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# Guide to Federal Employees Health Benefits Plans

For Individuals Receiving  
Compensation from the  
Office of Workers' Compensation Programs  
(OWCP)



**United States  
Office of  
Personnel  
Management**

Retirement and  
Insurance Service

Visit our web site at [www.opm.gov/insure](http://www.opm.gov/insure)

**RI 70-6  
Revised November 2001**

## 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.

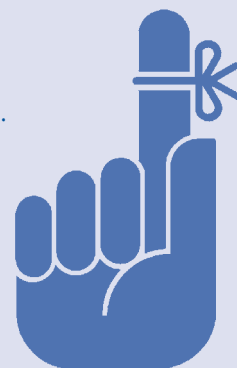
# Table of Contents

Page:

<b>FEHB and You</b> .....	1
How to Change Enrollment	
Getting Information and Selecting a Health Plan	
Quality	
• Enrollee Survey Results	
• Accreditation	
Benefits	
Cost	
How the Plan Works	
<b>FEHB Web Resources</b> .....	6
<b>Program Features</b> .....	7
<b>Definitions</b> .....	8
<b>Plan Comparisons</b>	
Nationwide Fee-For-Service Plans Open to All .....	13
Nationwide Fee-For-Service Plans Open Only to Specific Groups .....	17
Health Maintenance Organization Plans and Plans Offering a Point of Service Product .....	21
<b>Addressing the Postcard</b> .....	58

## Things to Remember

- The choices available to you may have changed. A number of plans withdrew from the FEHB Program, plans have merged, and some options won't be offered. Make sure your plan will be offered in 2002.
- Be aware of benefit changes for 2002.
- Check the premium for 2002.



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

## How to Change Enrollment

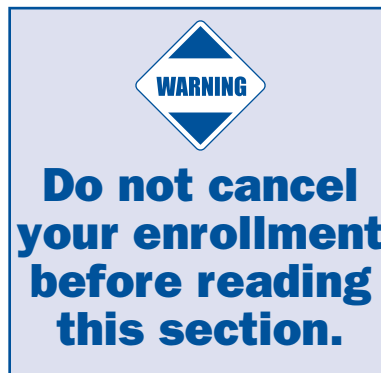
If you are enrolled and want to change your enrollment in Open Season, use the postcard on the back cover of this booklet to request a registration form to make a change. (Your health plan will send you its brochure. You can use the postcard to order brochures for other plans.)

Cut the postcard along the perforated lines, then complete the postcard and mail it to the OWCP district office that handles your case. See page 58 for the district office addresses. If you order brochures, you will be given another form to make a change. Any enrollment change you make will take effect January 27, 2002.

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 your brochure.

If you decide not to change your enrollment, no action by you is necessary.

You may voluntarily cancel your enrollment at any time. However, once your cancellation takes effect, you probably will not be able to enroll again as a retiree. You will **not** be entitled to a 31-day extension of coverage for conversion to a non-group (private) policy and neither you nor your family members will be entitled to temporarily continue coverage.



You will **not** be able to reenroll in FEHB except under the following circumstances:

- You have been continuously covered as a family member under another enrollment in FEHB since the date of your cancellation, **and** you lose the coverage because the enrollment ends or the enrollee changes from self and family to self only; or
- You suspended your FEHB coverage to enroll in a Medicare-sponsored health plan under the Social Security Act or because you are eligible under Medicaid or a similar State-sponsored program of medical assistance for the needy.

For more information on how to suspend your FEHB enrollment, contact the OWCP district office that handles your case.

Time limitations and other restrictions apply. For instance, you must submit documentation that you are suspending FEHB to enroll in a Medicare-sponsored health plan or furnish proof of eligibility for coverage under the Medicaid program or similar State-sponsored program of medical

assistance for the needy, in case you wish to reenroll in the FEHB Program at a later time.

If you had suspended FEHB coverage for either one of these reasons (and had submitted the required documentation) but now want to enroll in the FEHB Program again, you may enroll during Open Season. You may reenroll outside Open Season only if you move out of the Medicare-sponsored health plan's service area, the Medicare-sponsored health plan is discontinued, or you involuntarily lose coverage under the Medicaid program or similar State-sponsored program of medical assistance for the needy. If you cancelled your coverage for any other reason, you **cannot** reenroll.

# FEHB and You

The Federal Employees Health Benefits (FEHB) Program began operation in July 1960. It is the nation's largest employer-sponsored health insurance program. Almost 9 million people, including 2.2 million federal employees, 1.9 million retirees, and their eligible family members, are members of the Program.

## Getting information and selecting a health plan

Use this Guide and plan brochures to make your health plan decision. The Guide is a summary of FEHB plans; the plan brochures give specific benefit information. You can get brochures from the health plans or your human resources office. Our web site, [www.opm.gov/insure](http://www.opm.gov/insure) provides the Guide, brochures, and other helpful information.

Before selecting a health plan:

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

## Quality

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

\* **Enrollee Survey Results** in this Guide have been collected, scored, and reported by an independent organization - not by the health plans. We list here the survey categories and actions the health plan can take to make things better. **Note:** A plan may not be rated for one of

three reasons: 1) It is new to the FEHB Program, 2) It has fewer than 500 Federal enrollees, or 3) It did not administer the survey as we asked; these plans are identified with an X.

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

- Health plans that do well on the survey educate members up-front about the scope and limitations of covered benefits, referral requirements, and preauthorizations. They speed-up referrals for routine preventive care or established diagnoses, especially for chronic conditions. They empower their own customer service staff to resolve problems at the outset.

# FEHB and You

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

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

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

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

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

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

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

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

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

- Health plans that do well on the survey value you as a customer.

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

Use the following key to compare the accreditation status of different health plans (a lower number means a better accredited plan). See page 8 for definitions.

**NCQA** ([www.ncqa.org](http://www.ncqa.org)):

N1 = Excellent

N2 = Commendable

N3 = Accredited

N4 = Provisional

N6 = New health plan accreditation

**JCAHO** ([www.jcaho.org](http://www.jcaho.org)):

J1 = Accreditation with commendation

J2 = Accreditation without recommendations

J3 = Accreditation with recommendations

J5 = Provisional

J6 = Conditional

**URAC** ([www.urac.org](http://www.urac.org)):

U1 = Accredited

# F E H B a n d Y o u

## Benefits

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

- **Read plan brochures carefully.**
- **Check the brochure's Change page.**
- **Know what services are covered.**
- **Know what services are not covered.**

## Cost

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

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

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

## How the Plan Works

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

Generally, 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 are regional PPOs, the non-PPO benefit is the standard benefit. In "PPO-only" options, you must use PPO providers to get benefits.*

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

Health Maintenance Organizations (HMOs) use networks of physicians and facilities that are generally limited. You must use their network to get covered services and follow the plan's rules for referrals and other services. HMOs limit your out-of-pocket costs to the relatively low amounts shown in the benefit brochures.

# F E H B a n d Y o u

Some plans are Point Of Service (POS) plans and have features similar to both FFS plans and HMOs.

## **You are in a FFS plan and do not use the (PPO) (or one is not available):**

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

## **You are in a FFS plan and use the PPO:**

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

## **You are in a FFS plan's "PPO-only" option:**

- You **must** use network providers to get benefits
- You will generally pay copayments and have no deductibles
- You will have little, if any, paperwork

## **You belong to an HMO:**

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

## **You belong to a POS plan and use only the providers in that network:**

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

## **You belong to a POS and do not use network providers or referral procedures:**

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

## **Things to do to make a plan work best for you**

- When you need care, use your brochure to find out about the plan's **rules and coverage**. Know what services require precertification, prior approval, or referral before you use them.
- Use your plan's **home delivery** drug program if it has one. You generally get the convenience of a 90-day supply instead of a 30-day supply, usually with lower out-of-pocket expense.
- Request **generic drugs** instead of brand name drugs. A generic medication is a copy of a brand name drug. It has the same active ingredients and receives the same Food and Drug Administration approval but costs less.
- If you're in a FFS plan, use the plan's **PPO** if it has one. (Be aware, however, that some of the services, such as anesthesia and radiology, provided in a PPO hospital may not be covered by PPO arrangements.)
- Ask questions. You deserve a voice in your own health care.

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



# FEHB Web Resources

Visit us at [www.opm.gov/insure](http://www.opm.gov/insure) to find

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

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

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

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

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

On this page you'll find:

- General information about plans including plan quality, benefits, and cost.
- Information on how to enroll or make changes to your enrollment, including the enrollment form which you can complete on-line, print and give to your personnel office; information on Employee Express, and enrollment information for annuitants.
- Links to plan web sites and other web sites where you can find more about health care quality.

You can also look at and download:

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

# Program Features

- **No Waiting Periods.** You can use your benefits as soon as your coverage becomes effective. There are no pre-existing condition limitations.
- **A Choice of Coverage.** Choose between self only or self and family.
- **A Choice of Plans and Options.** Select from Fee-For-Service, Health Maintenance Organization, or Point of Service plans.
- **A Government Contribution.** The Government pays 72 percent of the average premium toward the total cost of your premium, but not more than 75 percent of the total premium for any plan.
- **Salary Deduction.** You pay your share of the premium through a payroll deduction.
- **Annual Opportunity to Change Plans.** Each year you can change your health plan enrollment. This year the Open Season runs from November 12, 2001 through December 10, 2001.
- **Continued Group Coverage.** Eligibility for you or your family members may continue following your divorce or death. Contact the OWCP district office that handles your case for more information.
- **Coverage After FEHB Ends.** You or your family members may be eligible for temporary continuation of FEHB coverage or for conversion to non-group (private) coverage when FEHB coverage ends. Contact the OWCP district office that handles your case for more information.



Federal Employees  
Health Benefits Program

**Better Information**  
**Better Choices**  
**Better Health**

# Definitions

**Accreditation** - A rigorous and comprehensive evaluation performed by independent organizations to assess the quality of the key systems and processes that managed care organizations use. Accreditation may also include an assessment of the care and service plans are delivering in important areas of public concern such as immunization, mammography, patient safety, and member satisfaction. The following three organizations perform accreditation reviews we recognize in this Guide:

**NCQA** - The National Committee for Quality Assurance. These are NCQA's accreditation levels:

- **Excellent** - NCQA's highest status. Levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement AND achieve HEDIS (see definition) results that are in the highest range of national or regional performance. Valid for 3 years.
- **Commendable** - Meets or exceeds NCQA's requirements for consumer protection and quality improvement. Valid for 3 years.
- **Accredited** - Meets most of NCQA's requirements for consumer protection and quality improvement. Valid for 3 years.
- **Provisional** - Meets some but not all of NCQA's requirements for consumer protection and quality improvement. Valid for 1 year.
- **New Health Plan** - Designed for health plans that are less than 2 years old.

**JCAHO** - The Joint Commission on Accreditation of Healthcare Organizations. These are JCAHO's accreditation levels:

- **Accreditation with commendation** - JCAHO's highest status. Awarded to a plan that has demonstrated exemplary performance (category discontinued as of 2003). Valid for 3 years.

- **Accreditation without recommendations** - Demonstrates satisfactory compliance with JCAHO standards in all performance areas. Valid for 3 years.
- **Accreditation with recommendations** - Demonstrates satisfactory compliance with JCAHO standards in most performance areas. Valid for 3 years.
- **Provisional** - Demonstrates satisfactory compliance with a subset of standards. Valid for 6 months until plan is re-surveyed.
- **Conditional** - Demonstrates the capability of achieving satisfactory compliance but has not done so.

**URAC** - Also known as the American Accreditation Healthcare Commission.

- **Accredited** - Demonstrates full compliance with standards. Valid for 2 years.

**Fee-For-Service (FFS)** - Health coverage in which doctors and other providers receive a fee for each service such as an office visit, test, procedure, or other health care service. The plan will either pay the medical provider directly or reimburse you for covered services after you have filed an insurance claim. When you need medical attention, you visit the doctor or hospital of your choice.

Things to consider:

Fee-For-Service PPOs, non-PPOs, and PPO-only all work a little differently. See page 5 for things you should know.

# Definitions

**Health Maintenance Organization (HMO)** - A health plan that provides care through contracted or employed physicians and hospitals located in particular geographic or service areas. HMOs emphasize prevention and early detection of illness. Your eligibility to enroll in an HMO is determined by where you live or, in some plans, where you work.

Things to consider:

- The HMO pays for all covered services as long as you use the doctors, including specialists, and hospitals in the HMO network.
- You will usually pay less than FFS when you get care.
- You will have very little, if any, paperwork
- More preventive health care services may be covered

**HEDIS**<sup>1</sup> - Health Plan Employer Data and Information Set. A set of health plan performance measures that cover things such as preventive care, prenatal care, treatment of acute and chronic diseases and member satisfaction with health plans and doctors that look at a plan's quality of care and services. NCQA requires HEDIS and JCAHO accepts HEDIS in accrediting health plans.

**In-network** - The doctors, clinics, health centers, hospitals, medical practices, and other providers that a plan contracts with or employs to care for its members. Examples include a Fee-For-Service plan's PPO or a Health Maintenance Organization. Members have less out-of-pocket costs when they use in-network providers.

**Managed care** - A very broad term that generally refers to a system that manages the quality of health care, access to care, and the cost of that care. For example, a formulary controls the quality of medications dispensed to enrollees; a referral ensures that you see the right specialist for your condition; and going to a hospital that has an agreement with your plan can save both you and the plan money.

**Out-of-network** - Members seek treatment from doctors, hospitals, and others outside the plan's panel of contracted or employed providers, and pay more to do so. Members in a PPO-only who receive services outside the PPO network pay all charges.

**Point of Service (POS)** - A product offered by an HMO or FFS plan that has features of both. If you join a POS offered by a Fee-For-Service plan, you receive care from the plan's network of providers and:

- You will generally pay less when you get care than you would under the traditional FFS coverage
- You will get full HMO-type benefits and coverage
- You will have very little paperwork

If you join a POS offered by an HMO, you are not limited to the plan's network of providers and:

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

In a POS you don't have to use the plan's network of providers, but there are advantages if you do.

**Preferred Provider Organization (PPO)** - Under the FEHB Program, PPOs are only available through enrollment in a Fee-For-Service plan. The PPO is similar to FFS insurance except it uses a network of providers. PPO's give you the choice of using any doctor or other provider you want, or using one who is part of the plan's network. You don't have to use the PPO, but there are advantages if you do (see Fee-For-Service).

Please note that some FFS plans may offer an enrollment option that is "PPO-only". Under this option, you **must** use network providers to get benefits.

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

<sup>1</sup>HEDIS is a registered trademark of the National Committee for Quality Assurance.

# Long Term Care Insurance Is Coming Later in 2002!

➡➡ **Many FEHB enrollees think that their health plan and/or Medicare will cover their long term care needs – Unfortunately, they are **WRONG!****

➡➡ **How are YOU planning to pay for the future custodial or chronic care you may need?**

➡➡ **You should consider buying long term care insurance.**

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

## What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. ***LTC insurance can supplement care provided by family members, reducing the burden you place on them.***

## I'm healthy. I won't need long term care. Or, will I?

- ***Welcome to the club!*** 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. ***Many people now consider long term care insurance to be vital to their financial and retirement planning.***

## Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed \$50,000. Home care for only three 8-hour shifts a week can exceed \$20,000 a year. And that's before inflation!

- Long term care can easily exhaust your savings. ***Long term care insurance can protect your savings.***

## But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care, a stay in an assisted living facility, or a continuing need for a home health aide to help you with activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. ***Long term care insurance can provide choices of care and preserve your independence.***

## When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

## How can I find out more about the program NOW?

Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at [www.opm.gov/insure/ltc](http://www.opm.gov/insure/ltc).

# Learning about today's Federal Benefit Programs can be beneficial to your health.

*Today's Medicare offers more.*

- ✓ *More preventive benefits.*
- ✓ *More information.*
- ✓ *More help with your questions.*



An education program of the Department of Health and Human Services and the Center for Medicare and Medicaid Services

## Medicare Questions?

[www.medicare.gov](http://www.medicare.gov)



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



Medicare & You Handbook



# The Department of Defense's New TRICARE-For-Life is an affordable alternative to FEHB.

- ✓ *Available to Uniformed Services Retirees with Medicare Parts A and B.*
- ✓ *Comprehensive medical and pharmacy coverage.*
- ✓ *Low out-of-pocket costs.*

## TRICARE-for-Life Questions?

[www.opm.gov/insure](http://www.opm.gov/insure)  
OR  
[www.tricare.OSD.mil](http://www.tricare.OSD.mil)



1-888-DOD-LIFE  
(1-888-363-5433)



# Plan Comparisons

## Nationwide Fee-for-Service Plans Open to All

**(Pages 14 through 16)**

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

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

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



## Nationwide Fee-for-Service Plans Open to All

### How to read this chart:

The table below highlights selected features that may help you narrow your choice of health plans. See the applicable column description for details. *Always consult plan brochures before making your final decision.* The chart does not show all of your possible out-of-pocket costs.

The **Deductibles** shown are the amount of covered expenses that you pay before your health plan begins to pay.

**Calendar Year** deductibles for families are two or more times the per person amount shown.

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

The **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	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Alliance Health Plan (AHP)	202/939-6325	1R1	1R2	120.44	223.44
APWU Health Plan (APWU)	800/222-2798	471	472	97.68	197.08
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	82.24	189.66
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	Local phone #	111	112	63.22	151.48
GEHA Benefit Plan-High (GEHA)	800/821-6136	311	312	119.40	239.00
GEHA Benefit Plan-Std (GEHA)	800/821-6136	314	315	55.00	125.00
Mail Handlers-High (MH)	800/410-7778	451	452	110.16	198.40
Mail Handlers-Std (MH)	800/410-7778	454	455	51.30	111.36
NALC (NALC)	888/636-6252	321	322	91.74	167.44
PBP Health Plan-High (PBP)	800/544-7111	361	362	326.84	680.64
PBP Health Plan-Std (PBP)	800/544-7111	364	365	101.90	197.00



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

# Nationwide Fee-for-Service Plans Open to All

**Enrollee Survey Results** — See pages 2-3 for a description.

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

# Plan Comparisons

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

**(Pages 18 through 20)**

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

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

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

### How to read this chart:

The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* The chart does not show all of your possible out-of-pocket costs.

The **Deductibles** shown are the amount of covered expenses that you pay before your health plan begins to pay.

**Calendar Year** deductibles for families are two or more times the per person amount shown.

Some plans apply **Prescription Drug** purchases to the Calendar Year 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	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Association Benefit Plan (ABP)	800/634-0069	421	422	94.54	221.84
Foreign Service (FS)	202/833-4910	401	402	74.88	210.38
Panama Canal Area <sup>◇</sup> (PCA)	732/222-2229	431	432	75.22	146.88
Rural Carrier Benefit Plan (Rural)	800/638-8432	381	382	120.32	196.90
SAMBA (SAMBA)	800/638-6589	441	442	133.94	329.52
Secret Service (SS)	800/424-7474	Y71	Y72	61.66	146.16

<sup>◇</sup> Offers a Point of Service product. See page 46.

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

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

**Enrollee Survey Results** — See pages 2-3 for a description.

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

# Plan Comparisons

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

(Pages 22 through 57)

**Health Maintenance Organization (HMO)** — A health plan that provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service you receive and free you from completing paperwork or being billed for covered services. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work. Some HMOs are affiliated with or have arrangements with HMOs in other service areas for non-emergency care if you travel or are away from home for extended periods. Plans that offer reciprocity discuss it in their brochure.

- The HMO provides a comprehensive set of services — as long as you use the doctors and hospitals affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and generally no deductible or coinsurance for in-hospital care.
- Most HMOs ask you to choose a doctor or medical group to be your primary care physician (PCP). Your PCP provides your general medical care. In many HMOs, you must get authorization or a “referral” from your PCP to see other providers. The referral is a recommendation by your physician for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures that you see the right provider for the care most appropriate to your condition.
- Care received from a provider not in the plan’s network is not covered unless it’s emergency care or the plan has a reciprocity arrangement.

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

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

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

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

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

**How to read this chart:** The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Alabama</b>					
PrimeHealth of Alabama, Inc. - Southern Alabama and the Montgomery Area	800/236-9421	AA1	AA2	63.12	200.10
The Oath - A Health Plan for Alabama, Inc. - Birmingham/Other areas	800/947-5093	DF1	DF2	68.50	229.56
<b>Arizona</b>					
Aetna U. S. Healthcare, Inc. - Phoenix/Tucson areas	800/537-9384	WQ1	WQ2	51.60	145.24
Health Net of Arizona, Inc. - Maricopa/Pima/Other AZ counties	800/289-2818	A71	A72	58.14	180.70
PacifiCare Health Plans - Maricopa/Pima/parts of Apache Junction	800/531-3341	A31	A32	58.00	203.32
<b>California</b>					
Aetna U. S. Healthcare, Inc. - Southern California area	800/537-9384	2X1	2X2	48.00	112.10
Blue Cross- HMO - Most of California	800/235-8631	M51	M52	52.64	134.28
Blue Shield of CA Access+ - Most of California	800/334-5847	SJ1	SJ2	56.04	139.00
CIGNA HealthCare of California - Northern/Southern California	800/244-6224	9T1	9T2	58.32	128.30
Health Net - Most of California	800/522-0088	LB1	LB2	57.52	136.16
Kaiser Permanente - Northern California	800/464-4000	591	592	53.16	126.88
Kaiser Permanente - Southern California	800/464-4000	621	622	55.98	129.38
PacifiCare Health Plans - Most of California	800/531-3341	CY1	CY2	46.68	121.74
UHP HEALTHCARE - LA/Orange/San Bernardino Counties	800/544-0088	C41	C42	39.86	84.94
Universal Care - Southern California	800/257-3087	6Q1	6Q2	42.00	110.92
Western Health Advantage - Northern California	888/563-2250	5Z1	5Z2	54.44	130.66



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

**Enrollee Survey Results** — See pages 2-3 for a description. An (X) means the plan did not conduct the survey as we asked. **Accredited** — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 3 and 8 for details. A lower number means a better accreditation.

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

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

**How to read this chart:** The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Colorado</b>					
Kaiser Permanente - Denver/Colorado Springs areas	800-632-9700	651	652	58.34	148.78
PacifiCare of Colorado-High -Denver/Colorado Springs/Ft.Collins	800/877-9777	D61	D62	65.02	233.56
PacifiCare of Colorado-Std - Denver/Colorado Springs/Ft.Collins	800/877-9777	D64	D65	38.64	100.10
Rocky Mountain HMO-High -Most of Colorado	800/346-4643	XJ1	XJ2	121.14	294.26
Rocky Mountain HMO-Std - Most of Colorado	800/346-4643	XJ4	XJ5	89.46	220.16
<b>Connecticut</b>					
ConnectiCare - All of Connecticut	800/251-7722	TE1	TE2	56.06	146.84
Health Net, Inc. - All of Connecticut	877/747-9585	DP1	DP2	101.52	383.80

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

**Enrollee Survey Results** — See pages 2-3 for a description. An (X) means the plan did not conduct the survey as we asked. **Accredited** — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 3 and 8 for details. A lower number means a better accreditation.

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

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

**How to read this chart:** The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>District of Columbia</b>					
Aetna U. S. Healthcare, Inc.-High -Washington, DC area	800/537-9384	JN1	JN2	67.74	162.56
Aetna U. S. Healthcare, Inc.-Std - Washington, DC area	800/537-9384	JN4	JN5	47.94	112.18
CareFirst BlueChoice - Washington, DC area	800/680-9495	2G1	2G2	63.78	143.50
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	53.52	132.20
MD-IPA - Washington, DC area	800/251-0956	JP1	JP2	60.28	144.68
<b>Florida</b>					
Av-Med Health Plan - G'ville/Jax/Orlando/So.FL/Tampa	800/882-8633	EM1	EM2	61.44	229.02
Capital Health Plan - Tallahassee area	850/383-3311	EA1	EA2	56.92	161.10
Foundation Health - Southern Florida	800/441-5501	5E1	5E2	40.02	110.08
HIP Health Plan of FL - South Florida	800/447-8255	3N1	3N2	54.28	158.94
Humana Medical Plan - South Florida	888/393-6765	EE1	EE2	53.24	133.12
Total Health Choice - Broward/Dade/Palm Beach Counties	305/408-5823	4A1	4A2	47.12	117.34

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

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

\* Previously CapitalCare, which had Commendable NCQA accreditation.

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

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Georgia</b>					
Aetna U. S. Healthcare, Inc. - Atlanta and Athens areas	800/537-9384	2U1	2U2	55.96	146.98
Kaiser Permanente - Atlanta area	800/611-1811	F81	F82	52.84	134.14
<b>Guam</b>					
PacifiCare Asia Pacific-High -Guam/N. Mariana Islands/Palau	671/647-3526	JK1	JK2	73.52	260.56
PacifiCare Asia Pacific-Std - Guam/N. Mariana Islands/Palau	671/647-3526	JK4	JK5	55.20	145.76
<b>Hawaii</b>					
HMSA - All of Hawaii	808/948-6499	871	872	53.78	119.72
Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu/Kauai	808/597-5955	631	632	61.10	131.38
Kaiser Permanente-Std - Islands of Hawaii/Maui/Oahu/Kauai	808/597-5955	634	635	46.64	100.28
<b>Idaho</b>					
Group Health Cooperative - Kootenai and Latah	800/497-2210	VR1	VR2	59.64	166.42

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

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Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Illinois</b>					
BlueCHOICE - St. Clair and Madison	800/634-4395	9G1	9G2	30.67	66.39
Group Health Plan - Southern/Metro East/Central	800/743-3901	MM1	MM2	102.52	197.36
Health Alliance HMO - Central/E.Central/N.West/South/West IL	800/851-3379	FX1	FX2	80.78	198.54
Humana Health Plan Inc. - Chicago area	888/393-6765	751	752	54.52	130.78
John Deere Health Plan - Bloomington/Joliet/Moline/Peoria/RockIsld	800/247-9110	YH1	YH2	63.40	206.70
Mercy Health Plans/Premier - Southwest Illinois	800/327-0763	7M1	7M2	72.44	176.88
OSF HealthPlans - Central/Central-Northwestern Illinois	800/673-5222	9F1	9F2	56.80	150.78
PersonalCare's HMO - Central Illinois	800/431-1211	GE1	GE2	45.20	116.22
UNICARE HMO - Chicagoland area	312/234-8855	171	172	42.02	131.04
Union Health Service - Chicago area	312/829-4224	761	762	48.54	120.38
<b>Indiana</b>					
Advantage Health Plan, Inc. - Most of Indiana	800/553-8933	6Y1	6Y2	61.28	143.90
Aetna U. S. Healthcare, Inc. - Southern Indiana	800/537-9384	7L1	7L2	57.56	142.18
Aetna U. S. Healthcare, Inc. - Southeastern Indiana	800/537-9384	RD1	RD2	87.12	268.56
Arnett HMO - Lafayette area	765/448-7440	G21	G22	62.62	204.52
Health Alliance HMO - Fountain/Vermillion/Warren Counties	800/851-3379	FX1	FX2	80.78	198.54
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	62.40	177.34
Humana Health Plan Inc. - Lake/Porter/LaPorte Counties	888/393-6765	751	752	54.52	130.78
M*Plan - Indiana Metropolitan areas	317/571-5320	IN1	IN2	83.32	193.50
Physicians HP of N. Indiana - Northeast Indiana	219/432-6690	DQ1	DQ2	61.16	137.46
UNICARE HMO - Lake/Porter Counties	888/234-8855	171	172	42.02	131.04
Welborn HMO - Evansville area	812/426-6600	H31	H32	73.00	247.88



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

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

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Iowa</b>					
Avera Health Plan - Northwestern Iowa	888/322-2115	AV1	AV2	26.30	60.36
Coventry Health Care of Iowa - Central Iowa/Cedar Rapids/Sioux City	800/257-4692	SV1	SV2	58.32	183.22
Health Alliance HMO - Central/Eastern Iowa	800/851-3379	FX1	FX2	40.39	99.27
John Deere Health Plan - Central/Eastern Iowa	800/247-9110	YH1	YH2	63.40	206.70
SecureCare of Iowa - Central/Eastern Iowa	888/881-8820	3Q1	3Q2	50.44	132.14
<b>Kansas</b>					
Coventry HC Kansas Cty formerly Kaiser - Kansas City area	913/642-2662	HA1	HA2	43.78	112.94
Coventry Health Care of Kansas - Wichita/Salinas areas	800/664-9251	7W1	7W2	60.60	171.36
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	56.84	136.38
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	43.32	103.92
Preferred Plus of Kansas - S. Central Area	800/660-8114	VA1	VA2	80.30	287.36
<b>Kentucky</b>					
Aetna U. S. Healthcare, Inc. - Louisville area	800/537-9384	7L1	7L2	57.56	142.18
Aetna U. S. Healthcare, Inc. - Northern Kentucky area	800/537-9384	RD1	RD2	87.12	268.56
Humana Health Plan - Louisville area	888/393-6765	D21	D22	62.40	177.34
United Health Care of Ohio, Inc. - Northern Kentucky	800/231-2918	3U1	3U2	101.80	237.48

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

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Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Louisiana</b>					
Amcare Health Plans - New Orleans area	800/772-2995	ZH1	ZH2	45.52	119.20
Amcare Health Plans - Baton Rouge/Alexandria/Shreveport areas	800/772-2995	ZQ1	ZQ2	55.24	144.70
Coventry Healthcare Louisiana former Maxicare LA - New Orleans area	800-993-6294	BJ1	BJ2	57.74	134.12
Coventry Healthcare Louisiana former Maxicare LA - Baton Rouge area	800-341-6613	JA1	JA2	72.76	176.72
Vantage Health Plan - Monroe area	888/823-1910	AQ1	AQ2	80.32	293.74
Vantage Health Plan - Shreveport/Alexandria areas	888/823-1910	MV1	MV2	96.88	338.18
<b>Maryland</b>					
Aetna U. S. Healthcare, Inc.-High -North/Central/Southern Maryland	800/537-9384	JN1	JN2	67.74	162.56
Aetna U. S. Healthcare, Inc.-Std - North/Central/Southern Maryland	800/537-9384	JN4	JN5	47.94	112.18
CareFirst BlueChoice - all of Maryland	800/680-9495	2G1	2G2	63.78	143.50
Kaiser Permanente - Baltimore/Washington, DC areas	301/468-6000	E31	E32	53.52	132.20
MD-IPA - All of Maryland	800/251-0956	JP1	JP2	60.28	144.68
<b>Massachusetts</b>					
Blue Chip, Coord Hlth Partners - Southeastern Massachusetts	401/459-5500	DA1	DA2	67.10	226.10
Fallon Community Health Plan - Central/Eastern Massachusetts	800/868-5200	JV1	JV2	81.68	159.16

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

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		Self only	Self & family	Self only	Self & family
<b>Michigan</b>					
Bluecare Network of MI - Cheboygan and Roscommon Counties Area	800/662-6667	G71	G72	231.38	633.24
Bluecare Network of MI - Midland County Area	800/662-6667	K51	K52	60.34	228.10
Bluecare Network of MI - Kalamazoo County Area	800/662-6667	KF1	KF2	107.62	388.36
Bluecare Network of MI - Genesee County Area	800/662-6667	KN1	KN2	64.70	276.70
Bluecare Network of MI - Kent County Area	800/662-6667	KR1	KR2	65.64	307.88
Bluecare Network of MI - Mid Michigan	800/662-6667	LN1	LN2	123.46	321.70
Bluecare Network of MI - Southeast MI	800/662-6667	LX1	LX2	44.54	133.24
Grand Valley Health Plan - Grand Rapids area	616/949-2410	RL1	RL2	58.48	210.78
Health Alliance - Southeastern Michigan/Flint area	800/422-4641	521	522	61.86	208.84
HealthPlus MI - Flint/Saginaw areas	800/332-9161	X51	X52	62.12	162.46
M-Care - Mid and Southeastern Michigan	800/658-8878	EG1	EG2	50.74	134.46
OmniCare - Southeastern Michigan	800/477-6664	KA1	KA2	51.32	128.82
The Wellness Plan - Detroit/Flint/Muskegon Areas	800/875-9355	K31	K32	45.52	123.82
Total Health Care - Greater Detroit/Flint areas	800/826-2862	N21	N22	52.82	132.92
<b>Minnesota</b>					
HealthPartners Classic-High -Minneapolis/St. Paul areas	952/883-5000	531	532	91.74	243.02
HealthPartners Classic-Std - Minneapolis/St. Paul areas	952/883-5000	534	535	80.96	217.22
HealthPartners Primary Clinic Plan - Minneapolis/St. Paul/St. Cloud areas	952/883-5000	HQ1	HQ2	136.20	349.80

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

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

**How to read this chart:** The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Missouri</b>					
BlueCHOICE - StLouis/Central/SW/Poplar Bluff area	800/634-4395	9G1	9G2	61.34	132.78
Coventry HC Kansas City formerly Kaiser - Kansas City area	913/642-2662	HA1	HA2	43.78	112.94
Group Health Plan - St. Louis area	800/743-3901	MM1	MM2	102.52	197.36
Humana Kansas City, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	56.84	136.38
Humana Kansas City, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	43.32	103.92
Mercy Health Plans/Premier - East/Central/Southwest Missouri	800/327-0763	7M1	7M2	72.44	176.88
<b>Nevada</b>					
Aetna U. S. Healthcare, Inc. - Southern Nevada/Las Vegas area	800/537-9384	8L1	8L2	56.22	146.08
Health Plan of Nevada - Las Vegas/Reno areas	702/871-0999	NM1	NM2	48.90	125.24
PacifiCare Health Plans - Clark County	800/531-3341	K91	K92	59.04	154.60



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

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

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

**How to read this chart:** The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>New Jersey</b>					
Aetna U. S. Healthcare, Inc. - All of New Jersey	800/537-9384	P31	P32	92.04	301.36
AmeriHealth HMO - All of New Jersey	800/454-7651	FK1	FK2	63.32	157.04
GHI Health Plan - Northern New Jersey	212/501-4444	801	802	92.56	273.86
HealthNet of Pennsylvania - Phila. and 7 adjacent PA and NJ counties	800/998-2840	271	272	105.82	261.88
<b>New Mexico</b>					
Cimarron Health Plan - All of New Mexico	800/473-0391	PX1	PX2	56.64	149.08
Lovelace Health Plan - All of New Mexico	800/244-6224	Q11	Q12	56.16	146.04
Presbyterian Health Plan - All NM counties except Otero & S. Eddy	505/923-5678	P21	P22	54.22	141.42

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

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

**How to read this chart:** The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>New York</b>					
Aetna U. S. Healthcare, Inc. - NYC area and Dutchess/Sullivan/Ulster	800/537-9384	JC1	JC2	56.04	140.94
Aetna U. S. Healthcare, Inc. - Syracuse area	800/537-9384	TG1	TG2	50.32	126.94
Blue Choice - Rochester area	800/462-0108	MK1	MK2	68.10	214.24
C.D.P.H.P. - Albany/Cooperstown areas	518/862-3750	PW1	PW2	59.46	161.98
C.D.P.H.P. - Hudson Valley area	518/862-3750	QB1	QB2	61.84	188.28
C.D.P.H.P. - Capital District area	518/862-3750	SG1	SG2	58.90	156.72
GHI Health Plan - All of New York	212/501-4444	801	802	92.56	273.86
GHI HMO Select - Bronx/Brklyn/Manhattan/Queens/Westchester	877/244-4466	6V1	6V2	64.10	197.82
GHI HMO Select - Capital/Hudson Valley Regions	877/244-4466	X41	X42	57.12	147.24
Health Net, Inc. - NYC/LI/Dtchs/Orgm/Putnm/RkInd/Wschs	877/747-9585	PD1	PD2	142.04	426.26
HIP of Greater New York - New York City area	800/HIP-TALK	511	512	54.46	206.76
HMO Blue - Utica/Rome/Central New York areas	800/722-7884	AH1	AH2	61.88	187.08
HMO-CNY - Syracuse/Binghamton/Elmira areas	800/828-2887	EB1	EB2	67.68	251.72
Independent Health Assoc - Western New York	800/453-1910	QA1	QA2	46.98	130.96
MVP Health Plan - Eastern Region	888/687-6277	GA1	GA2	57.36	148.14
MVP Health Plan - Central Region	888/687-6277	M91	M92	59.20	164.64
MVP Health Plan - Mid-Hudson Region	888/687-6277	MX1	MX2	64.82	222.94
Preferred Care - Rochester area	716/325-3113	GV1	GV2	59.40	187.86
Univera Healthcare - CNY - Syracuse/Southern Tier areas	315/638-2133	QE1	QE2	65.16	244.20
Univera Healthcare - CNY - Utica area	315/797-7019	SH1	SH2	65.16	244.20
Univera Healthcare - WNY - Western New York	716/847-0881	Q81	Q82	51.36	145.64
Vytra Health Plans - Queens/Nassau/Suffolk Counties	800/406-0806	J61	J62	101.00	330.64

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

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Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>North Dakota</b>					
Heart of America HMO - Northcentral North Dakota	701/776-5848	RU1	RU2	53.08	136.42
<b>Ohio</b>					
Aetna U. S. Healthcare, Inc. - Cleveland and Toledo areas	800/537-9384	7D1	7D2	75.42	223.26
Aetna U. S. Healthcare, Inc. - Greater Cincinnati area	800/537-9384	RD1	RD2	87.12	268.56
AultCare HMO - Stark/Carroll/Holmes/Tuscarawas/Wayne Co	330/438-6360	3A1	3A2	47.62	119.26
Health Maintenance Plan(HMP) - Most of Ohio	800/228-4375	R51	R52	72.94	186.22
Health Plan Upper OH Valley - Eastern Ohio	800/624-6961	U41	U42	58.66	198.50
HMO Health Ohio - Northeast Ohio	800/522-2066	L41	L42	64.40	212.08
Kaiser Permanente - Akron/Cleveland areas	800/686-7100	641	642	58.88	144.50
Paramount Health Care - Northwest/North Central Ohio	800/462-3589	U21	U22	64.88	241.24
SummaCare Health Plan - Cleveland, Akron areas	330/996-8415	5W1	5W2	50.28	138.28
SuperMed HMO - Northeast Ohio	800/522-2066	5M1	5M2	94.14	294.62
United Health Care of Ohio, Inc. - Cincinnati/Dayton/Springfield	800/231-2918	3U1	3U2	101.80	237.48

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			Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
<b>North Dakota</b>												
Heart of America HMO	\$10	None	50%	50%	50%							
<b>Ohio</b>												
Aetna U. S. Healthcare, Inc.	\$20	\$200-\$600	\$10	\$20	50%	○	◐	●	●	○	○	N2
Aetna U. S. Healthcare, Inc.	\$20	\$200-\$600	\$10	\$20	50%	○	◐	●	●	○	○	N2
AultCare HMO	\$10	None	\$5	\$10	\$10	●	●	●	●	●	●	
Health Maintenance Plan(HMP)	\$10	None	\$8	\$15	\$25	◐	●	●	●	◐	◐	
Health Plan Upper OH Valley	\$10	None	\$10	\$20	\$35	●	●	●	●	●	●	N1
HMO Health Ohio	\$10	None	\$10	\$20	\$20	◐	◐	◐	◐	○	○	N2
Kaiser Permanente	\$10	None	\$5	\$15	\$15	◐	●	◐	○	●	◐	N1
Paramount Health Care	\$10	None	\$5	\$15	\$25	●	●	●	●	●	●	N2
SummaCare Health Plan	\$10	None	\$5	\$10	\$10	●	●	●	●	◐	◐	N1
SuperMed HMO	\$10	None	\$10	\$20	\$20	◐	◐	◐	◐	○	○	N2
United Health Care of Ohio, Inc.	\$15	\$100	\$10	\$15	\$30	◐	●	◐	◐	◐	○	N1

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Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Oklahoma</b>					
Amcare Health Plans - Oklahoma City/Tulsa areas	800/772-2993	ZX1	ZX2	51.58	135.08
PacifiCare Health Plans - Central/Northeastern Oklahoma	800/531-3341	2N1	2N2	51.22	133.90
<b>Oregon</b>					
Kaiser Permanente-High -Portland/Salem areas	800/813-2000	571	572	72.48	168.68
Kaiser Permanente-Std - Portland/Salem areas	800/813-2000	574	575	60.00	137.70
PacifiCare Health Plans - Metro Portland/Salem/Corvallis/Eugene	800/531-3341	7Z1	7Z2	138.10	292.80
<b>Panama</b>					
Panama Canal Area - Republic of Panama	507/227-7555	431	432	75.22	146.88



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			Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
<b>Oklahoma</b>												
Amcare Health Plans	\$10	None	\$5	\$15	50%							N6
PacifiCare Health Plans	\$10	None	\$5	\$15	\$15	◐	○	○	○	◐	●	N1
<b>Oregon</b>												
Kaiser Permanente-High	\$10	None	\$10	\$20	\$20	◐	●	○	○	●	●	N1
Kaiser Permanente-Std	\$15	None	\$15	\$30	\$30	◐	●	○	○	●	●	N1
PacifiCare Health Plans	\$10	None	\$5	\$15	\$15	○	○	◐	◐	○	●	N1
<b>Panama</b>												
Panama Canal Area - In-Network	\$10	\$75	50%	50%	50%							
Panama Canal Area - Out-of-Network	50%	\$125	50%	50%	50%							

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Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Pennsylvania</b>					
Aetna U. S. Healthcare, Inc. - Southeastern PA	800/537-9384	P31	P32	92.04	301.36
HealthAmerica Pennsylvania - Greater Pittsburgh area	800/735-4404	261	262	57.68	153.10
HealthAmerica Pennsylvania - Central Pennsylvania	800/788-8445	SW1	SW2	62.06	198.74
HealthGuard - Berks/Cmbrlnd/Dauphine/Lanc/Lebanon/York	800/822-0350	NQ1	NQ2	49.78	129.44
Keystone Health Plan Central - Harrisburg/Northern Region/Lehigh Valley	800/622-2843	S41	S42	94.66	255.78
Keystone Health Plan East - Philadelphia area	800/227-3115	ED1	ED2	64.30	230.98
KeystoneBlue - Pittsburgh/Altoona/Erie areas	800/421-0959	EF1	EF2	95.26	416.42
HealthNet of Pennsylvania - Phila. and 7 adjacent PA and NJ counties	800/736-2096	271	272	105.82	261.88
HealthNet of Pennsylvania - Scranton/Wilkes Barre areas	800/736-2096	2K1	2K2	64.58	187.24
UPMC Health Plan - Pittsburgh Area	412/454-7529	8W1	8W2	46.76	119.28
<b>Puerto Rico</b>					
Triple-S - All of Puerto Rico	787/749-4777	891	892	45.58	97.88

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

**Enrollee Survey Results** — See pages 2-3 for a description. An **(X)** means the plan did not conduct the survey as we asked. **Accredited** — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 3 and 8 for details. A lower number means a better accreditation.

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

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

**How to read this chart:** The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Rhode Island</b>					
Blue Chip, Coord Hlth Partners - All of Rhode Island	401/459-5500	DA1	DA2	67.10	226.10
<b>South Dakota</b>					
Avera Health Plan - Eastern and Central South Dakota	888/322-2115	AV1	AV2	52.60	120.72
Sioux Valley Health Plan - Eastern/Central/Rapid City areas	800/752-5863	AU1	AU2	112.32	212.42
<b>Tennessee</b>					
Aetna U. S. Healthcare, Inc. - Nashville/Middle Tennessee areas	800/537-9384	6J1	6J2	62.68	251.82
Aetna U. S. Healthcare, Inc. - Memphis area	800/537-9384	UB1	UB2	51.78	184.26
HealthSpring - Nashville/Middle Tennessee areas	615/291-5030	6K1	6K2	58.18	201.78

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

**Enrollee Survey Results** — See pages 2-3 for a description. An (X) means the plan did not conduct the survey as we asked. **Accredited** — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 3 and 8 for details. A lower number means a better accreditation.

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

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

**How to read this chart:** The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Texas</b>					
Amcare Health Plans - Houston/El Paso areas	800/782-8373	2V1	2V2	51.44	134.72
Amcare Health Plans - Austin/San Antonio/Dallas/Ft. Worth areas	800/782-8373	ZG1	ZG2	50.88	133.26
FIRSTCARE - Waco area	800/884-4901	6U1	6U2	76.30	146.08
FIRSTCARE - West Texas	800/884-4901	CK1	CK2	106.62	202.62
HMO Blue Texas - Austin/C.Christi/S.Antonio/Victoria/Houston	800/833-5318	YM1	YM2	59.80	146.36
HMO Blue Texas - Dallas/Ft. Worth/East & West Texas	877/299-2377	YX1	YX2	71.24	200.64
Humana Health Plan of Texas - San Antonio area	888/393-6765	UR1	UR2	51.50	132.36
Mercy Health Plans/Premier - Webb/Zapata/Duval/Jim Hogg Counties	800/617-3433	HM1	HM2	63.54	188.64
PacifiCare Health Plans - San Antonio/Dallas/Ft Worth	800/531-3341	GF1	GF2	49.80	130.20
<b>Utah</b>					
Altius Health Plans - Wasatch Front	800/377-4161	9K1	9K2	97.62	198.54
<b>Vermont</b>					
MVP Health Plan - All of Vermont	888/687-6277	VW1	VW2	178.48	519.70

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

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

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

**How to read this chart:** The table below highlights selected features that may help you narrow your choice of health plans. *Always consult plan brochures before making your final decision.* This chart does not show all of your possible out-of-pocket costs.

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>Virginia</b>					
Aetna U. S. Healthcare, Inc.-High -N.VA/Fredericksburg areas	800/537-9384	JN1	JN2	67.74	162.56
Aetna U. S. Healthcare, Inc.-Std - N.VA/Fredericksburg areas	800/537-9384	JN4	JN5	47.94	112.18
CareFirst BlueChoice - Northern Virginia	800/680-9495	2G1	2G2	63.78	143.50
HealthKeepers - Eastern,Central,F'burg,Western,SW areas	800/421-1880	X81	X82	56.56	143.62
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	53.52	132.20
MD-IPA - N.VA/Cntrl VA/Richmond/Tidewater/Roanoke	800/251-0956	JP1	JP2	60.28	144.68
OPTIMA Health Plan - Peninsula/Southside Hampton Roads	800/206-1060	9R1	9R2	78.76	202.68
PARTNERS NHP of NC - Southwest Virginia	800/942-5695	EQ1	EQ2	81.16	176.20
Piedmont Community Healthcare - Lynchburg area	888/674-3368	2C1	2C2	73.46	169.56
<b>Washington</b>					
Aetna U. S. Healthcare, Inc. - Western/Southeast Washington	800/537-9384	8J1	8J2	55.36	143.96
Group Health Cooperative - Most of Western Washington	206/448-4140	541	542	64.48	145.48
Group Health Cooperative - Central WA/Spokane/Colville/Pullman	800/497-2210	VR1	VR2	59.64	166.42
Kaiser Permanente-High -Vancouver/Longview	800/813-2000	571	572	72.48	168.68
Kaiser Permanente-Std - Vancouver/Longview	800/813-2000	574	575	60.00	137.70
Kitsap Physicians Service-High -Most of Western Washington	800/552-7114	VT1	VT2	160.94	316.06
Kitsap Physicians Service-Std - Most of Western Washington	800/552-7114	VT4	VT5	72.38	146.46
PacifiCare Health Plans - Clark County	800/531-3341	7Z1	7Z2	138.10	292.80
PacifiCare Health Plans - Puget Sound/Most West WA	800/531-3341	WB1	WB2	66.02	239.36



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

**Enrollee Survey Results** — See pages 2-3 for a description. An (X) means the plan did not conduct the survey as we asked. **Accredited** — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 3 and 8 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Hospital per stay deductible/copay	Prescription drugs			Enrollee Survey Results ● above average, ◐ average, ○ below average						
			Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
<b>Virginia</b>												
Aetna U. S. Healthcare, Inc.-High	\$15	\$100-\$300	\$10	\$20	50%	○	○	○	◐	○	○	N2
Aetna U. S. Healthcare, Inc.-Std	\$20	\$200-\$600	\$10	\$20	50%	○	○	○	◐	○	○	N2
CareFirst BlueChoice*	\$10	None	\$10	\$20	\$35	◐	◐	◐	◐	○	○	N2
HealthKeepers	\$10	\$100	\$5	\$10	\$25	◐	◐	○	◐	◐	●	N1
Kaiser Permanente	\$10	\$100	\$10	\$20	\$20	◐	○	◐	○	●	○	N2
MD-IPA	\$10	None	\$5	\$15	\$30	●	●	◐	◐	●	◐	N1
OPTIMA Health Plan	\$10	None	\$10	\$20	\$40	●	●	●	●	●	●	N1
PARTNERS NHP of NC	\$10	\$250	\$7	\$15	\$35	◐	●	●	◐	◐	◐	N1
Piedmont Community Healthcare - In-Network	\$10	None	\$5	\$15	\$15							
Piedmont Community Healthcare - Out-of-Network	30%	None	\$5	\$15	\$15							
<b>Washington</b>												
Aetna U. S. Healthcare, Inc.	\$15	\$100-\$300	\$10	\$20	50%	○	○	◐	◐	○	○	
Group Health Cooperative	\$10	\$100-\$300	\$10	\$20	\$20	◐	◐	◐	◐	◐	◐	N1
Group Health Cooperative	\$10	\$100-\$300	\$10	\$20	\$20	◐	◐	◐	◐	◐	◐	N1
Kaiser Permanente-High	\$10	None	\$10	\$20	\$20	◐	●	○	○	●	●	N1
Kaiser Permanente-Std	\$15	None	\$15	\$30	\$30	◐	●	○	○	●	●	N1
Kitsap Physicians Service-High	\$10	\$200	50%	50%	50%	●	●	●	●	●	●	
Kitsap Physicians Service-Std	20%	None	\$5	\$15	\$100 or 50%	●	●	●	●	●	●	
PacifiCare Health Plans	\$10	None	\$5	\$15	\$15	○	○	●	◐	○	○	N1
PacifiCare Health Plans	\$10	None	\$5	\$15	\$15	○	○	●	◐	○	○	N1

\* Previously CapitalCare, which had Commendable NCQA accreditation.

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

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

Plan name – location	Telephone number	Enrollment code		Twice – Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
<b>West Virginia</b>					
Health Plan Upper OH Valley - Northern/Central West Virginia	800/624-6961	U41	U42	58.66	198.50
<b>Wisconsin</b>					
Dean Health Plan - South Central Wisconsin	800/279-1301	WD1	WD2	59.18	192.30
Group Health Coop - South Central Wisconsin	608/251-3356	WJ1	WJ2	58.08	176.76
Group Hlth Coop/Eau Claire - West Central Wisconsin	715/552-4300	WT1	WT2	155.32	459.00
HealthPartners Classic-High -Pierce/St. Croix Counties	952/883-5000	531	532	91.74	243.02
HealthPartners Classic-Std - Pierce/St. Croix Counties	952/883-5000	534	535	80.96	217.22
HealthPartners Primary Clinic - West Central Wisconsin	952/883-5000	HQ1	HQ2	136.20	349.80
Unity Health Plans - Southern/Central Wisconsin	800/362-3310	W41	W42	78.94	281.06
<b>Wyoming</b>					
WINhealth Partners - Wyoming	307/638-7700	PV1	PV2	57.58	176.90

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

# Addressing the Postcard

## Instructions for addressing the Postcard on the Back of this Booklet

Listed below are the OWCP District Office addresses. To identify the district office serving your compensation case file, look at the address label on the back of this booklet. Locate the two digit identifier which corresponds with the two digit identifier below. (Please note: The two digit identifier is not part of the case file number. The identifier stands alone.) Print the address shown next to that two digit identifier on the front of the postcard.

- |    |   |    |  |
|----|---|----|--|
| 01 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>JFK Federal Building, Room E260<br>Boston, MA 02203   | 12 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>1999 Broadway, Suite 600<br>Denver, CO 80202                   |
| 02 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>P.O. Box 566<br>New York, NY 10014-0566   | 13 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>P.O. Box 193769<br>San Francisco, CA 94119-3769                |
| 03 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>Curtis Center, Suite 715 East<br>170 S. Independence Mall West<br>Philadelphia, PA 19016-3308 | 14 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>1111 - 3rd Avenue, Suite 650<br>Seattle, WA 98101              |
| 06 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>214 North Hogan, Suite 1010<br>Jacksonville, FL 32202   | 16 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>525 Griffin Square, Room 100<br>Dallas, TX 75202               |
| 09 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>1240 East Ninth Street, Room 865<br>Cleveland, OH 44199                                       | 25 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>800 N. Capitol Street, NW<br>Washington, DC 20211              |
| 10 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>230 South Dearborn Street, 8th Floor<br>Chicago, IL 60604                                     | 50 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>National Office<br>P.O. Box 37117<br>Washington, DC 20013-7117 |
| 11 | Fiscal Officer<br>US DEPARTMENT OF LABOR, OWCP<br>City Center Square, Suite 750<br>1100 Main Street<br>Kansas City, MO 64105                    |    |  |

**Official Business**  
 Penalty for Private Use \$300

Forwarding and Address Correction Requested

*Detach*

**Request For Registration Form Or Brochures**

*This special postcard has been prepared to speed the return of health benefits open season information to you. Mail this form to the proper OWCP office (see page 58). Do not use it for any other purpose.*

- I want to make a change during open season and know what plan or option I wish to enroll in. I have the brochure of that plan and don't need brochures. Please send me a registration form (SF 2809) only.
- I am considering making a change during open season but would like more information. Please send me a registration form (SF 2809) and a brochure for each of the plans I have listed below.

List enrollment codes of the plans for the brochures you want. Codes for each FEHB plan appear in the plan comparison chart.	CODE	CODE	CODE
	<input type="text"/>	<input type="text"/>	<input type="text"/>
Print or type your full name and mailing address here. Address the other side and add a stamp. Then drop card in mail box.	CODE	CODE	CODE
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Name		
Street address			
City, state, and ZIP code			
Check here if we need to change your mailing (home) address in our records. <input type="checkbox"/>	Signature		Date

**IMPORTANT**

HMOs and Plans with a Point of Service product are open to compensationers in the plan's area.

Fee-for Service plans sponsored by employee organizations have specific membership requirements. Some are restricted and open only to compensationers who are already members of the sponsoring organization.

**Do not send this card to OPM.**

Keep a record of the date you mail this.



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**RETURN ADDRESS**

NAME \_\_\_\_\_

STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**Place  
postage  
stamp  
here**

*Address of OWCP Office:*