Nothing 30%	Nothing 30%	$25 $150/d	$12 $12	$20 $20
GEHA Benefit Plan	PPO Non-PPO	$300 $300	None None	None None	$2,500 $3,500	10% 25%	10% 25%	Nothing Nothing	10% 25%	10% 25%	$10 $10	$30 $30
Mail Handlers-High	PPO Non-PPO	$150 $150	$250C* $250C*	None $250	$2,500 $4,000	10% 30%	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%	$10 $10	$30 $45
Mail Handlers-Std	PPO Non-PPO	$200 $200	$600C* $600C*	$150 $300	$4,000 $4,000	10% 30%	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%	$10 $10	$40 $55
NALC	PPO Non-PPO	$275 $275	$25L $25L	None $100	$3,000 $3,500	15% 30%	15% 30%	Nothing 20%	Nothing 20%	15% 30%	$12 $12	$25 $25
Postmasters-High	PPO Non-PPO	$200 $275	$50 $100	None $150	$2,500 $2,500	10% 15%	10% 20%	Nothing Nothing	Nothing 15%	10% 20%	$5 $5	$12 $12
Postmasters-Std	PPO Non-PPO	$200 $350	$50 $100	None $250	$3,000 $4,500	10% 30%	10% 30%	Nothing 30%	Nothing 30%	10% 30%	$10 $10	$20 $20

Nationwide Fee-for-Service Plans Open to All

Satisfaction Indicators — See page 7 for a description of these results.

Plan name	Plan code	Plan performance based on enrollee rating Overall satisfaction- on a scale of 1 (highest) to 0 (lowest) All others- on a scale of 3 (highest) to 1 (lowest) (average for all FFS plans shown in heading)						
		Overall plan satisfaction (.82)	Getting needed care (2.85)	Getting care quickly (2.53)	How well doctors communicate (2.50)	Courteous and helpful office staff (2.63)	Customer service (2.50)	Claims processing (2.39)
Alliance Health Plan	1R	0.85	2.88	2.60	2.55	2.73	2.45	2.44
APWU Health Plan	47	0.74	2.81	2.50	2.47	2.59	2.37	2.26
Blue Cross and Blue Shield-High	10	0.77	2.85	2.40	2.45	2.54	2.43	2.36
Blue Cross and Blue Shield-Std	10	0.77	2.85	2.40	2.45	2.54	2.43	2.36
GEHA Benefit Plan	31	0.88	2.85	2.54	2.50	2.64	2.64	2.54
Mail Handlers-High	45	0.77	2.83	2.46	2.42	2.58	2.47	2.26
Mail Handlers-Std	45	0.77	2.83	2.46	2.42	2.58	2.47	2.26
NALC	32	0.70	2.77	2.52	2.48	2.64	2.40	2.26
Postmasters-High	36	0.84	2.87	2.60	2.57	2.71	2.42	2.42
Postmasters-Std	36	0.84	2.87	2.60	2.57	2.71	2.42	2.42

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

(Pages 18 through 21)

A change from prior years: We grouped together the HMO and POS plans to make your plan review easier. You can tell the POS plans because they have two rows for "In Network" and "Out of Network." 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) — 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 benefit brochure under *How to Get Benefits*.

- 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 offered by an HMO or FFS plan that has features of both.

In an HMO, the POS product lets you use providers who are not part of the HMO network. However, you pay more for using these non-network providers. You usually pay higher deductibles and coinsurances than you pay with a plan provider. You will also need to file a claim for reimbursement, like in an FFS plan. The HMO plan wants you to use its network of providers, but recognizes that sometimes enrollees want to choose their own provider.

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

Managed care is an important force in today's health care. Generally speaking, managed care is a system of health care delivery that tries to manage the quality of health care, access to health care, and the cost of that care. The following graph compares the extent to which different plan types use managed care.

Use of Managed Care Techniques and Concepts

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

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans.

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor. A (*) means a POS plan pays non-plan doctors based on a fee schedule.

Hospital Room Copay/Coinsurance is your share of hospital room and board charges. This is separate from any per admission deductible. A (*) means a POS plan pays non-plan hospitals based on a fee schedule.

Plan name – location	Telephone number	Enrollment code		Monthly Premium Your Share	
		Self only	Self & family	Self only	Self & family
California					
Aetna U.S. Healthcare - Southern California area	800/537-9384	2X1	2X2	50.81	101.62
Blue Shield of CA Access+HMO - Most of California	800/334-5847	SJ1	SJ2	99.47	196.95
Blue Cross CaliforniaCare - Most of California	800/235-8631	M51	M52	55.80	187.87
CIGNA HealthCare of California - Northern/Southern California	800/832-3211	9T1	9T2	155.93	272.20
Health Net - Most of California	800/522-0088	LB1	LB2	53.15	113.28
Kaiser Permanente - Southern California	800/464-4000	621	622	101.29	162.91
Maxicare Southern California - Southern California	800/234-6294	CM1	CM2	43.48	91.28
PacifiCare of California - Most of California	800/624-8822	CY1	CY2	82.48	277.20
Delaware					
Aetna U.S. Healthcare - All of Delaware	800/537-9384	NK1	NK2	279.87	520.06
Indiana					
Aetna U.S. Healthcare - Southern Indiana	800/537-9384	RD1	RD2	52.69	105.37
Humana Care Plan - Southern Indiana	888/393-6765	181	182	80.38	221.54
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	80.38	221.54
The M•Plan - Central/NE/SW Indiana	317/571-5320	IN1	IN2	135.85	262.32
Kentucky					
Aetna U.S. Healthcare - Lexington/Louisville areas	800/537-9384	RD1	RD2	52.69	105.37
Humana Care Plan - Louisville area	888/393-6765	181	182	80.38	221.54
Humana Health Plan - Lexington/Louisville	888/393-6765	D21	D22	80.38	221.54
Louisiana					
Aetna U.S. Healthcare - New Orleans area	800/537-9384	NG1	NG2	53.39	106.78
Blue Cross and Blue Shield-Std - New Orleans area	800/272-3029	104	105	65.09	144.69
Maxicare Louisiana - Baton Rouge/New Orleans areas	800/933-6294	JA1	JA2	49.18	102.89

Prescription Drugs, Generic, Brand shows what you pay for prescriptions when you use a plan pharmacy. Some plans charge different amounts for refills (*), select drugs and mail orders. In many plans, if you get the brand name instead of a generic substitution, you also pay the difference between the two. Where a copay/coinsurance are both shown, you pay the greater amount. Some POS plans pay a non-plan pharmacy only what they would have paid a plan pharmacy (#); you pay the difference.

Satisfaction Indicators — See page 7 for a description of these results. An (X) means the plan did not conduct the survey as we asked.

Accreditation status — N = National Committee for Quality Assurance; **J** = Joint Commission on Accreditation of Healthcare Organizations

Plan name	Primary care doctor office copay	Hospital room copay/coinsurance	Prescription drugs, generic	Prescription drugs, brand	Plan performance based on enrollee rating Overall satisfaction- on a scale of 1 (highest) to 0 (lowest) All others- on a scale of 3 (highest) to 1 (lowest) (average for all HMO/POS plans shown in heading) Overall plan satisfaction (.74)	Getting needed care (2.66)	Getting care quickly (2.39)	How well doctors communicate (2.46)	Courteous and helpful office staff (2.55)	Customer service (2.44)	Claims processing (2.22)	Accreditation status NCQA (N) JCAHO (J)
California												
Aetna U.S. Healthcare	$10	Nothing	$5	$10	0.67	2.52	2.20	2.37	2.43	2.35	2.10	
Blue Shield of CA Access+HMO	$10	Nothing	$6	$6	0.64	2.64	2.36	2.60	2.54	2.28	1.89	N
Blue Cross CaliforniaCare	$10	Nothing	$5	$10	0.69	2.53	2.21	2.28	2.43	2.33	2.43	N
CIGNA HealthCare of California	$10	Nothing	$5	$10	0.65	2.48	2.19	2.28	2.33	2.30	2.16	N
Health Net	$10	Nothing	$5	$10	0.72	2.59	2.35	2.35	2.48	2.35	2.27	N
Kaiser Permanente	$10	Nothing	$5	$5	0.87	2.74	2.32	2.40	2.58	2.50	2.12	N
Maxicare Southern California	$10	Nothing	$5	$10	0.69	2.47	2.18	2.32	2.41	2.37	2.85	
PacifiCare of California	$10	Nothing	$5	$10	0.71	2.51	2.24	2.34	2.44	2.44	2.31	N
Delaware												
Aetna U.S. Healthcare	$10	Nothing	$5	$10								
Indiana												
Aetna U.S. Healthcare	$10	Nothing	$5	$10	0.62	2.57	2.45	2.49	2.56	2.28	1.84	
Humana Care Plan	$10	Nothing	$5	$10	0.70	2.70	2.31	2.44	2.54	2.32	2.97	
Humana Health Plan	$10	Nothing	$5	$10	0.72	2.62	2.39	2.47	2.55	2.32	2.17	
The M•Plan	$10	Nothing	$5	$10	0.77	2.66	2.47	2.47	2.57	2.43	2.18	N
Kentucky												
Aetna U.S. Healthcare	$10	Nothing	$5	$10	0.62	2.57	2.45	2.49	2.56	2.28	1.84	
Humana Care Plan	$10	Nothing	$5	$10	0.70	2.70	2.31	2.44	2.54	2.32	2.97	
Humana Health Plan	$10	Nothing	$5	$10	0.72	2.62	2.39	2.47	2.55	2.32	2.17	
Louisiana												
Aetna U.S. Healthcare	$10	Nothing	$5	$10	X	X	X	X	X	X	X	
Blue Cross and Blue Shield-Std - In-Network	$10	Nothing	$5	$15	X	X	X	X	X	X	X	N
Blue Cross and Blue Shield-Std - Out-of-Network	25%	30%	45%	45%								
Maxicare Louisiana - In-Network	$10	Nothing	$7	$12	0.75	2.65	2.21	2.41	2.46	2.43	2.76	
Maxicare Louisiana - Out-of-Network	20%	20%	N/A	N/A								

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

How to read this chart: The table below highlights selected features that may help you narrow your choice of health plans.

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Plan name – location	Telephone number	Enrollment code		Monthly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Maryland					
Free State Health Plan - All of Maryland	800/445-6036	LD1	LD2	261.21	482.78
MD-IPA - All of Maryland	800/251-0956	JP1	JP2	62.66	116.46
Prudential HealthCare HMO - Most of Maryland	800/856-0764	JB1	JB2	250.92	462.11
North Carolina					
PARTNERS NHP of NC - Most of North Carolina	800/942-5695	EQ1	EQ2	54.95	109.88
UHC of North Carolina - Central/Eastern/Western	800/999-1147	XM1	XM2	157.62	359.97
Puerto Rico					
Triple-S - All of Puerto Rico	787/749-4777	891	892	53.50	126.65
Texas					
Aetna U.S. Healthcare - Dallas/Ft. Worth areas	800/537-9384	TS1	TS2	164.77	289.86
APWU Health Plan - Eastern and Central Texas	800/222-2798	471	472	129.65	278.07
Humana Health Plan of Texas - Dallas/Ft. Worth and Austin areas	888/393-6765	TW1	TW2	59.71	180.07
NYLCare Health Plans SW - Dallas/Ft. Worth/East & West Texas	800/486-3040	V21	V22	43.26	86.52
PacifiCare of Texas - S Ant/Hston/Glvston/Da/Ft Wor/Glf Coast	800/825-9355	GF1	GF2	81.08	273.58
Texas Health Choice, L. C. - Dallas/Ft Worth areas	972/458-5000	UK1	UK2	102.27	164.86

Prescription Drugs, Generic, Brand shows what you pay for prescriptions when you use a plan pharmacy. Some plans charge different amounts for refills (*), select drugs and mail orders. In many plans, if you get the brand name instead of a generic substitution, you also pay the difference between the two. Where a copay/coinsurance are both shown, you pay the greater amount. Some POS plans pay a non-plan pharmacy only what they would have paid a plan pharmacy (#); you pay the difference.

Satisfaction Indicators — See page 7 for a description of these results. An (X) means the plan did not conduct the survey as we asked.

Accreditation status — N = National Committee for Quality Assurance; **J** = Joint Commission on Accreditation of Healthcare Organizations

Plan name	Primary care doctor office copay	Hospital room copay/coinsurance	Prescription drugs, generic	Prescription drugs, brand	Plan performance based on enrollee rating (Overall satisfaction- on a scale of 1 (highest) to 0 (lowest) All others- on a scale of 3 (highest) to 1 (lowest) (average for all HMO/POS plans shown in heading)							Accreditation status NCQA (N) JCAHO (J)
					Overall plan satisfaction (.74)	Getting needed care (2.66)	Getting care quickly (2.39)	How well doctors communicate (2.46)	Courteous and helpful office staff (2.55)	Customer service (2.44)	Claims processing (2.22)	
Maryland												
Free State Health Plan - In-Network	$10	Nothing	$10	$20	0.74	2.69	2.38	2.53	2.56	2.43	2.25	N
Free State Health Plan - Out-of-Network	20%	20%	$10	$20								
MD-IPA	$10	Nothing	$5	$10	0.74	2.65	2.42	2.46	2.56	2.53	2.33	N
Prudential HealthCare HMO	$10	Nothing	$5	$15	0.69	2.65	2.38	2.46	2.58	2.23	1.89	N
North Carolina												
PARTNERS NHP of NC	$10	Nothing	$10	$10	0.82	2.74	2.46	2.44	2.54	2.54	2.41	N
UHC of North Carolina	$10	Nothing	$10	$15	0.82	2.83	2.48	2.52	2.62	2.59	2.45	N
Puerto Rico												
Triple-S - In-Network	$7.50	Nothing	Nothing	$10	0.90	2.93	2.27	2.56	2.55	2.64	2.19	
Triple-S - Out-of-Network	$7.50	All over $60/day	Nothing	$10								
Texas												
Aetna U.S. Healthcare	$10	Nothing	$5	$10	0.64	2.59	2.32	2.44	2.54	2.32	2.88	N
APWU Health Plan - In-Network	$10	Nothing	20%*	20%*								
APWU Health Plan - Out-of-Network	30%	30%	40%	40%								
Humana Health Plan of Texas	$10	Nothing	$5	$10	0.64	2.57	2.38	2.46	2.55	2.19	2.25	N
NYLCare Health Plans SW	$10	Nothing	$5	$10	0.70	2.53	2.28	2.36	2.47	2.43	2.22	N
PacifiCare of Texas	$10	Nothing	$5	$10	X	X	X	X	X	X	X	
Texas Health Choice, L. C.	$10	Nothing	$6	$12	0.76	2.56	2.36	2.32	2.50	2.28	2.24	N


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