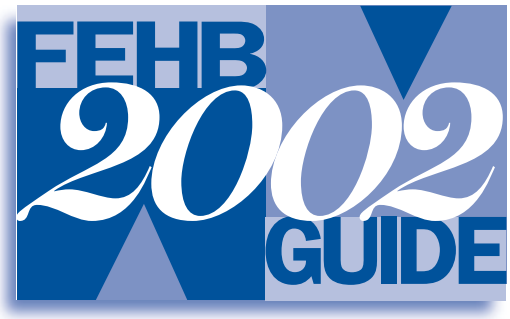

Guide to Federal Employees Health Benefits Plans

Participating in the DoD/FEHB Demonstration Project

United States Office of Personnel Management
Retirement and Insurance Service

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

RI 70-15
Revised November 2001

Patient Safety

Medical error and patient safety aren't well understood by most Americans. When we need vital or risky health care services, we want to believe that someone else has made sure that we'll get safe care. Sadly, every hour, 10 Americans die in a hospital due to avoidable errors; another 50 are disabled. Too many patients get the wrong medicines, the wrong tests and the wrong diagnosis. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1 **Speak up if you have questions or concerns.** Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.

2 **Keep a list of all the medicines you take.** Tell your doctor and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.

3 **Make sure you get the results of any test or procedure.** Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected -- in person, on the phone, or in the mail - don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.

4 **Talk with your doctor and health care team about your options if you need hospital care.** If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows ***results often are better at hospitals doing a lot of these procedures***. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.

5 **Make sure you understand what will happen if you need surgery.** Ask your doctor and surgeon: Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

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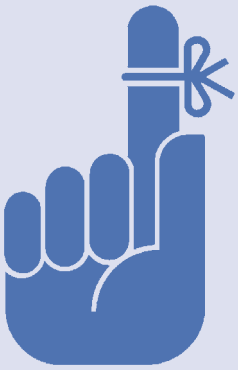
Things to Remember



- ☑ 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.

Eligibility and Enrollment Requirements

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

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

Who is Eligible

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

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

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

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

The Demonstration Areas

- Dover AFB, DE area, including most of Delaware and parts of Maryland
- Commonwealth of Puerto Rico
- Fort Knox, KY area, including parts of Indiana bordering Kentucky
- Greensboro/Winston Salem/High Point, NC area
- Dallas, TX area
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA area
- New Orleans, LA area
- Coffee County, GA area, including parts of Florida, Georgia and South Carolina
- Adair County, IA area, including most of Iowa and parts of Minnesota, South Dakota, Nebraska, Kansas and Missouri

Using Military Treatment Facilities

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

Opportunities to Enroll

Your next opportunity to enroll is during the 2001 Open Season, November 12, 2001, through December 10, 2001. You may select coverage for yourself (self-only) or for you and your family (self and family). Your coverage will begin January 1, 2002. DoD has set-up a Customer Care Center (CCC) in Iowa to provide you with information about how to enroll. CCC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the CCC is 1-877-DOD-FEHB (1-877-363-3342).

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

Eligibility and Enrollment Requirements

Dependent Coverage

You can choose self and family coverage for you, your spouse, and unmarried dependent children under age 22. Under certain circumstances, your FEHB enrollment may cover your disabled child 22 years old or older who is incapable of self-support. Contact the DoD Customer Care Center for more information.

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

Selecting a Plan

You can get brochures from the DoD Customer Care Center (CCC) by calling toll free 1-877-DOD-FEHB (1-877-363-3342). Brochures are also available on our web site at www.opm.gov/insure. When the CCC sends you the brochures you request, it will also send you an enrollment form for you to complete and return to the CCC. The CCC will verify your eligibility and confirm your enrollment.

Some FFS plans require that you join the organization that sponsors the plan.

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

Deduction from your Monthly Annuity

After the Government pays its share toward the total premium, you pay the rest. Each plan's premium in this Guide is the amount that will be withheld in 2002. Premiums take effect January 1, 2002, and are reflected in monthly annuities beginning in February 2002.

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

When Your Enrollment Ends

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

Eligibility for Temporary Continuation of Coverage (TCC) — Under this Demonstration Project, the only individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. TCC is available:

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

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

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

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

FEHB and You

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

Getting information and selecting a health plan

Use this Guide and plan brochures to make your health plan decision. The Guide is a summary of FEHB plans; the plan brochures give specific benefit information. You can get brochures from the health plans or by calling the CCC at 1-877-DOD-FEHB. Our web site, www.opm.gov/insure provides the Guide, brochures, and other helpful information.

Before selecting a health plan:

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

Quality

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

* **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.

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

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

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

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

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

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

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

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

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

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

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

Use the following key to compare the accreditation status of different health plans (a lower number means a better accredited plan). See page 9 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

FEHB and You

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 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.

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, including the enrollment form which you can complete on-line, print and give to your personnel office; information on Employee Express, and enrollment information for annuitants.
- Links to plan web sites and other web sites where you can find more about health care quality.

You can also look at and download:

- All of the FEHB Guides including the Guide For Federal Civilian Employees (Postal and Non-Postal), the Guide for Federal Retirees and Their Survivors, the Guide For Certain Temporary Employees, the Guide For Individuals Receiving Compensation From the Office of Workers' Compensation Programs, the Guide for those participating in the DOD/FEHB demonstration project, 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.

DoD Web Site

DoD also has a web site devoted to the DoD/FEHBP Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at **www.tricare.osd.mil/fehbp**.

Program Features

- **No Waiting Periods.** You can use your benefits as soon as your coverage becomes effective.
- **A Choice of Coverage.** Choose between self only or self and family.
- **A Choice of Plans and Options.** Select from Fee-For-Service, Health Maintenance Organization, or Point of Service plans.
- **A Government Contribution.** The Government pays 72 percent of the average premium toward the total cost of your premium, but not more than 75 percent of the total premium for any plan.
- **Premium Payment Deduction** from your check. For details see page 2.
- **Annual Enrollment Opportunity.** Each year during the 3-year demonstration project you can enroll or change your health plan enrollment.
- **Continued Group Coverage.** Eligibility for you or your family members may continue following your divorce or death. Contact the DoD Customer Care Center for more information.
- **Coverage After FEHB Ends.** You or your family members may be eligible for temporary continuation of FEHB coverage when FEHB coverage ends. Contact the DoD Customer Care Center for more information.

FEHB
Federal Employees
Health Benefits Program

Better Information
Better Choices
Better Health

Definitions

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

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

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

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

- **Accreditation with commendation** - JCAHO's highest status. Awarded to a plan that has demonstrated exemplary performance (category discontinued as of 2003). Valid for 3 years.
- **Accreditation without recommendations** - Demonstrates satisfactory compliance with JCAHO standards in all performance areas. Valid for 3 years.
- **Accreditation with recommendations** - Demonstrates satisfactory compliance with JCAHO standards in most performance areas. Valid for 3 years.
- **Provisional** - Demonstrates satisfactory compliance with a subset of standards. Valid for 6 months until plan is re-surveyed.
- **Conditional** - Demonstrates the capability of achieving satisfactory compliance but has not done so.

URAC - Also known as the American Accreditation Healthcare Commission.

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

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

Things to consider:

Fee-for-Service PPOs, non-PPOs, and PPO-only all work a little differently. See page 6 for things you should know.

Definitions

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

Things to consider:

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

HEDIS [1] - 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 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.

[1]HEDIS is a registered trademark of the National Committee for Quality Assurance.

Long Term Care Insurance Is Coming Later in 2002!

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

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

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

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

What is long term care (LTC) insurance?

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

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

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

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. ***Long term care insurance can protect your savings.***

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

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

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

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

How can I find out more about the program NOW?

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

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

Today's Medicare offers more.

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

Medicare & You
The knowledge to make good decisions

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

Medicare Questions?

www.medicare.gov

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

Medicare & You Handbook

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

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

TRICARE-for-Life Questions?

www.opm.gov/insure
OR
www.tricare.OSD.mil

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

Nationwide Fee-for-Service Plans Open to All

(Pages 14 through 16)

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

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

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

Nationwide Fee-for-Service Plans Open to All

How to read this chart:

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

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

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

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

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

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

Plan name	Telephone number	Enrollment code		Monthly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Alliance Health Plan (AHP)	202/939-6325	1R1	1R2	233.16	459.87
APWU Health Plan (APWU)	800/222-2798	471	472	432.45	930.25
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	74.04	170.99
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	Local phone #	111	112	65.07	153.94
GEHA Benefit Plan-High (GEHA)	800/821-6136	311	312	129.35	258.91
GEHA Benefit Plan-Std (GEHA)	800/821-6136	314	315	59.58	135.42
Mail Handlers-High (MH)	800/410-7778	451	452	120.90	284.24
Mail Handlers-Std (MH)	800/410-7778	454	455	95.88	226.41
NALC (NALC)	888/636-6252	321	322	99.39	181.39
PBP Health Plan-High (PBP)	800/544-7111	361	362	382.35	798.43
PBP Health Plan-Std (PBP)	800/544-7111	364	365	207.13	422.67

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					
						Inpatient		Outpatient other	Generic	Brand Name	Non-formulary	Home Delivery	
		Calendar Year	Prescription Drug			R&B	Other					Generic	Brand Name
AHP	PPO Non-PPO	$100 $300	$200 $200	$150 $250	10% 30%	10% 30%	10% 30%	10% 30%	10%/50% 10%/50% +	10%/50% 10%/50% +	10%/50% 10%/50% +	20% 20%	20% 20%
APWU	PPO Non-PPO	$275 $350	None None	None $200	10% 30%	10% 30%	10% 30%	10% 30%	$7 45%	25% 45%	25% 45%	$10 $10	20% 20%
BCBS	PPO Non-PPO	$250 $250	None None	$100 $300	10% 25%	Nothing 30%	Nothing 30%	10% 25%	25% 45%	25% 45%	25% 45%	$10/25% 45%	$35/25% 45%
BCBS	PPO only	None	None	$100/day;$500	$20/$30	Nothing	Nothing	$30	$10	$25	$35 or 50%	$10	$25
GEHA	PPO Non-PPO	$300 $300	None None	None None	10% 25%	Nothing Nothing	10% 25%	10% 25%	$5/50% $5 or 50%	$15/$30/50% $15/$30/50%	$15/$30/50% $15/$30/50%	$10 $10	$35/$50 $35/$50
GEHA	PPO Non-PPO	$450 $450	None None	None None	15% 35%	15% 35%	15% 35%	15% 35%	$5 $5 +	50% 50% +	50% 50% +	$15 $15	50% 50%
MH	PPO Non-PPO	$200 $200	$250 $250	None $250	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%	25% 50%	25% 50%	25% 50%	$10 $10	$30/$45 $30/$45
MH	PPO Non-PPO	$250 $250	$600 $600	$150 $300	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%	30% 50%	30% 50%	30% 50%	$10 $10	$40/$55 $40/$55
NALC	PPO Non-PPO	$250 $300	None $25 for Retail	None $100	15% 30%	10% 30%	10% 30%	15% 30%	25% 40%+	25% 40%+	25% 40%+	$12 $12	$25 $25
PBP	PPO Non-PPO	$200 $400	$100 $150	None $150	10% 20%	10% 25%	10% 25%	10% 20%	$10 or 20% 20%+	$25 or 20% 20%+	$40 or 20% 20%+	$10 $10	$25 $25
PBP	PPO Non-PPO	$250 $500	$100 $150	None $250	10% 30%	10% 30%	10% 30%	10% 30%	$15 or 20% 30%+	$30 or 20% 30%+	$40 or 20% 30%+	$15 $15	$30 $30

Nationwide Fee-for-Service Plans Open to All

Enrollee Survey Results — See pages 3-4 for a description.

Plan name	Plan code	Enrollee Survey Results ● above average, ◒ average, ○ below average					
		Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Alliance Health Plan	1R	●	○	●	●	◒	◒
APWU Health Plan	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	○	◒	●	●	○	○

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

(Pages 18 through 23)

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

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

Plans Offering a Point of Service (POS) Product — A product 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		Monthly premium your share	
		Self only	Self & family	Self only	Self & family
California					
Aetna U. S. Healthcare, Inc. - Southern California area	800/537-9384	2X1	2X2	69.71	139.41
Blue Cross- HMO - Most of California	800/235-8631	M51	M52	65.06	179.57
Blue Shield of CA Access+ - Most of California	800/334-5847	SJ1	SJ2	85.26	159.01
CIGNA HealthCare of California - Northern/Southern California	800/832-3211	9T1	9T2	127.77	195.54
Health Net - Most of California	800/522-0088	LB1	LB2	90.72	202.95
Kaiser Permanente - Southern California	800/464-4000	621	622	60.59	121.18
PacifiCare Health Plans - Most of California	800/531-3341	CY1	CY2	70.42	174.41
Florida					
Av-Med Health Plan - Broward/Dade/Palm Beach Counties	800/882-8633	EM1	EM2	128.90	310.31
Indiana					
Aetna U. S. Healthcare, Inc. - Southern Indiana	800-537-9384	7L1	7L2	160.72	261.43
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	107.42	285.39
Iowa					
Avera Health Plan - Northwestern Iowa	888/322-2115	AV1	AV2	56.98	130.78
Coventry Health Care of Iowa - Des Moines/Central Iowa/Waterloo	800/257-4692	SV1	SV2	44.23	223.60
Health Alliance HMO - Central/Eastern Iowa	800/851-3379	FX1	FX2	87.51	215.08
Kansas					
Coventry HC Kansas Cty formerly Kaiser - Kansas City area	913/642-2662	HA1	HA2	36.19	144.75
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	70.14	165.23
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	58.07	133.37

Prescription Drugs, Generic, Brand Name, and Non-formulatory 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 3-4 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 4 and 9 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
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	◒	◒	○	○	●	◒	N2
PacifiCare Health Plans	$10	None	$5	$15	$15	○	○	○	○	○	◒	N2
Florida												
Av-Med Health Plan	$10	$100	$5	$10	$25	◒	○	○	◒	●	◒	N2, J2
Indiana												
Aetna U. S. Healthcare, Inc.	$20	$200-$600	$10	$20	50%	○	○	◒	●	○	○	
Humana Health Plan	$10	None	$5	$20	$40	◒	○	◒	◒	○	○	N2
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
Kansas												
Coventry HC Kansas Cty formerly Kaiser	$10	None	$5	$15	$45							
Humana Health Plan, Inc. - High	$10	None	$5	$20	$40	○	○	◒	○	○	○	N2
Humana Health Plan, Inc. - Std	$15	$100	$10	$25	$45	○	○	◒	○	○	○	N2

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

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

Primary Care Doctor Office shows what you pay for each office visit to your primary care doctor.

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital.

Plan name – location	Telephone number	Enrollment code		Monthly premium your share	
		Self only	Self & family	Self only	Self & family
Kentucky					
Aetna U. S. Healthcare, Inc. - Louisville area	800-537-9384	7L1	7L2	160.72	261.43
Humana Health Plan - Louisville area	888/393-6765	D21	D22	107.42	285.39
Louisiana					
Coventry Healthcare Louisiana former Maxicare LA - New Orleans area	800/933-6294	BJ1	BJ2	43.79	216.66
Coventry Healthcare Louisiana former Maxicare LA - Baton Rouge area	800/341-6613	JA1	JA2	50.90	330.35
Maryland					
MD-IPA - All of Maryland	800/251-0956	JP1	JP2	89.59	150.81
Minnesota					
HealthPartners Classic-High -Minneapolis/St. Paul areas	952/883-5000	531	532	83.94	147.99
HealthPartners Classic-Std - Minneapolis/St. Paul areas	952/883-5000	534	535	66.10	132.21
HealthPartners Primary Clinic Plan - Minneapolis/St. Paul/St. Cloud areas	952/883-5000	HQ1	HQ2	120.86	181.71
Missouri					
BlueCHOICE - St. Louis/Central/SW/Poplar Bluff areas	800/634-4395	9G1	9G2	115.83	168.54
Coventry HC Kansas Cty formerly Kaiser - Kansas City area	913/642-2662	HA1	HA2	36.19	144.75
Group Health Plan - Southern/Metro East/Central/St. Louis	800/743-3901	MM1	MM2	115.16	209.06
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	70.14	165.23
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	58.07	133.37
Mercy Health Plans/Premier - East/Central Missouri	800/327-0763	7M1	7M2	166.94	273.86

Prescription Drugs, Generic, Brand Name, and Non-formulatory 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 3-4 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 4 and 9 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
Kentucky												
Aetna U. S. Healthcare, Inc.	$20	$200-$600	$10	$20	50%	○	○	◒	●	○	○	
Humana Health Plan	$10	None	$5	$20	$40	◒	○	◒	◒	○	○	N2
Louisiana												
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	
Maryland												
MD-IPA	$10	None	$5	$15	$30	●	●	◒	◒	●	◒	N1
Minnesota												
HealthPartners Classic-High	$15	None	$10	$20	$20	◒	●	◒	◒	◒	◒	N2
HealthPartners Classic-Std	$20	$200	$11	$22	$22	◒	●	◒	◒	◒	◒	N2
HealthPartners Primary Clinic Plan	$15	None	$10	$10	$10	◒	●	◒	◒	◒	◒	N1
Missouri												
BlueCHOICE	$10	None	$5	$10	$15	○	◒	●	●	◒	◒	
Coventry HC Kansas Cty formerly Kaiser	$10	None	$5	$15	$45	X	X	X	X	X	X	
Group Health Plan	$10	$100	$8	$20	$35	◒	◒	●	●	◒	●	
Humana Health Plan, Inc.-High	$10	None	$5	$20	$40	○	○	◒	○	○	○	N2
Humana Health Plan, Inc.-Std	$15	$100	$10	$25	$45	○	○	◒	○	○	○	N2
Mercy Health Plans/Premier - In-Network	$10	None	$7	$12	$25	●	●	●	◒	◒	●	
- Out-of-Network	30%	30%	N/A	N/A	N/A							

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

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

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		Monthly premium your share	
		Self only	Self & family	Self only	Self & family
Puerto Rico					
Triple-S - All of Puerto Rico	787/749-4777	891	892	54.25	128.43
Texas					
HMO Blue Texas - Dallas/Ft. Worth/East & West Texas	877/299-2377	YX1	YX2	142.46	224.96
PacifiCare Health Plans - San Antonio/Dallas/Ft Worth	800/531-3341	GF1	GF2	70.42	170.79

Prescription Drugs, Generic, Brand Name, and Non-formulatory 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 3-4 for a description. An (**X**) means the plan did not conduct the survey as we asked.

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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
Puerto Rico												
Triple-S - In-Network	$7.50	None	$2	$5/$10	$10 or 20%	●	●	○	●	●	○	
Triple-S - Out-of-Network	$7.50 + 10%	Most	25%	25%	25%							
Texas												
HMO Blue Texas	$10	$100	$5	$10	$25	○	○	○	◒	◒	◒	N2
PacifiCare Health Plans	$10	None	$5	$15	$15	○	○	○	◒	○	○	N2


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