



Guide to Federal Employees

HEALTH BENEFITS PLANS

For Federal Deposit Insurance Corporation Employees

Note: The rates in this Guide do not apply to FDIC Presidential Appointees or Retirees



United States
Office of
Personnel
Management

Retirement and
Insurance Service

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

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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.

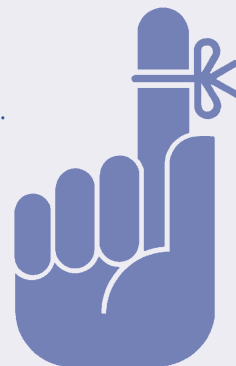
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Things to Remember

- 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.

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

Eligible FDIC employees should use this Guide, plan brochures and other available resources to make their health plan decision. This Guide contains a comprehensive chart with general information about each plan and shows the biweekly premium rates for FDIC employees. The premium listings in this Guide show your share of the total biweekly premium costs -- that is, the amount that you must pay - which will be withheld from your bi-weekly salary payments during the 2002 plan year. Also shown is the amount that FDIC pays which is the difference in what you pay and the total premium cost.

The individual plan brochures give specific benefit information. You can get brochures from the health plan or the benefits representative in your DOA/Personnel Services Branch or OIG/Human Resources Branch. OPM's Internet web site, www.opm.gov/insure, and FDIC's Intranet web site DOA/PSB/Benefits Services/Benefits for Employees, provide the RI 70-14 Guide, links to plan web sites, 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 also assesses the care and service health plans deliver in areas such as immunization rates, mammography rates, and member satisfaction. The National Committee for Quality Assurance (**NCQA**), the Joint Commission on Accreditation of Healthcare Organizations (**JCAHO**), and the American Accreditation Healthcare Commission/URAC (**URAC**) are independent, private, not-for-profit organizations dedicated to 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 7 for definitions.

NCQA (www.ncqa.org):

N1 = Excellent

N2 = Commendable

N3 = Accredited

N4 = Provisional

N6 = New health plan accreditation

JCAHO (www.jcaho.org):

J1 = Accreditation with commendation

J2 = Accreditation without recommendations

J3 = Accreditation with recommendations

J5 = Provisional

J6 = Conditional

URAC (www.urac.org):

U1 = Accredited

F E H B a n d Y o u

Benefits

Check to see if the plan offers the type of services you might need. Does it offer a prenatal program or programs for people with chronic diseases? Can you get preventive care or help 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 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 using 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 Deposit Insurance Corporation Employees, 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.
- **An Employer Contribution.** For 2002, the FDIC pays 85 percent of the average premium toward the total cost of your premium, but not more than 88.75 percent of the total premium for any individual plan. If you continue FEHB coverage as a retiree, the contribution made on your behalf will be different than an active FDIC employee. The government contribution will be 72 percent of the average premium, but not more than 75 percent of the total premium for any individual plan.
- **Salary Deduction.** For 2002, all eligible FDIC employees who elect FEHB health plan coverage, including permanent, temporary, full-time, or part-time employees, will pay the biweekly premium amount shown under the “Your Share” column of the plan comparison chart in this Guide. If you continue FEHB coverage as a retiree, you will pay the same premium cost as other non-FDIC Federal government retirees, which is different than the FDIC share that is paid for active employees
- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enrollment. This year the Open Season runs from November 12, 2001 through December 10, 2001.
- **Continued Group Coverage.** Eligibility for you or your family members may continue following your retirement, divorce, death, or changes in employment status. See your benefits representative in the DOA/Personnel Services Branch or OIG/Human Resources Branch.
- **Coverage After FEHB Ends.** You or your family members may be eligible for temporary continuation of FEHB coverage or for conversion to non-group (private) coverage when FEHB coverage ends. See your benefits representative in the DOA/Personnel Services Branch or OIG/Human Resources Branch.
- **Choice of Tax Treatment.** Your share of the premium may be withheld from your biweekly salary payment on a pre-tax or post tax basis. Premiums are automatically withheld on a pre-tax basis unless you submit a waiver of your participation in the FDIC Premium Conversion Plan. Your waiver will remain in effect until you submit a request to restore pre-tax payment of your health insurance premiums.



**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 4 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

HEDIS¹ - 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 option who receive services from 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.

¹HEDIS 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. FDIC must satisfy its bargaining obligations with the union. 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?

- The program's toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on OPM's web site at www.opm.gov/insure/ltc.

FDIC Premium Conversion Plan

Section 125 of the Internal Revenue Code allows an employer to provide a portion of an employee's salary in benefits rather than cash. Instead of paying a certain amount to an employee as taxable income, employers may offer a salary reduction premium payment plan that permits employees to pay for their share of the cost of group health insurance premiums with pre-tax dollars. Several years ago, the Federal Deposit Insurance Corporation (FDIC) established the Premium Conversion Plan as a tax-savings benefit for its employees. The FDIC Premium Conversion Plan enables employees to pay their share of Federal Employees Health Benefits (FEHB) Program premiums on a pre-tax basis, which reduces an employee's taxable income by the amount of health insurance premiums. As a result, taxes are calculated on a lower income base.

This feature is offered and administered by the FDIC and is separate from the Federal Flexible Benefits Premium Conversion Plan administered by U.S.OPM. FDIC employees will continue to be covered by the FDIC-sponsored premium conversion plan. FDIC employees, however, cannot participate in the U.S. OPM sponsored plan. Both the FDIC and the U.S. OPM plan comply with plan requirements under Section 125 of the Internal Revenue Code and provide the same benefit of lower tax liability. For specific details about the FDIC Premium Conversion Plan, contact your DOA/Personnel Services Branch or OIG/Human Resources Branch.

Open Season Dates **November 12, 2001 - December 10, 2001**

Effective Date Your change in tax treatment of your health insurance premiums will become effective December 16, 2001.
(Pay date of January 10, 2002)

Eligibility All employees who are eligible for and elect FEHB coverage. (By law, the Premium Conversion Plan is not available to retirees.)

Elections FEHB premiums are withheld on a pre-tax basis automatically, unless you waive this provision. If you would like to have your 2002 FEHB premiums paid with after-tax money, you must submit a Premium Conversion Waiver/Election form to your DOA/Personnel Services Branch or OIG/Human Resources Branch during this open season. If you submit a waiver your premiums will continue to be paid with after tax money until you submit a request to restore pre-tax payment of health insurance premiums. **The only time of year that you may change the method of payment from pre-tax to post-tax, or the reverse, is during the annual open season or following a qualified status change listed on the next page.** Premium Conversion Plan Waiver/Election forms may be obtained from your DOA/Personnel Services Branch or OIG/Human Resources Branch.

How does PCP Work? Under the health insurance premium conversion arrangement, your taxable income is reduced by the amount of health insurance premiums withheld for basic pay. The FEHB premium deduction will be withheld from pay as "pre-tax money" which means the premium amount is not subject to income, Social Security, or Medicare taxes. You save on Federal income taxes, and where applicable, also on state and local income taxes. The premium conversion feature applies only to health insurance premiums you pay under the FEHB Program, not for coverage purchased under any other health plan.

FDIC Premium Conversion Plan

Impact of Premium Conversion on Benefits

Paying for health insurance premiums on a pre-tax basis does not affect your other benefit programs; it only changes the way you pay for your share of the FEHB premium cost. Other benefits such as life insurance and retirement will continue to be based on adjusted basic salary before biweekly premiums are deducted.

Most employees prefer paying their premiums with pre-tax money because they save on taxes. However, there are two possible disadvantages to paying your premiums with pre-tax money that you should balance against the tax savings you receive. Those possible disadvantages are:

- Paying your premiums with pre-tax money reduces the earnings reported to the Social Security Administration. When you retire and begin to collect Social Security, you may receive a slightly lower Social Security benefit. Your Medicare, life insurance, retirement plan, and both the Thrift Savings Plan and the FDIC Savings Plan benefits will not be affected.
- There are some Internal Revenue Service (IRS) restrictions on the ability to reduce your health insurance coverage outside of an open season if you pay your premium contributions with pre-tax money. These are explained in detail in the “IRS Guidelines for Reducing Coverage” section below. If you pay premiums with after-tax money you will not be affected by the IRS guidelines that restrict reductions in coverage.

IRS Guidelines For Reducing Coverage

When your FEHB premium deductions are withheld on a pre-tax basis, certain IRS rules affect your ability to change coverage. FEHB enrollment changes may be made outside of an open season under certain circumstances. However, under the premium conversion plan, the opportunity to reduce or cancel your enrollment may be limited by the Internal Revenue Code. You may elect to reduce your coverage, that is, to cancel your health insurance enrollment, or change from family to self-only coverage, during the health insurance open season or following one of the qualifying status changes listed below:

- ➡ marriage, divorce or legal separation;
- ➡ birth of a child or adoption of a child;
- ➡ death of your spouse or loss of a qualified dependent
- ➡ start or end of your spouse’s employment
- ➡ change in your employment status or your spouse’s employment status from either full-time to part-time, (or the reverse)
- ➡ a continuous unpaid leave of absence of more than one pay period taken by you or your spouse;
- ➡ significant changes in your (or your spouse’s) health coverage because of your spouse’s employment.

If you want to reduce your health insurance coverage outside the FEHB open season, the change must be consistent with your qualified life status change. For example, if you have a new baby, you cannot change from a self and family to a self-only enrollment.

To reduce your coverage outside of a FEHB open season, complete and submit a Health Benefits Election Form (SF 2809) to your servicing DOA/Personnel Services Branch or OIG/Human Resources Branch and provide any necessary supporting documentation no later than 60 calendar days after a qualified status change has occurred, and provide any necessary supporting documentation.

FDIC Premium Conversion Plan

If you are the only person remaining in your self and family enrollment as a result of a change in marital or family status (death of a spouse, divorce, child marries or becomes age 22), you must elect to reduce the enrollment (self only or cancel) within 60 calendar days of such a life status change. Otherwise, the self and family enrollment will continue until another event (life status change or FEHB Open Season) occurs that will allow an election to reduce coverage. The effective date of change from family to self-only will be the first day of the pay period that follows the pay period in which your enrollment form is received.

Information in this section serves as the FDIC Premium Conversion Plan Summary Plan Description. If you need additional information, contact your DOA/Personnel Services Branch or OIG/Human Resources Branch for assistance.

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

Today's Medicare offers more.

- ✓ *More preventive benefits.*
- ✓ *More information.*
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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
OR
www.tricare.OSD.mil



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



Nationwide Fee-for-Service Plans Open to All

(Pages 16 through 18)

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

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

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

Nationwide Fee-for-Service Plans Open to All

How to read this chart:

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

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

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

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

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

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

Plan name	Telephone number	Enrollment code		Your Share		FDIC Share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Alliance Health Plan (AHP)	202/939-6325	1R1	1R2	42.56	71.38	115.52	263.75
APWU Health Plan (APWU)	800/222-2798	471	472	31.18	58.20	115.52	263.75
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	23.46	54.49	115.52	263.75
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	Local phone #	111	112	14.23	35.40	112.23	263.75
GEHA Benefit Plan-High (GEHA)	800/821-6136	311	312	42.04	79.16	115.52	263.75
GEHA Benefit Plan-Std (GEHA)	800/821-6136	314	315	12.37	28.12	97.63	221.88
Mail Handlers-High (MH)	800/410-7778	451	452	37.42	58.86	115.52	263.75
Mail Handlers-Std (MH)	800/410-7778	454	455	11.54	25.06	91.07	197.66
NALC (NALC)	888/636-6252	321	322	28.21	43.38	115.52	263.75
PBP Health Plan-High (PBP)	800/544-7111	361	362	145.76	299.98	115.52	263.75
PBP Health Plan-Std (PBP)	800/544-7111	364	365	33.29	58.16	115.52	263.75

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	\$25
GEHA	PPO	\$300	None	None	10%	Nothing	10%	10%	\$5/50%	\$15/\$30/50%	\$15/\$30/50%	\$10	\$35/\$50
	Non-PPO	\$300	None	None	25%	Nothing	25%	25%	\$5 or 50%	\$15/\$30/50%	\$15/\$30/50%	\$10	\$35/\$50
GEHA	PPO	\$450	None	None	15%	15%	15%	15%	\$5	50%	50%	\$15	50%
	Non-PPO	\$450	None	None	35%	35%	35%	35%	\$5 +	50% +	50% +	\$15	50%
MH	PPO	\$200	\$250	None	10%	Nothing	Nothing	10%	25%	25%	25%	\$10	\$30/\$45
	Non-PPO	\$200	\$250	\$250	30%	Nothing	Nothing	30%	50%	50%	50%	\$10	\$30/\$45
MH	PPO	\$250	\$600	\$150	10%	Nothing	Nothing	10%	30%	30%	30%	\$10	\$40/\$55
	Non-PPO	\$250	\$600	\$300	30%	Nothing	Nothing	30%	50%	50%	50%	\$10	\$40/\$55
NALC	PPO	\$250	None	None	15%	10%	10%	15%	25%	25%	25%	\$12	\$25
	Non-PPO	\$300	\$25 for Retail	\$100	30%	30%	30%	30%	40%+	40%+	40%+	\$12	\$25
PBP	PPO	\$200	\$100	None	10%	10%	10%	10%	\$10 or 20%	\$25 or 20%	\$40 or 20%	\$10	\$25
	Non-PPO	\$400	\$150	\$150	20%	25%	25%	20%	20%+	20%+	20%+	\$10	\$25
PBP	PPO	\$250	\$100	None	10%	10%	10%	10%	\$15 or 20%	\$30 or 20%	\$40 or 20%	\$15	\$30
	Non-PPO	\$500	\$150	\$250	30%	30%	30%	30%	30%+	30%+	30%+	\$15	\$30

Nationwide Fee-for-Service Plans Open to All

Enrollee Survey Results — See pages 1-2 for a description.

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

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

(Pages 20 through 22)

Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO) — A 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 (with Acronyms)	Telephone number	Enrollment code		Your Share		FDIC Share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Association Benefit Plan (ABP)	800/634-0069	421	422	29.61	70.58	115.52	263.75
Foreign Service (FS)	202/833-4910	401	402	19.78	64.85	115.52	263.75
Panama Canal Area [◇] (PCA)	732/222-2229	431	432	19.95	33.05	115.52	260.73
Rural Carrier Benefit Plan (Rural)	800/638-8432	381	382	42.50	58.11	115.52	263.75
SAMBA (SAMBA)	800/638-6589	441	442	49.31	124.42	115.52	263.75
Secret Service (SS)	800/424-7474	Y71	Y72	13.88	32.89	109.46	259.43

[◇] Offers a Point of Service product. See page 48.

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%	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 1-2 for a description.

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

Plan Comparisons

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

(Pages 24 through 59)

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		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Alabama							
PrimeHealth of Alabama, Inc. - Southern Alabama and the Montgomery Area	800/236-9421	AA1	AA2	14.20	59.71	112.05	263.75
The Oath - A Health Plan for Alabama, Inc. - Birmingham/Other areas	800/947-5093	DF1	DF2	16.59	74.44	115.52	263.75
Arizona							
Aetna U. S. Healthcare, Inc. - Phoenix/Tucson areas	800/537-9384	WQ1	WQ2	11.61	32.68	91.61	257.81
Health Net of Arizona, Inc. - Maricopa/Pima/Other AZ counties	800/289-2818	A71	A72	13.08	50.01	103.20	263.75
PacifiCare Health Plans - Maricopa/Pima/parts of Apache Junction	800/531-3341	A31	A32	13.05	61.32	102.94	263.75
California							
Aetna U. S. Healthcare, Inc. - Southern California area	800/537-9384	2X1	2X2	10.80	25.22	85.19	199.00
Blue Cross- HMO - Most of California	800/235-8631	M51	M52	11.84	30.22	93.43	238.36
Blue Shield of CA Access+ - Most of California	800/334-5847	SJ1	SJ2	12.61	31.28	99.46	246.73
CIGNA HealthCare of California - Northern/Southern California	800/244-6224	9T1	9T2	13.12	28.87	103.52	227.74
Health Net - Most of California	800/522-0088	LB1	LB2	12.94	30.64	102.10	241.69
Kaiser Permanente - Northern California	800/464-4000	591	592	11.96	28.55	94.35	225.23
Kaiser Permanente - Southern California	800/464-4000	621	622	12.60	29.11	99.37	229.66
PacifiCare Health Plans - Most of California	800/531-3341	CY1	CY2	10.51	27.39	82.87	216.11
UHP HEALTHCARE - LA/Orange/San Bernardino Counties	800/544-0088	C41	C42	8.97	19.11	70.77	150.79
Universal Care - Southern California	800/257-3087	6Q1	6Q2	9.45	24.96	74.55	196.87
Western Health Advantage - Northern California	888/563-2250	5Z1	5Z2	12.25	29.40	96.63	231.91

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 1-2 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 2 and 7 for details. A lower number means a better accreditation.

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

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

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		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Colorado							
Kaiser Permanente - Denver/Colorado Springs areas	800-632-9700	651	652	13.13	33.80	103.56	263.75
PacifiCare of Colorado-High -Denver/Colorado Springs/Ft.Collins	800/877-9777	D61	D62	14.63	76.44	115.43	263.75
PacifiCare of Colorado-Std - Denver/Colorado Springs/Ft.Collins	800/877-9777	D64	D65	8.70	22.52	68.60	177.67
Rocky Mountain HMO-High -Most of Colorado	800/346-4643	XJ1	XJ2	42.91	106.79	115.52	263.75
Rocky Mountain HMO-Std - Most of Colorado	800/346-4643	XJ4	XJ5	27.07	69.74	115.52	263.75
Connecticut							
ConnectiCare - All of Connecticut	800/251-7722	TE1	TE2	12.62	33.04	99.52	260.66
Health Net, Inc. - All of Connecticut	877/747-9585	DP1	DP2	33.10	151.56	115.52	263.75

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
			Colorado									
Kaiser Permanente	\$10	None	\$5	\$15	\$15	◐	◐	◐	○	●	◐	N1
PacifiCare of Colorado-High	\$10	None	\$5	\$10	\$20	○	○	◐	◐	○	◐	N2
PacifiCare of Colorado-Std	\$15	\$300	\$10	\$20	\$30	○	○	◐	◐	○	◐	N2
Rocky Mountain HMO-High	\$10	\$200	\$10	\$20	\$35	◐	●	●	●	○	●	N1
Rocky Mountain HMO-Std	\$25	\$500	\$10	\$20	\$35	◐	●	●	●	○	●	N1
Connecticut												
ConnectiCare	\$10	None	\$10	\$20	\$35	●	●	●	●	●	●	N1
Health Net, Inc.	\$10	None	\$10	\$20	\$35	●	●	●	◐	◐	●	

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

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

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

Plan name – location	Telephone number	Enrollment code		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
District of Columbia							
Aetna U. S. Healthcare, Inc.-High -Washington, DC area	800/537-9384	JN1	JN2	16.21	40.94	115.52	263.75
Aetna U. S. Healthcare, Inc.-Std - Washington, DC area	800/537-9384	JN4	JN5	10.79	25.24	85.10	199.14
CareFirst BlueChoice - Washington, DC area	800/680-9495	2G1	2G2	14.35	32.29	113.22	254.70
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	12.04	29.75	95.01	234.67
MD-IPA - Washington, DC area	800/251-0956	JP1	JP2	13.56	32.55	106.99	256.81
Florida							
Av-Med Health Plan - G'ville/Jax/Orlando/So.FL/Tampa	800/882-8633	EM1	EM2	13.83	74.17	109.06	263.75
Capital Health Plan - Tallahassee area	850/383-3311	EA1	EA2	12.81	40.21	101.04	263.75
Foundation Health - Southern Florida	800/441-5501	5E1	5E2	9.01	24.77	71.05	195.40
HIP Health Plan of FL - South Florida	800/447-8255	3N1	3N2	12.21	39.13	96.35	263.75
Humana Medical Plan - South Florida	888/393-6765	EE1	EE2	11.98	29.95	94.52	236.30
Total Health Choice - Broward/Dade/Palm Beach Counties	305/408-5823	4A1	4A2	10.60	26.40	83.64	208.27

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
District of Columbia												
Aetna U. S. Healthcare, Inc.-High	\$15	\$100-\$300	\$10	\$20	50%	○	○	○	◐	○	○	N2
Aetna U. S. Healthcare, Inc.-Std	\$20	\$200-\$600	\$10	\$20	50%	○	○	○	◐	○	○	N2
CareFirst BlueChoice*	\$10	None	\$10	\$20	\$35	◐	◐	◐	◐	○	○	N2
Kaiser Permanente	\$10	\$100	\$10	\$20	\$20	◐	○	◐	○	●	○	N2
MD-IPA	\$10	None	\$5	\$15	\$30	●	●	◐	◐	●	◐	N1
Florida												
Av-Med Health Plan	\$10	\$100	\$5	\$10	\$25	◐	○	○	◐	●	◐	N2,J2
Capital Health Plan	\$10	\$100	\$7	\$20	\$35	●	●	●	●	●	●	N1
Foundation Health	\$10	\$200 per 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

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		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Georgia							
Aetna U. S. Healthcare, Inc. - Atlanta and Athens areas	800/537-9384	2U1	2U2	12.59	33.07	99.32	260.88
Kaiser Permanente - Atlanta area	800/611-1811	F81	F82	11.89	30.18	93.79	238.11
Guam							
PacifiCare Asia Pacific-High -Guam/N. Mariana Islands/Palau	671/647-3526	JK1	JK2	19.10	89.94	115.52	263.75
PacifiCare Asia Pacific-Std - Guam/N. Mariana Islands/Palau	671/647-3526	JK4	JK5	12.42	32.79	97.97	258.72
Hawaii							
HMSA - All of Hawaii	808/948-6499	871	872	12.10	26.94	95.47	212.50
Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu/Kauai	808/597-5955	631	632	13.75	29.56	108.46	233.19
Kaiser Permanente-Std - Islands of Hawaii/Maui/Oahu/Kauai	808/597-5955	634	635	10.49	22.56	82.79	177.99
Idaho							
Group Health Cooperative - Kootenai and Latah	800/497-2210	VR1	VR2	13.42	42.87	105.85	263.75

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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						Accredited
			Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	
Georgia												
Aetna U. S. Healthcare, Inc.	\$15	\$100-\$300	\$10	\$20	50%	○	○	○	◐	○	○	N1
Kaiser Permanente	\$10	None	\$5/\$11 Comm	\$5/\$11 Comm	\$5/\$11 Comm	●	●	◐	○	●	◐	N1
Guam												
PacifiCare Asia Pacific-High	\$10	None	\$5	\$20	\$20	●	◐	○	◐	◐	○	
PacifiCare Asia Pacific-Std	\$15	\$150	\$5	\$20	\$20	●	◐	○	◐	◐	○	
Hawaii												
HMSA - In-Network	20%	None	\$5	\$15	\$15 or 50%	●	●	●	●	●	●	
HMSA - Out-of-Network	30%	30%	\$5 + 20%	\$15+20%	\$15 or 50%+							
Kaiser Permanente-High	\$10	None	\$7	\$7	\$7	●	●	◐	●	●	●	N1
Kaiser Permanente-Std	\$15	None	\$7	\$7	\$7	●	●	◐	●	●	●	N1
Idaho												
Group Health Cooperative	\$10	\$100-\$300	\$10	\$20	\$20	◐	◐	◐	◐	◐	◐	N1

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

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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		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Illinois							
BlueCHOICE - St. Clair and Madison	800/634-4395	9G1	9G2	66.45	143.85	30.67	66.39
Group Health Plan - Southern/Metro East/Central	800/743-3901	MM1	MM2	33.60	58.34	115.52	263.75
Health Alliance HMO - Central/E.Central/N.West/South/West IL	800/851-3379	FX1	FX2	22.73	58.93	115.52	263.75
Humana Health Plan Inc. - Chicago area	888/393-6765	751	752	12.27	29.43	96.79	232.13
John Deere Health Plan - Bloomington/Joliet/Moline/Peoria/RockIsld	800/247-9110	YH1	YH2	14.27	63.01	112.55	263.75
Mercy Health Plans/Premier - Southwest Illinois	800/327-0763	7M1	7M2	18.56	48.10	115.52	263.75
OSF HealthPlans - Central/Central-Northwestern Illinois	800/673-5222	9F1	9F2	12.78	35.05	100.84	263.75
PersonalCare's HMO - Central Illinois	800/431-1211	GE1	GE2	10.17	26.15	80.22	206.28
UNICARE HMO - Chicagoland area	312/234-8855	171	172	9.46	29.48	74.59	232.59
Union Health Service - Chicago area	312/829-4224	761	762	10.92	27.09	86.16	213.69
Indiana							
Advantage Health Plan, Inc. - Most of Indiana	800/553-8933	6Y1	6Y2	13.79	32.38	108.78	255.41
Aetna U. S. Healthcare, Inc. - Southern Indiana	800/537-9384	7L1	7L2	12.95	31.99	102.16	252.38
Aetna U. S. Healthcare, Inc. - Southeastern Indiana	800/537-9384	RD1	RD2	25.90	93.94	115.52	263.75
Arnett HMO - Lafayette area	765/448-7440	G21	G22	14.09	61.92	111.16	263.75
Health Alliance HMO - Fountain/Vermillion/Warren Counties	800/851-3379	FX1	FX2	22.73	58.93	115.52	263.75
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	14.04	48.33	110.78	263.75
Humana Health Plan Inc. - Lake/Porter/LaPorte Counties	888/393-6765	751	752	12.27	29.43	96.79	232.13
M*Plan - Indiana Metropolitan areas	317/571-5320	IN1	IN2	24.00	56.41	115.52	263.75
Physicians HP of N. Indiana - Northeast Indiana	219/432-6690	DQ1	DQ2	13.76	30.93	108.58	243.98
UNICARE HMO - Lake/Porter Counties	888/234-8855	171	172	9.46	29.48	74.59	232.59
Welborn HMO - Evansville area	812/426-6600	H31	H32	18.84	83.60	115.52	263.75

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Plan name	Primary care doctor office copay	Hospital per stay deductible/copay	Prescription drugs			Enrollee Survey Results ● above average, ◐ average, ○ below average						
			Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
			Illinois									
BlueCHOICE	\$10	None	\$5	\$10	\$15	○	◐	●	●	◐	◐	N2
Group Health Plan	\$10	\$100	\$8	\$20	\$35	◐	◐	●	●	◐	●	
Health Alliance HMO	\$10	\$100	\$7	\$14	\$25	●	●	●	●	◐	●	N1
Humana Health Plan Inc.	\$10	None	\$3	\$10	\$25	○	◐	○	○	○	○	N2
John Deere Health Plan	\$15	\$100	\$10	\$20	\$35	●	●	●	●	●	●	N1
Mercy Health Plans/Premier	\$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							
Indiana												
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	●	●	●	◐	◐	●	

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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		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Iowa							
Avera Health Plan - Northwestern Iowa	888/322-2115	AV1	AV2	56.98	130.78	26.30	60.36
Coventry Health Care of Iowa - Central Iowa/Cedar Rapids/Sioux City	800/257-4692	SV1	SV2	13.12	51.27	103.53	263.75
Health Alliance HMO - Central/Eastern Iowa	800/851-3379	FX1	FX2	87.51	215.08	40.39	99.27
John Deere Health Plan - Central/Eastern Iowa	800/247-9110	YH1	YH2	14.27	63.01	112.55	263.75
SecureCare of Iowa - Central/Eastern Iowa	888/881-8820	3Q1	3Q2	11.35	29.73	89.54	234.57
Kansas							
Coventry HC Kansas Cty formerly Kaiser - Kansas City area	913/642-2662	HA1	HA2	9.85	25.41	77.70	200.46
Coventry Health Care of Kansas - Wichita/Salinas areas	800/664-9251	7W1	7W2	13.64	45.34	107.57	263.75
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	12.79	30.68	100.90	242.07
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	9.75	23.38	76.90	184.47
Preferred Plus of Kansas - S. Central Area	800/660-8114	VA1	VA2	22.49	103.34	115.52	263.75
Kentucky							
Aetna U. S. Healthcare, Inc. - Louisville area	800/537-9384	7L1	7L2	12.95	31.99	102.16	252.38
Aetna U. S. Healthcare, Inc. - Northern Kentucky area	800/537-9384	RD1	RD2	25.90	93.94	115.52	263.75
Humana Health Plan - Louisville area	888/393-6765	D21	D22	14.04	48.33	110.78	263.75
United Health Care of Ohio, Inc. - Northern Kentucky	800/231-2918	3U1	3U2	33.24	78.40	115.52	263.75

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

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Plan name – location	Telephone number	Enrollment code		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Louisiana							
Amcare Health Plans - New Orleans area	800/772-2995	ZH1	ZH2	10.24	26.82	80.79	211.57
Amcare Health Plans - Baton Rouge/Alexandria/Shreveport areas	800/772-2995	ZQ1	ZQ2	12.43	32.56	98.07	256.83
Coventry Healthcare Louisiana former Maxicare LA - New Orleans area	800-993-6294	BJ1	BJ2	12.99	30.18	102.51	238.08
Coventry Healthcare Louisiana former Maxicare LA - Baton Rouge area	800-341-6613	JA1	JA2	18.72	48.02	115.52	263.75
Vantage Health Plan - Monroe area	888/823-1910	AQ1	AQ2	22.50	106.53	115.52	263.75
Vantage Health Plan - Shreveport/Alexandria areas	888/823-1910	MV1	MV2	30.78	128.75	115.52	263.75
Maryland							
Aetna U. S. Healthcare, Inc.-High -North/Central/Southern Maryland	800/537-9384	JN1	JN2	16.21	40.94	115.52	263.75
Aetna U. S. Healthcare, Inc.-Std - North/Central/Southern Maryland	800/537-9384	JN4	JN5	10.79	25.24	85.10	199.14
CareFirst BlueChoice - all of Maryland	800/680-9495	2G1	2G2	14.35	32.29	113.22	254.70
Kaiser Permanente - Baltimore/Washington, DC areas	301/468-6000	E31	E32	12.04	29.75	95.01	234.67
MD-IPA - All of Maryland	800/251-0956	JP1	JP2	13.56	32.55	106.99	256.81
Massachusetts							
Blue Chip, Coord Hlth Partners - Southeastern Massachusetts	401/459-5500	DA1	DA2	15.89	72.71	115.52	263.75
Fallon Community Health Plan - Central/Eastern Massachusetts	800/868-5200	JV1	JV2	23.18	39.24	115.52	263.75

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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
			Louisiana									
Amcare Health Plans	\$10	None	\$5	\$15	50%							N6
Amcare Health Plans	\$10	None	\$5	\$15	50%							N6
Coventry Healthcare Louisiana former Maxicare LA	\$15	\$100/day	\$10	\$20	\$45							
Coventry Healthcare Louisiana former Maxicare LA	\$15	\$100/day	\$10	\$20	\$45	X	X	X	X	X	X	
Vantage Health Plan	\$15	\$250	\$10	\$20	\$35							
Vantage Health Plan	\$15	\$250	\$10	\$20	\$35							
Maryland												
Aetna U. S. Healthcare, Inc.-High	\$15	\$100-\$300	\$10	\$20	50%	○	○	○	◐	○	○	N2
Aetna U. S. Healthcare, Inc.-Std	\$20	\$200-\$600	\$10	\$20	50%	○	○	○	◐	○	○	N2
CareFirst BlueChoice*	\$10	None	\$10	\$20	\$35	◐	◐	◐	◐	○	○	N2
Kaiser Permanente	\$10	\$100	\$10	\$20	\$20	◐	○	◐	○	●	○	N2
MD-IPA	\$10	None	\$5	\$15	\$30	●	●	◐	◐	●	◐	N1
Massachusetts												
Blue Chip, Coord Hlth Partners - In-Network	\$10	None	\$5	\$15	\$30	●	●	●	●	●	◐	N1
- Out-of-Network	20%	None	\$30 + 20%	\$30 + 20%	\$30 + 20%							
Fallon Community Health Plan	\$10	None	\$5	\$10	\$10	●	●	●	●	●	◐	N1

* Previously CapitalCare, which had Commendable NCQA accreditation.

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

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

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

Plan name – location	Telephone number	Enrollment code		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Michigan							
Bluecare Network of MI - Cheboygan and Roscommon Counties Area	800/662-6667	G71	G72	98.03	276.28	115.52	263.75
Bluecare Network of MI - Midland County Area	800/662-6667	K51	K52	13.58	73.71	107.12	263.75
Bluecare Network of MI - Kalamazoo County Area	800/662-6667	KF1	KF2	36.15	153.84	115.52	263.75
Bluecare Network of MI - Genesee County Area	800/662-6667	KN1	KN2	14.56	98.01	114.86	263.75
Bluecare Network of MI - Kent County Area	800/662-6667	KR1	KR2	15.16	113.60	115.52	263.75
Bluecare Network of MI - Mid Michigan	800/662-6667	LN1	LN2	44.07	120.51	115.52	263.75
Bluecare Network of MI - Southeast MI	800/662-6667	LX1	LX2	10.02	29.98	79.07	236.51
Grand Valley Health Plan - Grand Rapids area	616/949-2410	RL1	RL2	13.16	65.05	103.80	263.75
Health Alliance - Southeastern Michigan/Flint area	800/422-4641	521	522	13.92	64.08	109.81	263.75
HealthPlus MI - Flint/Saginaw areas	800/332-9161	X51	X52	13.98	40.89	110.28	263.75
M-Care - Mid and Southeastern Michigan	800/658-8878	EG1	EG2	11.42	30.25	90.06	238.66
OmniCare - Southeastern Michigan	800/477-6664	KA1	KA2	11.55	28.99	91.10	228.67
The Wellness Plan - Detroit/Flint/Muskegon Areas	800/875-9355	K31	K32	10.24	27.86	80.80	219.77
Total Health Care - Greater Detroit/Flint areas	800/826-2862	N21	N22	11.88	29.91	93.76	235.92
Minnesota							
HealthPartners Classic-High -Minneapolis/St. Paul areas	952/883-5000	531	532	28.21	81.17	115.52	263.75
HealthPartners Classic-Std - Minneapolis/St. Paul areas	952/883-5000	534	535	22.82	68.27	115.52	263.75
HealthPartners Primary Clinic Plan - Minneapolis/St. Paul/St. Cloud areas	952/883-5000	HQ1	HQ2	50.44	134.56	115.52	263.75

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
			Michigan									
Bluecare Network of MI	\$10	None	\$10	\$20	\$20	◐	○	●	●	○	◐	N1
Bluecare Network of MI	\$10	None	\$10	\$20	\$20	◐	○	●	●	○	◐	N1
Bluecare Network of MI	\$10	None	\$10	\$20	\$20	◐	○	●	●	○	◐	N1
Bluecare Network of MI	\$10	None	\$10	\$20	\$20	◐	○	●	●	○	◐	N1
Bluecare Network of MI	\$10	None	\$10	\$20	\$20	◐	○	●	●	○	◐	N1
Bluecare Network of MI	\$10	None	\$10	\$20	\$20	◐	○	●	●	○	◐	N1
Bluecare Network of MI	\$10	None	\$10	\$20	\$20	◐	○	●	●	○	◐	N1
Grand Valley Health Plan	\$10	None	\$5	\$5	\$5	●	◐	●	●	●	●	N1
Health Alliance	\$10	None	\$2	\$2	\$2	●	◐	◐	◐	◐	◐	N1
HealthPlus MI	\$10	None	\$5	\$5	\$5	●	●	●	●	●	●	N1
M-Care	\$10	None	\$5	\$10	\$10	●	◐	◐	◐	●	●	N1
OmniCare	\$10	None	\$2	\$2	\$2	○	○	○	○	○	○	N4
The Wellness Plan	\$10	None	\$5	\$5	\$5	○	○	○	○	○	○	
Total Health Care	\$10	None	Nothing	Nothing	Nothing							
Minnesota												
HealthPartners Classic-High	\$15	None	\$10	\$20	\$20	◐	●	◐	◐	◐	◐	N1
HealthPartners Classic-Std	\$20	\$200	\$11	\$22	\$22	◐	●	◐	◐	◐	◐	N1
HealthPartners Primary Clinic Plan	\$15	None	\$10	\$10	\$10	◐	●	◐	◐	◐	◐	N1

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

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

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

Plan name – location	Telephone number	Enrollment code		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Missouri							
BlueCHOICE - St.Louis/Central/SW/Poplar Bluff area	800/634-4395	9G1	9G2	13.80	29.88	108.87	235.70
Coventry HC Kansas Cty formerly Kaiser - Kansas City area	913/642-2662	HA1	HA2	9.85	25.41	77.70	200.46
Group Health Plan - St. Louis area	800/743-3901	MM1	MM2	33.60	58.34	115.52	263.75
Humana Kansas City, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	12.79	30.68	100.90	242.07
Humana Kansas City, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	9.75	23.38	76.90	184.47
Mercy Health Plans/Premier - East/Central/Southwest Missouri	800/327-0763	7M1	7M2	18.56	48.10	115.52	263.75
Nevada							
Aetna U. S. Healthcare, Inc. - Southern Nevada/Las Vegas area	800/537-9384	8L1	8L2	12.65	32.87	99.81	259.31
Health Plan of Nevada - Las Vegas/Reno areas	702/871-0999	NM1	NM2	11.00	28.18	86.82	222.29
PacifiCare Health Plans - Clark County	800/531-3341	K91	K92	13.29	36.96	104.80	263.75

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
			Missouri									
BlueCHOICE	\$10	None	\$5	\$10	\$15	○	◐	●	●	◐	◐	N2
Coventry HC Kansas Cty formerly Kaiser	\$10	None	\$5	\$15	\$45	X	X	X	X	X	X	
Group Health Plan	\$10	\$100	\$8	\$20	\$35	◐	◐	●	●	◐	●	
Humana 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	●	●	●	◐	◐	●	
- Out-of-Network	30%	30%	N/A	N/A	N/A							
Nevada												
Aetna U. S. Healthcare, Inc.	\$15	\$100-\$300	\$10	\$20	50%	○	○	○	○	◐	○	N6
Health Plan of Nevada - In-Network	\$10	\$100/dayX2	\$5	\$20	\$35	○	○	○	○	○	○	N3
- Out-of-Network	20%	20%	20%	20%	20%							
PacificCare Health Plans	\$10	None	\$5	\$15	\$15	○	○	○	○	○	◐	N2

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

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

Plan name – location	Telephone number	Enrollment code		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
New Jersey							
Aetna U. S. Healthcare, Inc. - All of New Jersey	800/537-9384	P31	P32	28.36	110.34	115.52	263.75
AmeriHealth HMO - All of New Jersey	800/454-7651	FK1	FK2	14.25	38.18	112.41	263.75
GHI Health Plan - Northern New Jersey	212/501-4444	801	802	28.62	96.59	115.52	263.75
HealthNet of Pennsylvania - Phila. and 7 adjacent PA and NJ counties	800/998-2840	271	272	35.25	90.60	115.52	263.75
New Mexico							
Cimarron Health Plan - All of New Mexico	800/473-0391	PX1	PX2	12.75	34.20	100.55	263.75
Lovelace Health Plan - All of New Mexico	800/244-6224	Q11	Q12	12.64	32.86	99.70	259.23
Presbyterian Health Plan - All NM counties except Otero & S. Eddy	505/923-5678	P21	P22	12.20	31.82	96.25	251.01

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

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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		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
New York							
Aetna U. S. Healthcare, Inc. - NYC area and Dutchess/Sullivan/Ulster	800/537-9384	JC1	JC2	12.61	31.71	99.48	250.17
Aetna U. S. Healthcare, Inc. - Syracuse area	800/537-9384	TG1	TG2	11.32	28.56	89.33	225.32
Blue Choice - Rochester area	800/462-0108	MK1	MK2	16.39	66.78	115.52	263.75
C.D.P.H.P. - Albany/Cooperstown areas	518/862-3750	PW1	PW2	13.38	40.65	105.53	263.75
C.D.P.H.P. - Hudson Valley area	518/862-3750	QB1	QB2	13.91	53.80	109.77	263.75
C.D.P.H.P. - Capital District area	518/862-3750	SG1	SG2	13.25	38.02	104.56	263.75
GHI Health Plan - All of New York	212/501-4444	801	802	28.62	96.59	115.52	263.75
GHI HMO Select - Bronx/Brklyn/Manhattan/Queens/Westchester	877/244-4466	6V1	6V2	14.42	58.57	113.77	263.75
GHI HMO Select - Capital/Hudson Valley Regions	877/244-4466	X41	X42	12.85	33.13	101.38	261.36
Health Net, Inc. - NYC/LI/Dtchs/Orng/Putnm/Rkldnd/Wschs	877/747-9585	PD1	PD2	53.36	172.79	115.52	263.75
HIP of Greater New York - New York City area	800/HIP-TALK	511	512	12.25	63.04	96.68	263.75
HMO Blue - Utica/Rome/Central New York areas	800/722-7884	AH1	AH2	13.92	53.20	109.83	263.75
HMO-CNY - Syracuse/Binghamton/Elmira areas	800/828-2887	EB1	EB2	16.18	85.52	115.52	263.75
Independent Health Assoc - Western New York	800/453-1910	QA1	QA2	10.57	29.47	83.39	232.47
MVP Health Plan - Eastern Region	888/687-6277	GA1	GA2	12.90	33.33	101.81	262.95
MVP Health Plan - Central Region	888/687-6277	M91	M92	13.32	41.98	105.07	263.75
MVP Health Plan - Mid-Hudson Region	888/687-6277	MX1	MX2	14.59	71.13	115.07	263.75
Preferred Care - Rochester area	716/325-3113	GV1	GV2	13.37	53.59	105.45	263.75
Univera Healthcare - CNY - Syracuse/Southern Tier areas	315/638-2133	QE1	QE2	14.80	81.76	115.52	263.75
Univera Healthcare - CNY - Utica area	315/797-7019	SH1	SH2	14.80	81.76	115.52	263.75
Univera Healthcare - WNY - Western New York	716/847-0881	Q81	Q82	11.55	32.77	91.16	258.51
Vytra Health Plans - Queens/Nassau/Suffolk Counties	800/406-0806	J61	J62	32.84	124.98	115.52	263.75

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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	
New York													
Aetna U. S. Healthcare, Inc.	\$20	\$200-\$600	\$10	\$20	50%	◐	◐	○	◐	◐	○	N1	
Aetna U. S. Healthcare, Inc.	\$20	\$200-\$600	\$10	\$20	50%	◐	◐	○	◐	◐	○	N1	
Blue Choice	\$10	None	\$5	\$15	\$30	●	●	●	●	●	●	N2	
C.D.P.H.P.	\$10	None	\$5	\$20	\$20	●	●	●	◐	●	●	N1	
C.D.P.H.P.	\$10	None	\$5	\$20	\$20	●	●	●	◐	●	●	N1	
C.D.P.H.P.	\$10	None	\$5	\$20	\$20	●	●	●	◐	●	●	N1	
GHI Health Plan	- In-Network - Out-of-Network	\$15 50% of sch.	None None	\$10 N/A	\$20 N/A	\$50 N/A	●	●	◐	◐	○	○	
GHI HMO Select	\$10	None	\$10	\$20	\$30	○	○	●	◐	○	○	N6	
GHI HMO Select	\$10	None	\$10	\$20	\$30	○	○	●	◐	○	○	N6	
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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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		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
North Carolina							
PARTNERS NHP of NC - Most of North Carolina	800/942-5695	EQ1	EQ2	22.92	47.76	115.52	263.75
North Dakota							
Heart of America HMO - Northcentral North Dakota	701/776-5848	RU1	RU2	11.94	30.70	94.23	242.15
Ohio							
Aetna U. S. Healthcare, Inc. - Cleveland and Toledo areas	800/537-9384	7D1	7D2	20.05	71.29	115.52	263.75
Aetna U. S. Healthcare, Inc. - Greater Cincinnati area	800/537-9384	RD1	RD2	25.90	93.94	115.52	263.75
AultCare HMO - Stark/Carroll/Holmes/Tuscarawas/Wayne Co	330/438-6360	3A1	3A2	10.71	26.84	84.52	211.70
Health Maintenance Plan(HMP) - Most of Ohio	800/228-4375	R51	R52	18.81	52.77	115.52	263.75
Health Plan Upper OH Valley - Eastern Ohio	800/624-6961	U41	U42	13.20	58.91	104.13	263.75
HMO Health Ohio - Northeast Ohio	800/522-2066	L41	L42	14.49	65.70	114.31	263.75
Kaiser Permanente - Akron/Cleveland areas	800/686-7100	641	642	13.25	32.51	104.52	256.50
Paramount Health Care - Northwest/North Central Ohio	800/462-3589	U21	U22	14.60	80.28	115.15	263.75
SummaCare Health Plan - Cleveland, Akron areas	330/996-8415	5W1	5W2	11.31	31.11	89.26	245.46
SuperMed HMO - Northeast Ohio	800/522-2066	5M1	5M2	29.41	106.97	115.52	263.75
United Health Care of Ohio, Inc. - Cincinnati/Dayton/Springfield/Toledo	800/231-2918	3U1	3U2	33.24	78.40	115.52	263.75

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

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Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 7 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						Accredited
			Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	
North Carolina												
PARTNERS NHP of NC	\$10	\$250	\$7	\$15	\$35	◐	●	●	◐	◐	◐	N1
North Dakota												
Heart of America HMO	\$10	None	50%	50%	50%							
Ohio												
Aetna U. S. Healthcare, Inc.	\$20	\$200-\$600	\$10	\$20	50%							N2
Aetna U. S. Healthcare, Inc.	\$20	\$200-\$600	\$10	\$20	50%	○	◐	●	●	○	○	N2
AultCare HMO	\$10	None	\$5	\$10	\$10	●	●	●	●	●	●	
Health Maintenance Plan (HMP)	\$10	None	\$8	\$15	\$25	◐	●	●	●	◐	◐	
Health Plan Upper OH Valley	\$10	None	\$10	\$20	\$35	●	●	●	●	●	●	N1
HMO Health Ohio	\$10	None	\$10	\$20	\$20	◐	◐	◐	◐	○	○	N2
Kaiser Permanente	\$10	None	\$5	\$15	\$15	◐	●	◐	○	●	◐	N1
Paramount Health Care	\$10	None	\$5	\$15	\$25	●	●	●	●	●	●	N2
SummaCare Health Plan	\$10	None	\$5	\$10	\$10	●	●	●	●	◐	◐	N1
SuperMed HMO	\$10	None	\$10	\$20	\$20	◐	◐	◐	◐	○	○	N2
United Health Care of Ohio, Inc.	\$15	\$100	\$10	\$15	\$30	◐	●	◐	◐	◐	○	N1

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

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

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

Plan name – location	Telephone number	Enrollment code		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Oklahoma							
Amcare Health Plans - Oklahoma City/Tulsa areas	800/772-2993	ZX1	ZX2	11.61	30.39	91.55	239.76
PacifiCare Health Plans - Central/Northeastern Oklahoma	800/531-3341	2N1	2N2	11.52	30.13	90.91	237.69
Oregon							
Kaiser Permanente-High -Portland/Salem areas	800/813-2000	571	572	18.58	44.00	115.52	263.75
Kaiser Permanente-Std - Portland/Salem areas	800/813-2000	574	575	13.50	30.98	106.50	244.42
PacifiCare Health Plans - Metro Portland/Salem/Corvallis/Eugene	800/531-3341	7Z1	7Z2	51.39	106.06	115.52	263.75
Panama							
Panama Canal Area - Republic of Panama	507/227-7555	431	432	19.95	33.05	115.52	260.73

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

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

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

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

Plan name – location	Telephone number	Enrollment code		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Pennsylvania							
Aetna U. S. Healthcare, Inc. - Southeastern PA	800/537-9384	P31	P32	28.36	110.34	115.52	263.75
HealthAmerica Pennsylvania - Greater Pittsburgh area	800/735-4404	261	262	12.98	36.21	102.40	263.75
HealthAmerica Pennsylvania - Central Pennsylvania	800/788-8445	SW1	SW2	13.97	59.03	110.17	263.75
HealthGuard - Berks/Cmbrlnd/Dauphine/Lanc/Lebanon/York	800/822-0350	NQ1	NQ2	11.20	29.13	88.37	229.77
Keystone Health Plan Central - Harrisburg/Northern Region/Lehigh Valley	800/622-2843	S41	S42	29.67	87.55	115.52	263.75
Keystone Health Plan East - Philadelphia area	800/227-3115	ED1	ED2	14.47	75.15	114.13	263.75
KeystoneBlue - Pittsburgh/Altoona/Erie areas	800/421-0959	EF1	EF2	29.97	167.87	115.52	263.75
HealthNet of Pennsylvania - Phila. and 7 adjacent PA and NJ counties	800/736-2096	271	272	35.25	90.60	115.52	263.75
HealthNet of Pennsylvania - Scranton/Wilkes Barre areas	800/736-2096	2K1	2K2	14.53	53.28	114.64	263.75
UPMC Health Plan - Pittsburgh Area	412/454-7529	8W1	8W2	10.52	26.84	83.00	211.72
Puerto Rico							
Triple-S - All of Puerto Rico	787/749-4777	891	892	10.25	22.02	80.90	173.74

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	
			Pennsylvania										
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		
Puerto Rico													
Triple-S	- In-Network - Out-of-Network	\$7.50 \$7.50 + 10%	None Most	\$2 25%	\$5/\$10 25%	\$10 or 20% 25%	●	●	○	●	●	○	

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

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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		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Rhode Island							
Blue Chip, Coord Hlth Partners - All of Rhode Island	401/459-5500	DA1	DA2	15.89	72.71	115.52	263.75
South Dakota							
Avera Health Plan - Eastern and Central South Dakota	888/322-2115	AV1	AV2	11.83	27.16	93.37	214.28
Sioux Valley Health Plan - Eastern/Central/Rapid City areas	800/752-5863	AU1	AU2	38.50	65.87	115.52	263.75
Tennessee							
Aetna U. S. Healthcare, Inc. - Nashville/Middle Tennessee areas	800/537-9384	6J1	6J2	14.10	85.57	111.25	263.75
Aetna U. S. Healthcare, Inc. - Memphis area	800/537-9384	UB1	UB2	11.65	51.79	91.91	263.75
HealthSpring - Nashville/Middle Tennessee areas	615/291-5030	6K1	6K2	13.09	60.55	103.29	263.75

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
			Rhode Island									
Blue Chip, Coord Hlth Partners - In-Network	\$10	None	\$5	\$15	\$30	●	●	●	●	●	◐	N1
- Out-of-Network	20%	None	\$30 + 20%	\$30 + 20%	\$30 + 20%							
South Dakota												
Avera Health Plan	\$10	\$250	\$10	\$20	\$35							
Sioux Valley Health Plan - In-Network	\$10	\$100	\$10	\$20	\$20							J3,N6
- Out-of-Network	40%	40%	40%	40%	40%							
Tennessee												
Aetna U. S. Healthcare, Inc.	\$20	\$200-\$600	\$10	\$20	50%	○	○	◐	◐	○	○	N1
Aetna U. S. Healthcare, Inc.	\$20	\$200-\$600	\$10	\$20	50%	◐	◐	○	◐	◐	◐	N1
HealthSpring	\$10	None	\$10	\$20	\$35							N1

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

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

Plan name – location	Telephone number	Enrollment code		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Texas							
Amcare Health Plans - Houston/El Paso areas	800/782-8373	2V1	2V2	11.58	30.31	91.31	239.15
Amcare Health Plans - Austin/San Antonio/Dallas/Ft. Worth areas	800/782-8373	ZG1	ZG2	11.45	29.98	90.31	236.54
FIRSTCARE - Waco area	800/884-4901	6U1	6U2	20.49	32.87	115.52	259.31
FIRSTCARE - West Texas	800/884-4901	CK1	CK2	35.65	60.97	115.52	263.75
HMO Blue Texas - Austin/C.Christi/S.Antonio/Victoria/Houston	800/833-5318	YM1	YM2	13.45	32.93	106.14	259.81
HMO Blue Texas - Dallas/Ft. Worth/East & West Texas	877/299-2377	YX1	YX2	17.96	59.98	115.52	263.75
Humana Health Plan of Texas - San Antonio area	888/393-6765	UR1	UR2	11.59	29.78	91.40	234.96
Mercy Health Plans/Premier - Webb/Zapata/Duval/Jim Hogg Counties	800/617-3433	HM1	HM2	14.30	53.98	112.79	263.75
PacifiCare Health Plans - San Antonio/Dallas/Ft Worth	800/531-3341	GF1	GF2	11.21	29.30	88.40	231.12
Utah							
Altius Health Plans - Wasatch Front	800/377-4161	9K1	9K2	31.15	58.93	115.52	263.75
Vermont							
MVP Health Plan - All of Vermont	888/687-6277	VW1	VW2	71.58	219.51	115.52	263.75

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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
			Texas									
Amcare Health Plans	\$10	None	\$5	\$15	50%	X	X	X	X	X	X	N6
Amcare Health Plans	\$10	None	\$5	\$15	50%							N6
FIRSTCARE	\$10	None	\$10	\$20	\$30	○	◐	◐	●	◐	◐	
FIRSTCARE	\$10	None	\$10	\$20	\$30	●	●	●	●	●	●	
HMO Blue Texas	\$10	\$100	\$5	\$10	\$25	○	○	○	◐	○	○	N2
HMO Blue Texas	\$10	\$100	\$5	\$10	\$25	○	○	○	◐	◐	◐	N2
Humana Health Plan of Texas	\$10	None	\$5	\$20	\$40	○	○	○	○	◐	○	
Mercy Health Plans/Premier - In-Network	\$10	None	\$7	\$12	\$25	●	●	◐	●	●	●	
Mercy Health Plans/Premier - Out-of-Network	40%	40%	N/A	N/A	N/A							
PacifiCare Health Plans	\$10	None	\$5	\$15	\$15	○	○	○	◐	○	○	N2
Utah												
Altius Health Plans	\$10	None	\$10	\$15	\$30	○	◐	○	◐	○	○	
Vermont												
MVP Health Plan	\$10	None	\$5	\$20	\$20	◐	●	●	●	●	●	N2

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Plan name – location	Telephone number	Enrollment code		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Virginia							
Aetna U. S. Healthcare, Inc.-High -N.VA/Fredericksburg areas	800/537-9384	JN1	JN2	16.21	40.94	115.52	263.75
Aetna U. S. Healthcare, Inc.-Std - N.VA/Fredericksburg areas	800/537-9384	JN4	JN5	10.79	25.24	85.10	199.14
CareFirst BlueChoice - Northern Virginia	800/680-9495	2G1	2G2	14.35	32.29	113.22	254.70
HealthKeepers - Eastern,Central,F'burg,Western,SW areas	800/421-1880	X81	X82	12.73	32.32	100.39	254.94
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	12.04	29.75	95.01	234.67
MD-IPA - N.VA/Cntrl VA/Richmond/Tidewater/Roanoke	800/251-0956	JP1	JP2	13.56	32.55	106.99	256.81
OPTIMA Health Plan - Peninsula/Southside Hampton Roads	800/206-1060	9R1	9R2	21.72	61.00	115.52	263.75
Piedmont Community Healthcare - Lynchburg area	888/674-3368	2C1	2C2	19.07	44.44	115.52	263.75
Washington							
Aetna U. S. Healthcare, Inc. - Western/Southeast Washington	800/537-9384	8J1	8J2	12.46	32.39	98.27	255.52
Group Health Cooperative - Most of Western Washington	206/448-4140	541	542	14.51	32.73	114.44	258.24
Group Health Cooperative - Central WA/Spokane/Colville/Pullman	800/497-2210	VR1	VR2	13.42	42.87	105.85	263.75
Kaiser Permanente-High -Vancouver/Longview	800/813-2000	571	572	18.58	44.00	115.52	263.75
Kaiser Permanente-Std - Vancouver/Longview	800/813-2000	574	575	13.50	30.98	106.50	244.42
Kitsap Physicians Service-High -Most of Western Washington	800/552-7114	VT1	VT2	62.81	117.69	115.52	263.75
Kitsap Physicians Service-Std - Most of Western Washington	800/552-7114	VT4	VT5	18.53	32.95	115.52	259.96
PacifiCare Health Plans - Clark County	800/531-3341	7Z1	7Z2	51.39	106.06	115.52	263.75
PacifiCare Health Plans - Puget Sound/Most West WA	800/531-3341	WB1	WB2	15.35	79.34	115.52	263.75

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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
Virginia												
Aetna U. S. Healthcare, Inc.-High	\$15	\$100-\$300	\$10	\$20	50%	○	○	○	◐	○	○	N2
Aetna U. S. Healthcare, Inc.-Std	\$20	\$200-\$600	\$10	\$20	50%	○	○	○	◐	○	○	N2
CareFirst BlueChoice*	\$10	None	\$10	\$20	\$35	◐	◐	◐	◐	○	○	N2
HealthKeepers	\$10	\$100	\$5	\$10	\$25	◐	◐	○	◐	◐	●	N1
Kaiser Permanente	\$10	\$100	\$10	\$20	\$20	◐	○	◐	○	●	○	N2
MD-IPA	\$10	None	\$5	\$15	\$30	●	●	◐	◐	●	◐	N1
OPTIMA Health Plan	\$10	None	\$10	\$20	\$40	●	●	●	●	●	●	N1
Piedmont Community Healthcare - In-Network	\$10	None	\$5	\$15	\$15							
Piedmont Community Healthcare - Out-of-Network	30%	None	\$5	\$15	\$15							
Washington												
Aetna U. S. Healthcare, Inc.	\$15	\$100-\$300	\$10	\$20	50%	○	○	◐	◐	○	○	
Group Health Cooperative	\$10	\$100-\$300	\$10	\$20	\$20	◐	◐	◐	◐	◐	◐	N1
Group Health Cooperative	\$10	\$100-\$300	\$10	\$20	\$20	◐	◐	◐	◐	◐	◐	N1
Kaiser Permanente-High	\$10	None	\$10	\$20	\$20	◐	●	○	○	●	●	N1
Kaiser Permanente-Std	\$15	None	\$15	\$30	\$30	◐	●	○	○	●	●	N1
Kitsap Physicians Service-High	\$10	\$200	50%	50%	50%	●	●	●	●	●	●	
Kitsap Physicians Service-Std	20%	None	\$5	\$15	\$100 or 50%	●	●	●	●	●	●	
PacifiCare Health Plans	\$10	None	\$5	\$15	\$15	○	○	●	◐	○	○	N1
PacifiCare Health Plans	\$10	None	\$5	\$15	\$15	○	○	●	◐	○	○	N1

* Previously CapitalCare, which had Commendable NCQA accreditation.

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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		Your share		FDIC share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
West Virginia							
Health Plan Upper OH Valley - Northern/Central West Virginia	800/624-6961	U41	U42	13.20	58.91	104.13	263.75
Wisconsin							
Dean Health Plan - South Central Wisconsin	800/279-1301	WD1	WD2	13.31	55.81	105.04	263.75
Group Health Coop - South Central Wisconsin	608/251-3356	WJ1	WJ2	13.07	48.04	103.10	263.75
Group Hlth Coop/Eau Claire - West Central Wisconsin	715/552-4300	WT1	WT2	60.00	189.16	115.52	263.75
HealthPartners Classic-High -Pierce/St. Croix Counties	952/883-5000	531	532	28.21	81.17	115.52	263.75
HealthPartners Classic-Std - Pierce/St. Croix Counties	952/883-5000	534	535	22.82	68.27	115.52	263.75
HealthPartners Primary Clinic - West Central Wisconsin	952/883-5000	HQ1	HQ2	50.44	134.56	115.52	263.75
Unity Health Plans - Southern/Central Wisconsin	800/362-3310	W41	W42	21.81	100.19	115.52	263.75
Wyoming							
WINhealth Partners - Wyoming	307/638-7700	PV1	PV2	12.96	48.11	102.22	263.75

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 1-2 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 2 and 7 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						Accredited
			Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	
West Virginia												
Health Plan Upper OH Valley	\$10	None	\$10	\$20	\$35	●	●	●	●	●	●	N1
Wisconsin												
Dean Health Plan	\$10	None	\$10	\$15	\$15	●	●	●	●	●	●	N1
Group Health Coop	\$10	None	\$6	\$12	\$12	●	●	●	●	●	●	N1
Group Hlth Coop/Eau Claire	\$10	None	\$10	\$10	\$10	●	●	●	●	●	●	
HealthPartners Classic-High	\$15	None	\$10	\$20	\$20	◐	●	◐	◐	◐	◐	N1
HealthPartners Classic-Std	\$20	\$200	\$11	\$22	\$22	◐	●	◐	◐	◐	◐	N1
HealthPartners Primary Clinic	\$15	None	\$10	\$10	\$10	◐	●	◐	◐	◐	◐	N1
Unity Health Plans	\$10	None	\$6	\$12	\$24	●	●	●	◐	◐	●	
Wyoming												
WINhealth Partners	\$10	None	\$10	\$15	\$40							

