FEHB 2005 GUIDE

Guide to Federal Employees Health Benefits Plans

For United States Postal Service Employees

Center for
Retirement and
Insurance Services

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

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UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options strengthening the Federal Employees Health Benefits (FEHB) Program and once again highlighting its strength as one of the best benefits systems among employers anywhere. I am firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. I am pleased to present the *2005 Guide to Federal Employees Health Benefits Plans* to assist you in making an informed decision.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with Health Savings Account (HSA) and Health Reimbursement Arrangements (HRA) components. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money.

If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this guide, in the brochures of the various health plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources helpful, and thank you once again for your service to the nation.

Sincerely,

Kay Coles James
Director

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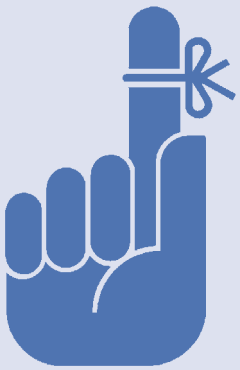

The information in this Guide gives you an overview of the FEHB Program and its participating plans. Read the plan brochures before you make any final decisions about health plans. Note that some union and association plans available to all federal employees charge a membership fee in addition to health coverage premiums.

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FEHB and You

Overview

The United States Postal Service (USPS() provides health benefits to its career employees by participating in the Federal Employees Health Benefits (FEHB) Program, which is administered by the U.S. Office of Personnel Management (OPM), Office of Retirement and Insurance Services. FEHB began operation in July 1960 and almost 815 million people are in the program, including 2.2 million federal and postal employees, 1.85 million retirees, and eligible family members. It is the largest employer-sponsored health insurance program in the world. OPM interprets health insurance laws and writes regulations for the FEHB Program. It gives advice and guidance to the USPS and other participating agencies to process your enrollment changes and to deduct your premiums. OPM also contracts with and monitors all of the plans participating in the FEHB Program.

The purpose of this 2005 Guide to Federal Employees Health Benefits (FEHB) Plans is to provide information about enrollment and premium features that USPS career employees must consider when selecting a health insurance plan under the FEHB Program. The Guide is a summary of FEHB plans – the plan brochures give specific benefit information. You can get individual plan brochures directly from the health plans, from your local personnel office, or from the OPM web site **www.opm.gov/insure** which also has a copy of this guide in addition to various health plan brochures and helpful information.

You may choose from among Fee-for-Service (FFS) plans regardless of where you live (see pages 29 through 38) and from Health Maintenance Organizations (HMO's) plans if you live (or sometimes if you work) within the area serviced by the plan (see pages 39 through 65). Some HMOs also offer a Point-of-Service (POS) product which allows you to use providers who are not part of the HMO network, but at an increased cost.

While FEHB eligibility, enrollment requirements and the plans available for 2005 are the same for federal and USPS employees alike, the Postal Service pays a higher percentage contribution towards career postal employee premium rates than the rest of the federal government. All employee premium rates are calculated using the "Fair Share Formula."

Coverage

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

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

- During Open Season
- When certain life events occur (see table on pages 24 through 27 of this Guide) **NOTE: These elections MUST be made within certain time limits as specified in the table.**

Your choice of plans and options includes Self Only coverage just for you, or Self and Family coverage for you, your spouse, and unmarried dependent children under age 22 (and in some cases, a disabled child 22 years or older who is incapable of self-support).

Eligible Family Members – Eligible family members for "self and family" health benefits registration purposes include an enrollee's:

- Spouse
- Unmarried dependent children under age 22, including legally adopted children and recognized natural (born out-of-wedlock) children.
- Unmarried dependent stepchildren and foster children, (including foster children who are also your grandchildren) under age 22 if they live with the enrollee in a regular parent-child relationship.
- Unmarried dependent children age 22 or over who are incapable of self-support because of physical or mental incapacity that existed before their 22nd birthday.

FEHB and You

Ineligible Members – Even though the following family members may live with and/or be dependent upon the enrollee, they are NOT ELIGIBLE for coverage under the enrollee's "self and family" FEHB program enrollment:

- Parents and other relatives
- Former spouses.

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

- Child reaching age 22
- Separation
- Retirement
- Divorce
- Application for Spouse Equity
- Death
- Relocation
- LWOP Status*

- Leave Without Pay Status – FEHB Program regulations state that you may continue your FEHB coverage for up to 365 days while you are in an LWOP status, provided that you continue to pay the employee share of the premium. The Postal Service will invoice you for your share of the premium unless you complete and submit to your personnel office PS Form 3111, FEHB Coverage or Termination While In Leave Without Pay (LWOP) Status, to terminate coverage. At 365 days in LWOP status, your FEHB coverage terminates.

It is your responsibility to report life events that may cause you or your family member to lose eligibility. It is also your responsibility to complete and submit any required paperwork to change your enrollment and/or apply for any continuation of coverage, if eligible, within the time limits specified in the Table of Qualifying Life Events on pages 24 through 27 of this guide. If you have questions, see your local personnel office.

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

FEHB Open Season

Each year you have the opportunity to enroll or change enrollment during an open season. The 2004 Open Season is from November 8 through December 14 at 5:00 p.m. Central Time. Employees may make any one – or a combination – of the following changes:

- Enroll if not enrolled
- Change from one plan to another
- Change from one option to another
- Change from Self Only to Self and Family
- Change from Self and Family to Self Only
- Change from pre-tax to post tax premium deductions or vice versa (see pages 4 through 6 of this Guide)
- Cancel enrollment

If you decide to do any of the above actions, you MUST follow the instructions on the FEHB Worksheet contained in the center of this Guide and enter your election in *PostalEASE* by 5:00 p.m. Central Time on December 14, 2004. It is critical that this be done timely.

Your new enrollment or any changes that you make to your existing coverage will take effect on January 8, 2005 and the change in premium rate deductions will be seen in your January 28, 2005, earnings statement. If you change plans, any covered expenses incurred between January 1-7, 2005, will count toward the prior year deductible of the plan you are changing from.

If you decide NOT to change your enrollment, DO NOTHING, and your present enrollment will continue automatically unless your plan is not participating in

FEHB and You

2005. If your plan is not participating in 2005 you MUST choose another plan during open season or you will not have FEHB coverage. Ask your local personnel office for a list of the plans that will terminate at the end of the 2004 plan year.

If you decide to cancel your coverage during open season, you must cancel your enrollment in *PostalEASE*, which includes a confirmation by you that you clearly accept the consequences of canceling. The cancellation will become effective on January 7, 2005.

If you pay premium contributions on a pre-tax basis (which most career employees do) you will not be able to cancel or reduce (change from Self and Family to Self Only) coverage unless you experience a qualifying life event and your election is in keeping with the change. See pages 4 through 6 of this Guide on Pre-tax Payment of Premium Contributions and the OPM table of permissible changes on pages 24 through 27 of this Guide.

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

You, as an employee, are responsible for being informed about your health benefits. You should thoroughly read this Guide, the brochures of plans that interest you, and the bulletin board notices on health benefits topics. These include family member eligibility, the option to continue or terminate an enrollment during periods of non-pay status or insufficient pay, dual enrollment prohibition, coverage for former spouses, and discontinued health insurance plans. Be sure to read the section on the pre-tax payment of health insurance premium contributions, which specifies Internal Revenue Service (IRS) restrictions for reducing or canceling coverage (see pages 4 through 6 of this Guide). Also be sure to refer to the table of permissible changes on pages 24 through 27 of this Guide.

After referring to these sources, if you still have questions regarding eligibility, enrollment criteria, continued coverage after certain life events, or on any other FEHB policies, or if you need assistance making your choice in *PostalEASE*, contact your local personnel office.

NOTE: Falsifying or misrepresenting family member eligibility or enrollmen is a violation of federal law and may subject an employee to fine, imprisonment and/or disciplinary action.

You can also look at and download:

- All of the FEHB Guides including the Guide for USPS Employees, the FEHB Guide for United States Postal Service Inspectors and Office of Inspector General Employees, the FEHB Guide for Certain Temporary (Non-career) USPS Employees, and the FEHB Guide For TCC and Former Spouse Enrollees.

- Plan brochures that include benefits, cost, and other major features of each health plan.

Pre-Tax Payment of Premium Contributions

The Postal Service has established the pre-tax payment of health insurance premium contributions as a tax-saving benefit feature for its employees. This feature has been sponsored by the Postal Service since 1994. Payment of premiums on a pre-tax basis prohibits enrollees from reducing coverage unless they qualify as described in the section "Reducing Coverage" below.

Pre-Tax Withholding

If you are a career employee, your premium contributions will automatically be withheld from pay as "pre-tax money," which means the premium amount is not subject to income, Social Security, or Medicare taxes.

Premiums are collected on a pre-tax basis automatically, unless you waive this treatment. Once you begin to pay FEHB premiums with pre-tax money, this method continues each year.

Although you are automatically enrolled to pay premium contributions with pre-tax money, you do have an opportunity during FEHB Open Season, or if you have a qualifying life event, to waive this treatment and pay your premiums with "after-tax money". This means you give up the tax savings of paying with pre-tax money.

There are two possible disadvantages of paying your premiums with pre-tax money that you should balance against the tax savings you receive.

First, when you retire, if you begin to collect Social Security (normally this occurs at age 62 at the earliest), you may receive a slightly lower Social Security benefit. Paying your FEHB premiums with pre-tax money reduces the earnings reported to the Social Security Administration. (Your Medicare, life insurance, retirement plan, and Thrift Savings Plan benefits are not affected.)

Second, there are some restrictions on reducing or canceling your coverage outside FEHB Open Season that apply if you pay your premium contributions with pre-tax money. These are explained in the section "Reducing Coverage" below.

Most employees prefer paying their premiums with pre-tax money because they save on taxes. Nevertheless, if for any reason you do not want this method of payment, and instead wish to have premiums paid with after-tax money, you must submit a form that is available from your local personnel office to waive the pre-tax treatment. For more information, see the section "How to Waive or Restore Pre-Tax Payment" on page 5 of this Guide.

Reducing Coverage

When your premium contributions are withheld on a pre-tax basis, certain Internal Revenue Service (IRS) guidelines affect your ability to change coverage. You may elect to reduce your coverage, that is, to cancel your FEHB enrollment, or to go from Self and Family to Self Only coverage, only during an FEHB Open Season, unless you have a qualifying life event. These are shown in the chart on pages 24 to 27 of this Guide titled "USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment." Refer to the column labeled "FEHB Enrollment Change That May Be Permitted" and the header "Cancel or Change to Self Only." You also must satisfy the time limits shown in the column labeled "Time Limits in Which Change May Be Permitted."

If you are the only person left in your Self and Family enrollment as a result of a qualifying life event in marital or family status, you must elect to reduce the enrollment (elect Self Only coverage or cancel coverage) by submitting the FEHB PostalEASE Worksheet to your local personnel office within the time limit shown in the column labeled "Time Limits in Which Change May Be Permitted" in the chart on pages 24 to 27 of this Guide. Otherwise, your self and family enrollment will continue until another event (that is, a qualifying life event or FEHB Open Season) occurs that allows you to elect to reduce coverage.

Pre-Tax Payment of Premium Contributions

Reducing your FEHB coverage outside of FEHB Open Season must be in keeping with, or on account of, your qualifying life event. For example, if you have a new baby, you usually would not change from Self and Family to a Self Only enrollment, or cancel coverage.

To reduce your FEHB coverage outside of FEHB Open Season, submit an FEHB PostalEASE Worksheet to your local personnel office within the time limits shown in the column labeled "Time Limits in Which Change May be Permitted" in the table on pages 24 to 27 of this Guide. You must provide any supporting documentation requested by your local personnel office. The effective date of a change from Self and Family to Self Only will be the first day of the pay period that follows the pay period in which your Worksheet is received by your personnel office. The effective date of a cancellation will be the last day of the pay period in which your Worksheet is received by your personnel office, if received within the specified time limits.

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

Retirement is NOT a qualifying life event that allows cancellation prior to the date of your retirement. If you wish to cancel an enrollment at retirement, your personnel office will accept your completed SF 2809 and forward it to OPM for processing after separation from the Postal Service. (Annuitants' FEHB premium contributions are not withheld as a pre-tax payment, thus once you are an annuitant, reduction in coverage is allowed at any time.)

During periods of non-pay status or insufficient pay, you may terminate your FEHB enrollment. The effective date of termination is retroactive to the end of the last pay period in which a premium contribution was withheld from pay. Contact your local personnel office for more information about how termination during periods of non-pay status or insufficient pay affects FEHB enrollment.

How to Waive or Restore Pre-Tax Payments

If you pay premiums with after-tax money, you will not be affected by the IRS guidelines described above that restrict reductions in coverage. You may reduce your level of FEHB coverage at any time of year without having a qualifying life event. You will give up the tax savings from paying your premium contributions with pre-tax money.

If you wish to pay your premiums with after-tax money, you must contact your local personnel office and ask for Postal Service (PS) Form 8201, Pre-tax Health Insurance Premium Waiver/Restoration Form. During Open Season, complete the form and return it to your local personnel office by close of business December.14, 2004. If this is your initial opportunity to enroll in FEHB, you have 60 days to submit your election to your local personnel office. You also may make such an election when you have a qualifying life event which is shown in the chart on pages 24 to 27 of this Guide. Refer to the column labeled "Premium Conversion Election Change That May Be Permitted." You must also satisfy the time limits shown in the column labeled "Time Limits in Which Change May Be Permitted."

If you submit a waiver, your premiums will continue to be paid with after-tax money in future years, unless you later submit another PS 8201 to restore pre-tax payment of FEHB premiums.

If you previously submitted a waiver in order to pay with after-tax money, and you want to begin paying your premiums with pre-tax money, you may submit PS 8201 to restore pre-tax payment of your premium contributions. You may change the method of payment from pre-tax to after-tax, or the reverse only during the annual FEHB Open Season or following a qualifying life event and within the time limits described earlier in this section.

Pre-Tax Payment of Premium Contributions

Your Right To More Information

This section of the FEHB Guide serves as your summary plan description of the USPS Plan for the Pre-tax Payment of Health Insurance Premiums. There is also a legal plan document containing the full legal plan provisions, which you may arrange to view by writing to:

PRETAX PAYMENT OF HEALTH INSURANCE PREMIUMS
PLAN ADMINISTRATOR
475 L'ENFANT PLAZA SW ROOM 9670
WASHINGTON DC 20260-4210

USPS Flexible Spending Accounts

Flexible Spending Accounts for U.S. Postal Service Career Employees

Any of these expenses in your future?

Doctor visits. Orthodontia. Eye exams, contacts and eyeglasses. Laser vision surgery. Medical and dental deductibles and co-pays. Prescription and over-the-counter drugs. Nursery school. Day care. Summer day camp. Day care for a dependent parent.

Plan ahead and save money.

Set aside dollars in a Flexible Spending Account (FSA). They're tax free. And, FSAs cover eligible expenses for you and your eligible dependents.

Start saving now.

Whether you're selecting a new health benefits plan, or keeping the same one you have now, plan to cover your out-of-pocket health care expenses, including dental and vision expenses, with a Health Care FSA. Enroll in the FSA program during the current open season and your full annual Health Care FSA contribution will be available to you beginning Jan. 1, 2005, even though your payments are spread out over the 2005 pay dates.

What a difference an FSA makes!

You won't pay federal income, Social Security or Medicare taxes on the amount you contribute to an FSA. When you take the tax savings into consideration, an FSA can make a big difference in the amount of money you spend on your family's health.

- Without an FSA you might spend $400 next year on prescriptions and over-the-counter drugs. With an FSA you may only pay $250.
- Without an FSA you'll pay about $325 for eyeglasses compared to $200 with an FSA.
- Without an FSA, you could pay your dentist or orthodontist $2,000 next year. An FSA can help trim that cost down to about $1,250.

Better hurry.

FSA open season ends 5 p.m. Central Time, Dec. 31, 2004. An FSA brochure coming soon to your mailbox will explain more about how you can save with FSAs.

Enroll now!

Call 1-800-842-2026 for more information on how an FSA can work for you and your family and to make sure the expenses you're planning to cover are eligible. Then use convenient *PostalEASE* to enroll.

FSAs and HSAs

Please note that you are not eligible to enroll in a Health Care FSA if you have a Health Savings Account (HSA). To have an HSA, you must enroll in one of the "High Deductible Health Plans" listed at the end of this Guide. If you have an HSA, you may enroll in a Dependent Care FSA as long as you are otherwise eligible.

Now when you access *PostalEASE* by phone or on the Web, instead of your Social Security Number, use your eight-digit employee ID — found at the top of your earnings statement — and your USPS PIN.

The change helps safeguard your Social Security Number by reducing its exposure on printed documents and other media, and that helps protect your privacy.

The Federal Long Term Care Insurance Program

It's important protection.

Here's why you should consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP):

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself—or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

To find out more and to request an application. Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Picking a Health Plan

Step 1: What type of health plan is best for you? You have some basic questions to answer about how you pay for and access medical care. Here are the different types of plans from which to choose.

	Choice of doctors, hospitals, pharmacies, and other providers	Specialty care	Out-of-pocket costs	Paperwork
Fee-for-Service w/PPO	You must use the plan's network for full benefits. Not using PPO providers means only some or none of your benefits will be paid.	Referral not required to get benefits.	You pay fewer costs if you use a PPO provider than if you don't.	Some if you don't use network providers.
Health Maintenance Organization	You generally must use the network. You pay all costs for care outside the network.	Referral generally required from primary care doctor to get benefits.	Your out-of-pocket costs are generally limited to copayments.	Little, if any.
Point-of-Service	You must use the network for full benefits. You may go outside the network but it will cost you more.	Referral generally required to get full benefits.	You pay less if you use a network provider than if you don't.	Little if you use the network. You have to file your own claims if you don't use the network.
Consumer-Driven Plans	You may use network and non-network providers. Not using the network will cost you more.	Referral not required to get full benefits.	You will pay an annual deductible and cost-sharing. You pay less if you use the network.	Some if you don't use network providers.
High Deductible Health Plans w/HSA or HRA	Some plans are network only, others pay something even if you do not use a network provider.	Referral not required to get full benefits.	You will pay an annual deductible and cost-sharing. You pay less if you use the network.	If you have an HSA account, you may have to file a claim to obtain reimbursement.

See Definitions starting on page 8 for a more detailed description of each type of plan.

Picking a Health Plan

Step 2: Medical care services. Are preventive care services important to you? What about the freedom to choose your own doctors? Do you prefer to pay a higher deductible in return for a lower premium? Estimate what you might spend on your health care for deductibles, coinsurance/copayments, and services that are not covered. What is the maximum you will have to pay out-of-pocket each year?

An easy-to-use tool allowing you to compare plans is available on the web at www.opm.gov/insure/04/spmt/plansearch.aspx. If you do not have Internet access, use the chart below by consulting the health plans' brochures to review your costs, including premiums, and estimate what you might spend on health care next year. Plan brochures can be obtained from your Human Resources office or on the OPM web site at www.opm.gov/insure/health.

	Health Plan _____	**Health Plan _____**	**Health Plan _____**
Annual premium			
Annual deductible			
Office visit to primary care doctor			
Office visit to specialist			
Hospital inpatient deductible/copay-ment/ coinsurance			
Hospital room & board charges			
Generic drug (local pharmacy)			
Brand name drug (local pharmacy)			
Catastrophic protection limit			
Home health care visits			
Durable medical equipment			
Maternity care			
Well-child care			
Routine physicals			
Accreditation			
The following information can be found in the Member Survey Results section in the benefit charts.			
Overall member satisfaction with plan			
Getting needed care			
Getting care quickly			
How well doctors communicate			
Customer service			
Claims processing			

Picking a Health Plan

Step 3: Consider quality. How well do health plans keep their members healthy? How well do health plans treat members when they are sick? Good quality health care means doing the right thing at the right time, in the right way, for a person to achieve the best possible results. Good quality doesn't always mean receiving more care. We provide two types of quality information: accreditation (independent evaluations from private organizations) and member survey opinions (by enrollees).

HMO Accreditation. The evaluations shown in this Guide are performed by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and URAC. The following are the accreditation levels used by each organization. Check your health plan's brochure for its accreditation level.

National Committee for Quality Assurance (www.ncqa.org)	**Excellent** – Levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement AND achieve health plan performance results that are in the highest range of national or regional performance.	**Commendable** – Meets or exceeds NCQA's requirements for consumer protection and quality improvement.	**Accredited** – Meets most of NCQA's requirements for consumer protection and quality improvement.	**Provisional** – Meets some but not all of NCQA's requirements for consumer protection and quality improvement.	**New Health Plan** – Applies to health plans that are less than two years old.
Joint Commission on Accreditation of Healthcare Organizations (www.jcaho.org)	**Accreditation with Full Compliance-** Demonstrates satisfactory compliance with JCAHO standards in all performance areas.	**Accreditation with Requirements for Improvement** – Demonstrates satisfactory compliance with JCAHO standards in most performance areas.	**Provisional** – Demonstrates a previously unaccredited plan's satisfactory compliance with a subset of standards.	**Conditional** – Demonstrates failure to meet standard(s) or specific policy requirement(s) but is believed capable to do so in a specified time period.	
URAC (www.urac.org)	**Full Accreditation** – Demonstrates full compliance with standards.	**Conditional** – Meets most of the standards but needs some improvement before achieving full compliance.	**Provisional** – A plan that has otherwise complied with all standards but has been in operation for less than 6 months.		

Note: *This chart shows the accreditation levels available under each accrediting organization listed. It is not intended to draw comparisons among the different accrediting organizations.*

Member Survey. The results shown in the plan comparison sections are collected, scored, and reported by an independent organization – not by the health plans. For each survey measure, individual plan scores are compared to a national average for all plans of the same type. Plan scores are reported as at, above, or below the national average. Here is a brief explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• Were you satisfied with the choices your health plan gave you to select a personal doctor? • Were you satisfied with the time it takes to get a referral to a specialist?
Getting Care Quickly	• Did you get the advice or help you needed when you called your doctor during regular office hours? • Could you get an appointment for regular or routine care when you wanted?
How Well Doctors Communicate	• Did your doctor listen carefully to you and explain things in a way you could understand? • Did your doctor spend enough time with you?
Customer Service	• Was your plan helpful when you called its customer service department? • Did you have paperwork problems? • Were the plan's written materials understandable?
Claims Processing	• Did your plan pay your claims correctly and in a reasonable time?

Picking a Health Plan

Fee-for-Service (FFS) plans and their Preferred Provider Organizations (PPO) are organized much differently and perform different functions than Health Maintenance Organizations (HMO) and Point-of-Service (POS) plans. Consequently, the accreditation of these plans is different from HMOs and POS plans. The following chart shows activities common to FFS/PPO plans and the X indicates that your FFS/PPO plan (or a vendor with which it contracts) has achieved accreditation in these areas.

	Behavioral Health	Case Management	Disease Management	Health Utilization Management	Health Network Accreditation	Health Plan Accreditation
APWU Health Plan	X	X	X	X	X	
Blue Cross and Blue Shield		X				
GEHA		X	X	X	X	
Mail Handlers			X	X		
NALC	X			X		
PBP Health Plan					X	
Rural Carrier				X		X

Behavioral Health – a utilization management program that specializes in mental health and substance abuse or chemical dependency services.

Case Management – identifying plan members with special healthcare needs, developing a strategy that meets those needs, and coordinating and monitoring the ongoing care.

Disease Management – intensively managing a particular disease. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. Similar to case management but more focused on a defined set of diseases.

Health Utilization Management – managing the use of medical services so that a patient receives necessary, appropriate, high-quality care in a cost-effective manner. It requires plans to use clinical personnel to make decisions.

Health Network Accreditation – this standard includes key quality benchmarks for network management, provider credentialing, utilization management, quality management and improvement and consumer protection.

Health Plan Accreditation – a comprehensive assessment of a plan's performance in key areas including network management, provider credentialing, utilization management, quality management and improvement, and consumer protection.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems, such as permanent disabilities, extended hospital stays, longer recoveries, and additional treatments. By asking questions, learning more, and understanding your risks, you can improve the safety of your health care, and that of your family. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery?
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- **www.ahrq.gov/consumer/pathqpack.htm.** The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- **www.patientsafety.gov.** The VA National Center for Patient Safety is dedicated to improving the care of America's veterans and offering patients and health care providers, as well as the general public, information on what can be done to improve patient safety.
- **www.npsf.org.** The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- **www.leapfroggroup.org.** The Leapfrog Group is active in promoting safe practices in hospital care.
- **www.ahqa.org.** The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

FEHB Web Resources

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

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

- An interactive tool that allows you to make side-by-side comparisons of the costs, benefits, and quality indicators of the plans in your area.
- All health plan brochures.
- A comparison of how FEHB plans perform in important medical areas under the Health Plan Employer Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures that allows users to reliably compare managed care health plan performance across specific clinical areas. The performance measures are related to many significant diseases such as cancer, heart disease, asthma, and diabetes. Compare plan results at www.opm.gov/insure/health/hedis2004.
- Information on enrolling, including online enrollment for employees of selected agencies.
- Information on how plans in the FEHB Program coordinate benefit payments with Medicare.
- A comprehensive set of Frequently Asked Questions and answers on all aspects of the Program.
- An online version of the FEHB Handbook for more information on FEHB policies and procedures.

Program Features

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

- **A Choice of Coverage.** Choose between Self Only or Self and Family.

- **A Choice of Plans and Options.** Select from Fee-for-Service (with the option of a Preferred Provider Organization), Health Maintenance Organization, Point-of-Service plans, Consumer-Driven plans, or High Deductible Health Plans.

- **A Government Contribution.** The USPS pays 85 percent of the average premium toward the total cost of your premium, up to a maximum of 88.75 percent of the total premium for any plan.

- **Salary Deduction.** You pay your share of the premium through a payroll deduction and have the choice of doing so using pre-tax dollars. When your premium contributions are withheld on a pre-tax basis, certain Internal Revenue Service guidelines affect your ability to change coverage. You may elect to cancel your FEHB enrollment, or to go from Self and Family to Self Only coverage, only during an FEHB Open Season, unless a qualified life status change occurs. See your Human Resources office for details.

- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enrollment. This year the Open Season runs from November 8, 2004, through December 14, 2004. Other events allow for certain types of changes throughout the year. See your Human Resources office for details.

- **Continued Group Coverage.** Eligibility for you or your family members may continue following your retirement, divorce, death, or changes in employment status. See your Human Resources office for more information.

- **Coverage after FEHB Ends.** You or your family members may be eligible for temporary continuation of FEHB coverage or for conversion to non-group (private) coverage when FEHB coverage ends or while awaiting approval by OPM for an application for Spouse Equity. See your Human Resources office for more information.

- **Consumer Protections.** Go to www.opm.gov/insure/health/consumers to: see your appeal rights to OPM if you and your plan have a dispute over a claim; read the Patients' Bill of Rights and the FEHB Program and; learn about your privacy protections when it comes to your medical information.

FEHB
Federal Employees
Health Benefits Program

Better Information
Better Choices
Better Health

Definitions

Accreditation - The status granted to a health care organization following a rigorous, comprehensive, and independent evaluation. The evaluation includes an assessment of the care and service being delivered in important areas of public concern, such as immunization rates, mammography rates, and member satisfaction.

Brand name drug – A prescription drug that is protected by a patent, supplied by a single company, and marketed under the manufacturer's brand name.

Coinsurance - The amount you pay as your share for the medical services you receive, such as a doctor's visit. Coinsurance is a percentage of the cost of the service (you pay 20%, for example).

Consumer-Driven Health Plans (CDHP) - Describes a wide range of approaches to give you more incentive to control the cost of either your health benefits or health care. You have greater freedom in spending health care dollars up to a designated amount, and you receive full coverage for in-network preventive care. In return, you pay significantly higher costs after you have used up the designated amount. The catastrophic limit is usually higher than those in other plans.

Copayment - The amount you pay as your share for the medical services you receive, such as a doctor's visit. A copayment is a fixed dollar amount (you pay $15, for example).

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

Formulary – A list of both generic and brand name drugs that are preferred by your health plan. Health plans choose formulary drugs that are medically safe and cost effective. A team including pharmacists and physicians meet to review the formulary and make changes as necessary.

Generic drug – A generic medication is a copy of the brand name drug. A generic drug provides the same effectiveness and safety as a brand name drug and usually costs less. A generic drug may have a different color or shape than its brand name counterpart, but it must have the same active ingredients, strength, and dosage form (pill, liquid, or injection).

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.

Health Reimbursement Arrangements (HRA) - Health Reimbursement Arrangements are a common feature of Consumer-Driven Health Plans. They may be referred to by the health plan under a different name, such as Personal Care Account. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA. HRAs are similar to HSAs except an enrollee cannot make deposits into an HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

Definitions

Health Savings Account (HSA) - A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a tax-free basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax free, and that amount is available on a tax-free basis to pay medical costs. To open an HSA you must be covered under a High Deductible Health Plan and cannot be eligible for Medicare or covered by another plan that is not a High Deductible Health Plan or a dependent on another person's tax return. HSAs are subject to a number of rules and limitations established by the Department of the Treasury. Visit **www.ustreas.gov/offices/public-affairs/hsa** for more information.

High Deductible Health Plan (HDHP) - A High Deductible Health Plan is a health insurance plan in which the enrollee pays a deductible of at least $1,050 (self-only coverage) or $2,100 (family coverage). The annual out-of-pocket amount (including deductibles and copayments) the enrollee pays cannot exceed $5,000 (self-only coverage) or $10,000 (family coverage). HDHPs can have first dollar coverage (no deductible) for preventive care and higher out-of-pocket copayments and coinsurance for services received from non-network providers. HDHPs offered by the FEHB Program establish and partially fund HSAs for all eligible enrollees and provide a comparable HRA for enrollees who are ineligible for an HSA. The HSA premium funding or HRA credit amounts vary by plan.

In-Network - You receive treatment from the doctors, clinics, health centers, hospitals, medical practices, and other providers with whom your plan has an agreement to care for its members. Examples include a Fee-For-Service plan's PPO or a Health Maintenance Organization. Members have fewer out-of-pocket costs when they use in-network providers.

Out-of-Network - You receive treatment from doctors, hospitals, and medical practitioners other than those with whom the plan has an agreement, and pay more to do so. Members in a PPO-only option who receive services outside the PPO network generally pay all charges.

Point-of-Service (POS) - A product offered by a health plan that has both in-network and out-of-network features. In a POS you don't have to use the plan's network of providers for every service but you generally pay more out of network.

Preferred Provider Organization (PPO) - FFS Plans and many HDHPs use PPOs which are a network of providers. PPOs give you the choice of using doctors and other providers in the network or using non-network providers. You don't have to use the PPO, but there are advantages if you do. (Be aware, however, that some of the services provided in a PPO hospital may not be covered by PPO arrangements. Room and board will be covered, but anesthesia and radiology, for instance, may be covered under non-PPO benefits.) Note that some FFS plans may offer an enrollment option that is "PPO-only." You **must** use network providers to receive benefits from a PPO-only plan.

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

FEHB and *PostalEASE*

The United States Postal Service is now using PostalEASE to enter Federal Employee Health Benefit (FEHB) Program Open Season enrollments and changes. By using *PostalEASE* for health benefits, and by sending information to health insurance companies electronically instead of via paper forms as in past open seasons, the Postal Service expects that employees who make health benefits changes will get their new insurance cards more quickly. All the information you need for using *PostalEASE* is included in the FEHB *PostalEASE* Worksheet found on pages 19 to 21 of this Guide. Just follow the instructions to:

- Enroll
- Change Enrollment
- Cancel Enrollment
- Review or change your pending open season transaction
- Review or update your dependent information
- Review your current enrollment information
- Receive a copy of a health benefits election that was processed using *PostalEASE*

If you want to make a change for the 2005 plan year, you may do so during the annual FEHB Open Season, which is from November 8 through December 14, 2004, at 5:00 PM Central Time. If you currently have an FEHB enrollment and you do not want to make any changes, *do nothing*. Your coverage will continue automatically.

Please do not wait until late in the open season to enter your choice via *PostalEASE*. If you select Self and Family coverage, then you'll need to enter information about your dependents. Although this will take extra time, providing this information is required under FEHB regulations. Just complete the FEHB *PostalEASE* Worksheet and follow the instructions carefully.

All open season Self Only enrollments, changes to Self Only coverage, and cancellations, should be entered as employee "self service" transactions using *PostalEASE*. Since dependent information is not required, such transactions are simple. Most Self and Family enrollments can also be completed as employee self service transactions, although they require additional information. The easiest way to do this is via the *PostalEASE* Employee Web, which is available through the Blue page or on a kiosk. Many Self and Family transactions can also be completed by telephone. If you are unable to enter your dependent information via the telephone, the *PostalEASE* system will refer you to the Web, a kiosk, or your local personnel office. *PostalEASE* provides the enrollment date, processing date, and effective date when you complete your transaction. You may delete or change a pending transaction until it is processed. If you are newly eligible for FEHB as a career employee, you may also use *PostalEASE* during the first 60 days after your date of appointment.

This Guide contains important FEHB policy information that used to be provided to you as part of the SF 2809 *Health Benefits Election Form*. Be sure you understand how your health benefits work, including information on which family members are eligible, how you pay for your health benefits premiums using pre-tax dollars, and the limitations on making a health benefits change outside of open season. As a reminder, to continue health benefits coverage during retirement, you must have had five consecutive years of FEHB coverage immediately prior to your retirement. If you need help understanding any of this information, or you need help using *PostalEASE*, you should contact your local personnel office for assistance.

FEHB Program *PostalEASE* Worksheet

Federal Employees Health Benefits (FEHB) Program PostalEase Worksheet

The *PostalEASE* telephone system and web site provide a convenient, confidential, and secure way for you to newly enroll, change your current enrollment, or cancel your enrollment in the Federal Employees Health Benefits (FEHB) Program. If you have access to *PostalEASE* on the Intranet (from the blue page) or at an Employee Self-Service Kiosk (available in some facilities), using either of these may be easier than using the telephone.

Through *PostalEASE* you may:

- Make a change to your current enrollment during FEHB Open Season (November 8, 2004 – December 14, 2004, 5 p.m. Central Time)
- Make an election as a new employee within 60 days of your date of hire.
- Update your dependents' information — **although if you are not making a change in your enrollment at the same time, you must also contact your health plan carrier directly** with this information. *PostalEASE* will **not** transmit dependent change information to the insurance carrier if an enrollment transaction has not occurred.

You cannot use *PostalEASE* to newly enroll or change your enrollment due to the occurrence of a permitting event, nor to cancel or reduce your coverage due to a qualified life status change. You must contact your local personnel office to assist you with these actions.

If you are not making any changes to your current FEHB enrollment, then you do not need to do anything.

Preparing for PostalEASE FEHB Enrollment

1. **Read the Privacy Act Statement** on the other side of this page.
2. **Read and understand the RI 70-2**, ***Guide to the FEHB Plans***, which is mailed to you each FEHB Open Season.
3. **Make sure you have the following information** ready before using *PostalEASE*.
   a. Your USPS personal identification number (**PIN**). If you don't know your PIN, just call *PostalEASE*. When prompted to enter your PIN, pause and you will be given the option of having it mailed to your address of record. Usually it will be mailed by the next business day. Or, request your USPS PIN from *PostalEASE* on the Intranet (from the blue page) or at an Employee Self-Service Kiosk (available in some facilities).
   b. Your Employee Identification number (EID).
   c. Your daytime **phone number**.
   d. The name of the **health benefits plan** in which you are enrolling.
   e. The **code** of the health benefits plan in which you are **enrolling**. For the name and code, refer to the list of codes in RI 70-2, *Guide to FEHB Plans*, or to the health plan brochure.
   f. The names, Social Security Numbers (optional), addresses, and dates of birth for all **eligible family members** that will be covered under your health benefits enrollment. For more information on family member eligibility, see RI 70-2, *Guide to FEHB Plans*.
   g. The name and policy number of any **other group insurance** you or any of your eligible family members may have (including Tricare, Medicare, etc.).
   h. If you are changing plans or canceling coverage, the **code** of the health benefits plan in which you are **currently enrolled** — that is, the plan that you will not have after your choice takes effect. The code for your current plan is found on your biweekly earnings statement. It is the three-character code that follows the letters "HP" or "HB." For example, the Blue Cross Self and Family Standard plan will be shown as HP105 or HB105, and you will enter the code 105 in *PostalEASE*. You may also refer to the list of codes in RI 70-2, *Guide to FEHB Plans*.
4. **Complete the worksheet** that follows, using the information you prepared above.

PostalEASE FEHB Worksheet

Now You Are Ready To Call

- If you have access to the *PostalEASE* Employee Web on the Intranet (from the blue page) or to an Employee Self-Service Kiosk (available in some facilities), using either may be simpler than using the telephone. Just follow the instructions.
- Otherwise, call *PostalEASE* toll-free at 1-877-4PS-EASE (1-877-477-3273).
- When prompted, select Federal Employees Health Benefits.
- Follow the script and prompts to enter your EID, your USPS PIN, and other required information. (Having your completed *PostalEASE* FEHB Worksheet on hand will help you complete your transaction.)
- If you currently have an FEHB enrollment and you do not want to make any changes . . . ***do nothing***.

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

PRIVACY ACT STATEMENT: The collection of this information is authorized by 39 USC 401, 1001, 1003, 1005; 5 USC 8339; 42 USC 2000e-16, and Executive Orders 11478 and 11590. This information will be used to process your enrollment in the Federal Employees Health Benefit system and to manage your claim under that plan. As a routine use, the information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes; where pertinent, in a legal proceeding to which the USPS is a party or has an interest; to a government agency in order to obtain information relevant to a USPS decision concerning employment, security clearances, contracts, licenses, grants, permits or other benefits; to a government agency upon its request when relevant to its decision concerning employment, security clearances, security or suitability investigations, contracts, licenses, grants or other benefits; to a congressional office at your request; to an expert, consultant, or other person under contract with the USPS to fulfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review of private relief legislation; to an independent certified public accountant during an official audit of USPS finances; to an investigator, administrative judge or complaints examiner appointed by the Equal Employment Opportunity Commission for investigation of a formal EEO complaint under 29 CFR 1614; to the Merit Systems Protection Board or Office of Special Counsel for proceedings or investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to agencies having taxing authority for taxing purposes; to financial organizations receiving allotments; to State Employment Security Agencies to process unemployment compensation claims; to a Federal or state agency providing parent locator service or to other authorized persons as defined by Pub. L. 93-647; to the National Association of Postal Supervisors that relates to postal supervisors; to a prospective employer for consideration of employment; to management for compilation of a local seniority list for posting; to the EEOC for enforcement of Federal EEO regulations; to the appropriate finance center as required under the provisions of the Dual Compensation Act; to the Office of Personnel Management, Social Security Administration, Veterans Administration, Office of Workers' Compensation Programs; health insurance carriers, or plans, or other program management agencies or retirement systems for use in determining a claim for benefits; and to OPM for its active employee/annuitant data systems used to analyze Federal retirement and insurance costs. Providing the information is voluntary; however, if this information is not provided, we may not be able to process your enrollment. We also request that you provide your social security number so that it may be used as your individual identifier in the Federal Employee Health Benefits system. Executive order 9397 dated November 22, 1943, allows Federal Agencies to use the social security number as an individual identifier to distinguish between people with the same or similar names.
Computer Matching: Limited information may be disclosed to a Federal, state, or local government administering benefits or other programs pursuant to statute for purpose of conducting computer matching programs under the Act. These programs include, but are not limited to, matches performed to verify an individual's initial or continuing eligibility for, indebtedness to, or compliance with requirements of a benefit program.

PostalEASE FEHB Worksheet

This worksheet will help you prepare to call *PostalEASE*, or use *PostalEASE* on the Intranet (from the blue page), or on an Employee Self - Service Kiosk (now available in some facilities). You may also prepare this worksheet and contact your local personnel office if you cannot enroll or make a change because *PostalEASE* does not accept the required documentation.

Note: If you have any trouble using *PostalEASE*, or if you are unable to use the telephone because you are deaf or hard of hearing, or you cannot use the telephone, Internet, or Employee Self-Service Kiosk for medical reasons, you may contact your local personnel office for assistance. **If you contact your local personnel office, be sure to complete this worksheet first.**

Part 1 – Employee Information

Your Name (Last, First, Middle Initial)	Employee Identification Number

Type Of Action You Are Requesting

Open Season: ❑ New Enrollment ❑ Change Current Enrollment ❑ Cancel Enrollment

New Hire: ❑ New Enrollment ❑ Waive Enrollment

Special Enrollment (if you are notified that your current plan is being discontinued or your service area is reduced):

❑ Change Current Enrollment ❑ Cancel Enrollment

New Plan Enrollment Code _____ **New Plan Name** _____

Old Plan Enrollment Code (if you are changing plans or cancelling your current plan) _____

Please note:

Changes due to a qualifying life event (QLE) cannot be made via *PostalEASE*.

If you wish to make any change that is not listed under "Type of Action You Are Requesting" above, you must contact your local personnel office. You will need to present documentation showing that your election is due to a QLE and that you are contacting personnel within the required time frame.

For more information on qualifying life events, please refer to the RI 70-2, *Guide to FEHB Plans*, which is mailed to you each FEHB open season.

Your Other Group Insurance (Not used for waiving enrollment as a new employee)

Do you have any group health insurance coverage other than under the FEHB plan in which you are now enrolling or already enrolled?

❑ Yes ❑ No

Identify Type of Other Insurance Coverage

❑ Medicare Part A ❑ Medicare Part B

❑ Tricare or Champus Policy No. (if known) _____

Other Group Insurance Co. Name

_____

Policy No. (if known) _____

Your Gender: ❑ Male ❑ Female	**Married:** ❑ Yes ❑ No	**Daytime Telephone Number** (with area code)

PostalEASE FEHB Worksheet

Part 2 – Dependent Information (for Self and Family coverage only)

A complete mailing address (if different from yours) and other insurance information (if any) must be provided for each covered dependent. If you are adding or updating information for a dependent who does not reside with you, you will need to use the PostalEASE Employee Web on the Intranet (blue page) or at an Employee Self-Service Kiosk (available in some facilities) or visit your local personnel office to make or change your FEHB enrollment.

❑ **Please check here if all dependents reside with you.**

Family Members Names (Last, First, Middle Initial)	**Address** (Street, City, State, Zip) (If different from yours)	**Gender**	**Date of Birth**	**Relationship Code***	**SSN** (Optional)	**Other Group Insurance Co.** Name & Policy No.

* Relationship Codes:
01 = Spouse
02 = Spouse from a common law marriage (requires certification to be filed with local personnel office)
19 = Child
09 = Adopted child
10 = Foster child (requires certification to be filed with local personnel office)
17 = Stepson or stepdaughter
99 = Unmarried child over age 22 incapable of self-support (requires certification to be filed with local personnel office)

Employee Signature _____

Record the Confirmation Number You Receive From *PostalEASE Here* _____

For Personnel Office Use Only

REMARKS: Specific information on type of qualifying life event, reason for correction, type of certification, supporting documentation, reason for verification, etc., should be provided here.

_____

_____

_____

_____

Employing Office _____ Date Received in Personnel Office _____

Address _____

Contact Name _____ Date of QLE/Birth _____

File copy in OPF for any FEHB transaction processed by HR and ASC

USPS Employees:

Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

The following chart combines and replaces the OPM chart titled "Table of Permissible Changes in Enrollment for SF2809," previously published in the SF2809 Health Benefits Election Form, and the list of qualified life status changes published in 2002 and earlier editions of RI 70-2, Guide to Federal Employees Health Benefits Plans For United States Postal Service Employees, and the FEHB guides for USPS law enforcement and noncareer employees. (Since USPS is using PostalEASE for Federal Employees Health Benefits (FEHB) elections, SF2809 is no longer used.)

1. the term "permitting event" is used to describe events that allow an FEHB enrollment change—refer to the column in the Table labeled "FEHB Enrollment Change that May Be Permitted" and the headers "From Enrolled to Not Enrolled," "From Self Only to Self and Family," and "From One Plan or Option to Another;"

2. the term "qualified life status change" is used to describe events that allow employees who are paying premiums on a pre-tax basis to cancel coverage, or to reduce coverage from Self and Family to Self Only—refer to the column in the Table labeled "FEHB Enrollment Change that May Be Permitted" and the header "Cancel or Change to Self Only;"

3. the term "qualified life status change" is used to describe events that allow employees to waive (end) or participate (begin) pre-tax payment of health insurance premiums—refer to the column in the Table labeled "Premium Conversion Election Change that May Be Permitted."

All employees must meet the time limits stated in the far right column. Employees who are paying premiums on a pre-tax basis may only make changes that are in keeping with, or on account of, the change described in the table. For example, if you have a new baby, you would usually not cancel coverage. This restriction does not apply to open season changes, or to the initial opportunity to enroll. USPS career employees are automatically enrolled for pre-tax payment of health insurance premiums; noncareer employees must elect it. Employees who are paying premiums on an after-tax basis may cancel coverage or reduce coverage from Self and Family to Self Only at any time—they do not need to have an event.

USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

See explanatory note on first page of this chart.

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1A	Initial Opportunity to Enroll, for example: • New employee • Change from excluded position • Temporary (Non-career) employee who completes 1 year of service and is eligible to enroll under 5 USC 8906a	Yes	N/A	N/A	N/A	Automatic unless waived *(except for temporary employees)*	Yes *(Automatic for temporary employees)*	Within 60 days after becoming eligible
1B	Open Season	Yes	Yes	Yes	Yes	Yes	Yes	As announced by OPM
1C	Change in family status that results in increase or decrease in number of eligible family members, for example: • Marriage, divorce, annulment, legal separation • Birth, adoption, acquiring foster child or stepchild, issuance of court order requiring employee to provide coverage for child • Last dependent child loses coverage, for example child reaches age 22 or marries, stepchild moves out of employee's home, disabled child becomes capable of self-support, child acquires other coverage by court order • Death of spouse or dependent	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after change in family status
		Employees may enroll or change beginning 31 days before the event						
1D	Any change in employee's employment status that could result to entitlement to coverage, for example: • Reemployment after a break in service of more than 3 days • Return to pay status from nonpay status, or return to receiving pay sufficient to cover premium withholdings, if coverage terminated *(If coverage did not terminate, see 1G)*	Yes	N/A	N/A	N/A	Automatic unless waived	Yes	Within 60 days after employment status change
1E	Any change in employee's employment status that could affect the cost of insurance, including: • Change from temporary appointment with eligibility for coverage under 5 USC 8906a to appointment that permits receipt of government contribution • Change from full time to part time career or the reverse	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after employment status change

USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

See explanatory note on first page of this chart.

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only** [1]	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1F	Employee restored to civilian position after serving in uniformed service [2]	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after return to civilian position
1G	Employee, spouse or dependent: • begins nonpay status or insufficient pay [3] or • ends nonpay status or insufficient pay if coverage continued • *(If employee's coverage terminated, see 1D)* • *(If spouse's or dependent's coverage terminated, see 1M)*	No	No	No	Yes	Yes	Yes	Within 60 days after employment status change
1H	Salary of temporary employee insufficient to make withholdings for plan in which enrolled	N/A	No	Yes	Yes	Yes	Yes	Within 60 days after receiving notice from employing office
1I	Employee (or covered family member) enrolled in FEHB health maintenance organization (HMO) moves or becomes employed outside the geographic area from which the FEHB carrier accepts enrollments or, if already outside the area, moves further from this area. [4]	N/A	Yes	Yes	N/A *(see M1)*	No *(see M1)*	No *(see M1)*	Upon notifying employing office of move
1J	Transfer from post of duty within a state of the United States or the District of Columbia to post of duty outside a State of the United States or District of Columbia, or reverse	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after arriving at new post
		Employees may enroll or change beginning 31 days before leaving the old post of duty						
1K	Separation from Federal Employment when the employee or employee's spouse is pregnant	Yes	Yes	Yes	N/A	N/A	N/A	During empoyee's final pay period
1L	Employee becomes entitled to Medicare and wants to change to another plan or option. [5]	No	No	Yes *(Change may be made only once)*	N/A *(see M1)*	No *(see M1)*	No *(see M1)*	Any time beginning on the 30th day before becoming eligible for Medicare

[1] Employees may change to Self Only outside of Open Season only if **the QLE caused** the enrollee to be the last eligible family member under the FEHB enrollment. Employees may cancel enrollment outside if Open Season only if **the QLE caused** the enrollee and all the eligible family members to acquire other health insurance coverage.

[2] Employees who enter active military service are given the opportunity to terminate coverage. Termination for this reason does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement. Additional information on the FEHB coverage of employees who return from active military service will be forthcoming.

[3] Employees who begin nonpay status or insufficient pay **must** be given an opportunity to elect to continue or terminate coverage. A termination differs from a cancellation as it allows conversion to nongroup coverage and does not count against the employee for purposes of meeting the requirements for continuing coverage after retirement.

USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

See explanatory note on first page of this chart.

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1M	Employees or eligible family member **loses** coverage under FEHB or another group insurance plan including the following: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to self-only of the covering enrollment • Loss of coverage due to termination of membership in employee organization sponsoring the FEHB plan [6] • Loss of coverage under another federally-sponsored health benefits program, including: TRICARE, Medicare, Indian Health Service • Loss of coverage under Medicaid or similar State-sponsored program of medical assistance for the needy • Loss of coverage under a non-Federal health plan, including foreign, state or local government, private sector • Loss of coverage due to change in worksite or residence *(Employees in an FEHB HMO, also see 1I)*	Yes	Yes	Yes	Yes	Yes	Yes	Within 60 days after loss of coverage
		Employees may enroll or change beginning 31 days before the event						
1N	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-Federally employed spouse terminates employment to accompany the employee	Yes	Yes	Yes	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area to 180 days after arriving in the new commuting area

[4] This code reflects the FEHB regulation that gives employees enrolled in an FEHB HMO who **change from Self Only to Self and Family or from one plan or option to another** a different timeframe than that allowed under 1M. For change to Self Only, cancellation, or change in premium conversion status see 1M.

[5] This code reflects the FEHB regulation that gives employees enrolled in FEHB a one-time opportunity to change plans or options under a different timeframe than that allowed by 1P. For change to Self Only, cancellation, or change in premium conversion status, see 1P.

[6] If employees membership terminates, (e.g., for failure to pay membership dues), the employee organization will notify the agency to **terminate** the enrollment.

USPS Employees: Table of Permissible Changes in FEHB Enrollment and Pre-Tax/After-Tax Premium Payment

See explanatory note on first page of this chart.

	Qualifying Life Events (QLEs) that May Permit Change in FEHB Enrollment or Premium Conversion Election	FEHB Enrollment Change that May Be Permitted				Premium Conversion Election Change that May Be Permitted		Time Limits in which Change May Be Permitted
Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only**	**Participate**	**Waive**	**When You Must File Health Benefits Election with Your Employing Office**
1O	Employee or eligible family member loses coverage due to discontinuation in whole or part of FEHB plan[7]	Yes	Yes	Yes	Yes	Yes	Yes	During open season, unless OPM sets a different time
1P	Employee or eligible family member **gains** coverage under FEHB or another group insurance plan, including the following: • Medicare *(Employees who become eligible for Medicare and want to change plans or options, see 1I)* • TRICARE for Life, due to enrollment in Medicare • TRICARE due to change in employment status, including: (1) entry into active military service, (2) retirement from reserve military service under chapter 67, title 10 • Medicaid or similar state sponsored program of medical assistance for the needy • Health insurance acquired due to change of worksite or residence that affects eligibility for coverage • Health insurance acquired due to spouse's or dependent's change in employment status (including state, local or foreign government or private sector employment)[8]	No	No	No	Yes	Yes	Yes	Within 60 days after QLE
1Q	Change in spouse's or dependent's coverage options under a non-Federal health plan, for example: • Employer starts or stops offering a different type of coverage *(If no other coverage is available, also see 1M)* • Change in cost of coverage • HMO adds a geographic service area that now makes spouse eligible to enroll in that HMO • HMO removes a geographic area that makes spouse ineligible for coverage under that HMO, but other plans or options are available *(If no other coverage is available, see 1M)*	No	No	No	Yes	Yes	Yes	Within 60 days after QLE

[7] Employee's failure to select another FEHB plan is deemed a cancellation for purposes of meeting the requirements for continuing coverage after retirement.

[8] Under IRS rules, this includes start/stop of employment or nonpay status, strike or lockout, and change in worksite.

Stop Health Care Fraud

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium. OPM's Office of the Inspector General investigates allegations of fraud, waste, and abuse in the FEHB Program, regardless of the agency that employs you or from which you retired.

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

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

CALL – THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

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

- Remember, FEHB-covered family members may not include:
  - your former spouse after a divorce decree or annulment is final (even if a court orders it); or
  - your child over age 22 unless he/she became incapable of self support before age 22.
- If you have any questions about the eligibility of a dependent, check with your Human Resources office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Plan Comparisons

Nationwide Fee-For-Service Plans Open to All

(Pages 30 through 34)

Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO) – A Fee-For-Service plan provides flexibility in using medical providers of your choice. You may choose medical providers who have a contract with the health plan to offer discounted charges. You can also choose medical providers who are not contracted with the plan, but you will pay more of the cost.

Medical providers who have contracts with the health plan (Preferred Provider Organization or PPO) offer discounted charges. You usually pay a copayment or a coinsurance charge and do not file claims or other paperwork. Going to a PPO hospital does not guarantee PPO benefits for all services received in the hospital. Lab work and radiology services from independent practitioners within the hospital are frequently not covered by a PPO agreement. If you receive treatment from medical providers who are not contracted with the health plan, you either pay them directly and submit a claim for reimbursement to the health plan or the health plan pays the provider directly according to plan coverage, and you pay a deductible and coinsurance. You pay a greater amount of the out-of-pocket cost.

PPO-only – A PPO-only plan provides medical services only through medical providers that have contracts. There is no medical coverage if you or your family members receive care from providers not contracted with the plan.

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

Doctors shows what you pay for inpatient surgical services and for office visits.

Your share of **Hospital Inpatient Room and Board** covered charges is shown.

The **Generic** drug figure is the copayment or coinsurance most commonly paid by members of this health plan for a Generic formulary drug.

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self Only	Self & Family	Self Only	Self & Family
APWU Health Plan-High (APWU)	800/222-2798	471	472	36.06	66.66
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	27.05	64.21
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	Local phone #	111	112	17.10	40.05
GEHA Benefit Plan-High (GEHA)	800/821-6136	311	312	65.63	127.53
GEHA Benefit Plan-Std (GEHA)	800/821-6136	314	315	14.97	34.03
Mail Handlers-High (MH)	800/410-7778	451	452	127.35	242.94
Mail Handlers-Std (MH)	800/410-7778	454	455	21.50	43.04
NALC	888/636-6252	321	322	34.65	52.65
PBP Health Plan-High (PBP)	800-544-7111	361	362	149.72	304.79
PBP Health Plan-Std (PBP)	800-544-7111	364	365	49.70	111.01

Brand Name/Non-formulary is what you pay for a manufacturer's Brand name drug on this health plan's formulary. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in this column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a Non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

The prescription drug copayments or coinsurances described in this chart do not represent the complete range of cost-sharing under these plans. Many plans have variations in their prescription drug benefits (e.g., you pay the greater of a dollar amount or a percentage, or you pay one amount for your first prescription and then a different amount for refills). The prescription drug figures in this chart show what most plan members pay for their medications under each plan. **You must read the plan brochure for a complete description of prescription drug and all other benefits.**

Plan	Benefit Type	Medical-Surgical – You Pay								
		Deductible			Copay ($)/Coinsurance (%)					
		Per Person		Hospital Inpatient	Doctors		Hospital Inpatient	Prescription Drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services	R&B	Generic	Brand Name / Non-formulary	Mail Order Discounts
APWU -High	PPO Non-PPO	$275 $500	None None	None $300	$18 30%	10% 30%	10% 30%	$8 50%	25%/25% 50%/50%	Yes No
BCBS -Std	PPO Non-PPO	$250 $250	None None	$100 $300	$15 25%	10% 25%	Nothing 30%	25% 45%+	25%/25% 45%+/45%+	Yes No
BCBS -Basic	PPO Only	None	None	$100/day x 5	$20	$100	Nothing	$10	$25/$35 or 50%	No
GEHA -High	PPO Non-PPO	$350 $350	None None	$100 $300	$20 25%	10% 25%	Nothing Nothing	$5 $5	$25/N/A $25+/N/A	Yes Yes
GEHA -Std	PPO Non-PPO	$450 $450	None None	None None	$10 35%	15% 35%	15% 35%	$5 $5	50%/N/A 50%+/N/A	No No
MH -High	PPO Non-PPO	$250 $300	$200 $200	$100 $300	$20/$10 30%	10% 30%	Nothing 30%	$10 50%	$25/$40 50%/50%	Yes Yes
MH -Std	PPO Non-PPO	$300 $350	$350 $350	$200 $400	$20/$10 30%	10% 30%	Nothing 30%	$10 50%	$30/$45 50%/50%	Yes Yes
NALC	PPO Non-PPO	$250 $300	None $25	None $100	$20 30%	10% 30%	10% 30%	25% 50%	25%/25% 50%/50%+	Yes No
PBP -High	PPO Non-PPO	$200 $500	$90 $90	None $150	10% 25%	10% 25%	10% 25%	$3 20%+	$25 or 20%/$40 or 20% 20%+/20%+	Yes Yes
PBP -Std	PPO Non-PPO	$250 $600	$90 $90	None $250	$8 30%	9% 30%	10% 30%	$4 30%+	$30 or 20%/$40 or 20% 30%+/30%+	Yes Yes

Nationwide Fee-for-Service Plans Open to All

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. Here is a brief explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• Were you satisfied with the choices your health plan gave you to select a personal doctor? • Were you satisfied with the time it takes to get a referral to a specialist?
Getting Care Quickly	• Did you get the advice or help you needed when you called your doctor during regular office hours? • Could you get an appointment for regular or routine care when you wanted?
How Well Doctors Communicate	• Did your doctor listen carefully to you and explain things in a way you could understand? • Did your doctor spend enough time with you?
Customer Service	• Was your plan helpful when you called its customer service department? • Did you have paperwork problems? • Were the plan's written materials understandable?
Claims Processing	• Did your plan pay your claims correctly and in a reasonable time?

		Member Survey Results ● above average, ◒ average, ○ below average					
Plan Name	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
APWU Health Plan-High	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 Benefit Plan-High	45	◒	●	◒	◒	●	◒
Mail Handlers Benefit Plan-Std	45	◒	●	◒	◒	●	◒
NALC	32	●	◒	◒	◒	●	●
PBP Health Plan-High	36	◒	◒	●	●	○	○
PBP Health Plan-Std	36	◒	◒	●	●	○	○

Fee-for-Service Plans – Blue Cross and Blue Shield Service Benefit Plan – Member Survey Results for Select States

Again this year we are providing more detailed information regarding the quality of services provided by our health plans. We are including the results of the Member Satisfaction survey at the *state level* for eight local Blue Cross Blue Shield (BCBS) Plans. Prior to 2003, BCBS conducted a single survey representing all of its members *nationwide*. We now provide local member satisfaction results for both the Standard Option plan and the Basic Option plan.

In the future, we expect to increase the number of plans conducting local or regional Member Satisfaction surveys. We look forward to making those results available to help you select quality health plans.

Below are Member Survey ratings for local BCBS plans by location.

Plan Name		Location	Plan Code	Member Survey Results ● above average, ◒ average, ○ below average: Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Arizona	10	◒	○	○	○	◒	◒
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	California	10	◒	◒	◒	◒	◒	◒
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	District of Columbia	10	◒	◒	○	○	○	◒
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Florida	10	●	◒	○	○	◒	◒
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Illinois	10	●	◒	◒	◒	◒	◒
	- Basic		11	○	○	○	◒	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Maryland	10	◒	◒	○	◒	◒	◒
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Texas	10	●	◒	○	◒	◒	◒
	- Basic		11	○	○	○	○	○	○
Blue Cross and Blue Shield Service Benefit Plan	- Standard	Virginia	10	●	◒	◒	◒	●	●
	- Basic		11	○	○	◒	○	●	●

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Plan Comparisons

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

(Pages 36 through 38)

Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO) – A Fee-for-Service plan provides flexibility in using medical providers of your choice. You may choose medical providers who have a contract with the health plan to offer discounted charges. You can also choose medical providers who are not contracted with the plan, but you will pay more of the cost.

Medical providers who have contracts with the health plan (Preferred Provider Organization or PPO) offer discounted charges. You usually pay a copayment or a coinsurance charge and do not file claims or other paperwork. Going to a PPO hospital does not guarantee PPO benefits for all services received in the hospital. Lab work and radiology services from independent practitioners within the hospital are frequently not covered by a PPO agreement. If you receive treatment from medical providers who do not contract with the health plan, you either pay them directly and submit a claim for reimbursement to the health plan or the health plan pays the provider directly according to plan coverage, and you pay the remaining charges directly. You pay a greater amount of the out-of-pocket cost.

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

How to read this chart:

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

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

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

In some plans your combined **Prescription Drug** purchases from 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 **Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

Doctors shows what you pay for inpatient surgical services and for office visits.

Your share of **Hospital Inpatient Room and Board** covered charges is shown.

The **Generic** drug figure is the copayment or coinsurance most commonly paid by members of this health plan for a Generic formulary drug.

Plan Name	Telephone Number	Enrollment Code		Biweekly Premium Your Share	
		Self Only	Self & Family	Self Only	Self & Family
Rural Carrier Benefit Plan (Rural)	800/638-8432	381	382	53.84	72.31

Brand Name/Non-formulary is what you pay for a manufacturer's Brand name drug on this health plan's formulary. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in this column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a Non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

The prescription drug copayments or coinsurances described in this chart do not represent the complete range of cost-sharing under these plans. Many plans have variations in their prescription drug benefits (e.g., you pay the greater of a dollar amount or a percentage, or you pay one amount for your first prescription and then a different amount for refills). The prescription drug figures in this chart show what most plan members pay for their medications under each plan. **You must read the plan brochure for a complete description of prescription drug and all other benefits.**

Plan	Benefit Type	Medical-Surgical – You Pay								
		Deductible			Copay ($)/Coinsurance (%)					
		Per Person		Hospital Inpatient	Doctors		Hospital Inpatient	Prescription Drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services	R&B	Generic	Brand Name / Non-formulary	Mail Order Discounts
Rural	PPO	$350	$200	$100	$20	10%	Nothing	30%	30%/30%	Yes
	Non-PPO	$400	$200	$300	25%	20%	20%	30%	30%/30%	Yes

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

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. Here is a brief explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• Were you satisfied with the choices your health plan gave you to select a personal doctor? • Were you satisfied with the time it takes to get a referral to a specialist?
Getting Care Quickly	• Did you get the advice or help you needed when you called your doctor during regular office hours? • Could you get an appointment for regular or routine care when you wanted?
How Well Doctors Communicate	• Did your doctor listen carefully to you and explain things in a way you could understand? • Did your doctor spend enough time with you?
Customer Service	• Was your plan helpful when you called its customer service department? • Did you have paperwork problems? • Were the plan's written materials understandable?
Claims Processing	• Did your plan pay your claims correctly and in a reasonable time?

		Member Survey Results ● above average, ◒ average, ○ below average					
Plan Name	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Rural Carrier Benefit Plan	38	●	●	●	◒	●	◒

Plan Comparisons

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

(Pages 40 through 65)

Health Maintenance Organization (HMO) – A Health Maintenance Organization 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. If you travel or are away from home for extended periods, some HMOs are affiliated with or have arrangements with HMOs in other service areas for non-emergency care (reciprocity). 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 sometimes a copayment for in-hospital care.
- Most HMOs ask you to choose a doctor or medical group as 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.
- Medical Care from a provider not in the plan's network is not covered unless it's emergency care or your plan has an arrangement with another plan.

Plans Offering a Point-of-Service (POS) Product – A Point-of-Service plan is like having two plans in one – an HMO and a FFS plan. A POS allows you and your family members to choose between using, (1) a network of providers in a designated service area (like an HMO), or (2) out-of-network providers (like a FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non-HMO or non-POS providers, you pay a deductible and coinsurance. Your out-of-pocket costs are higher and you file your own claims for reimbursement.

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 Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
Arizona						
Aetna - Phoenix/Tucson Areas	800/537-9384	WQ1	WQ2	15.84	39.61	NCQA
Health Net of Arizona, Inc. - Maricopa/Pima/Other AZ counties	800/289-2818	A71	A72	17.03	43.17	NCQA
PacifiCare of Arizona - Maricopa, Pima County & Apache Junction	800-531-3341	A31	A32	18.03	47.01	NCQA
California						
Aetna - Los Angeles and San Diego Areas	800/537-9384	2X1	2X2	12.94	31.88	NCQA
Blue Cross- HMO - Most of California	800/235-8631	M51	M52	17.38	44.59	NCQA
Blue Shield of CA Access+ - Most of California	800/880-8086	SJ1	SJ2	17.90	44.41	NCQA
Health Net of California - Most of California	800/522-0088	LB1	LB2	17.30	40.95	NCQA
Kaiser Foundation Health Plan, Inc.-High -Northern California	800/464-4000	591	592	19.17	54.67	NCQA
Kaiser Foundation Health Plan, Inc.-Std - Northern California	800/464-4000	594	595	14.77	35.25	NCQA
Kaiser Foundation Health Plan, Inc.-High -Southern California	800/464-4000	621	622	17.52	40.50	NCQA
Kaiser Foundation Health Plan, Inc.-Std - Southern California	800/464-4000	624	625	13.72	31.70	NCQA
PacifiCare of California - Most of California	800-531-3341	CY1	CY2	15.86	36.79	NCQA
UHP Healthcare - LA/Orange/San Bernardino Counties	800/544-0088	C41	C42	11.10	23.84	JCAHO
Universal Care-High -Southern California	800/635-6668	6Q1	6Q2	14.60	38.55	NCQA
Colorado						
Aetna - Denver Area	800/537-9384	9E1	9E2	17.81	55.53	NCQA
Kaiser Permanente-High -Denver/Colorado Springs areas	800/632-9700	651	652	18.10	43.62	NCQA
Kaiser Permanente-Std - Denver/Colorado Springs areas	800/632-9700	654	655	13.74	33.11	NCQA
PacifiCare of Colorado - Denver/Colorado Springs/Ft.Collins	800/877-9777	D61	D62	19.52	58.45	NCQA
Connecticut						
ConnectiCare - All of Connecticut	800/251-7722	TE1	TE2	18.93	73.71	NCQA
Delaware						
Coventry Health Care of Delaware -High -Most of Delaware	800/833-7423	2J1	2J2	38.58	136.05	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Arizona											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	○	○	○	◒	◒	◒
Health Net of Arizona, Inc.	$15/$30	$200/day x 3	$15	$30/$50	Yes	○	◒	○	◒	○	○
PacifiCare of Arizona	$15/$30	$150/day x 3	$10	$30/$50	Yes	○	○	○	○	○	◒
California											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	○	○	○	○	○	◒
Blue Cross- HMO	$10/$10	None	$5	$10/50%	Yes	◒	○	○	○	○	◒
Blue Shield of CA Access+	$10/$10	None	$5	$10/$25	Yes	◒	○	○	◒	◒	◒
Health Net of California	$15/$15	$250	$15	$35/$50	Yes	◒	○	○	◒	◒	◒
Kaiser Foundation Health Plan, Inc.-High	$15/$15	$100	$10	$25/$25	No	●	○	○	○	●	◒
Kaiser Foundation Health Plan, Inc.-Std	$30/$30	$500	$10	$30/$30	No	●	○	○	○	●	◒
Kaiser Foundation Health Plan, Inc.-High	$15/$15	$100	$10	$25/$25	No	●	○	○	○	●	◒
Kaiser Foundation Health Plan, Inc.-Std	$30/$30	$500	$10	$30/$30	No	●	○	○	○	●	◒
PacifiCare of California	$10/$30	$100/day x 3	$10	$30/$50	Yes	◒	○	○	○	◒	◒
UHP Healthcare	$10/$10	$300	$10	$30/$50	No						
Universal Care-High	$10/$10	$300	$10	$20/$30	Yes	○	○	○	◒	◒	◒
Colorado											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
Kaiser Permanente-High	$15/$30	$250	$10	$25/$25	No	◒	◒	◒	○	◒	◒
Kaiser Permanente-Std	$20+20%/$40+20%	$250/dayx3	$15	$35/$35	No	◒	◒	◒	○	◒	◒
PacifiCare of Colorado	$20/$40	$400/day x 5	$10	$40/$50	Yes	○	◒	●	◒	◒	●
Connecticut											
ConnectiCare	$15/$20	$50 per day/$250 max	$15	$20/$35	Yes	●	●	●	◒	◒	●
Delaware											
Coventry Health Care of Delaware -High	$10/$20	None	$10	$20/$45	Yes						

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 Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
District of Columbia						
Aetna Open Access-High -Washington, DC Area	800/537-9384	JN1	JN2	21.26	44.35	NCQA
Aetna Open Access-Basic - Washington, DC Area	800/537-9384	JN4	JN5	13.04	30.51	NCQA
CareFirst BlueChoice - Washington, D.C. Metro Area	866/520-6099	2G1	2G2	26.90	56.55	NCQA
Kaiser Permanente-High -Washington, DC area	301/468-6000	E31	E32	17.91	42.63	NCQA
Kaiser Permanente-Std - Washington, DC area	301/468-6000	E34	E35	14.42	34.31	NCQA
M.D. IPA - Washington, DC area	800/251-0956	JP1	JP2	18.12	43.50	NCQA
Florida						
Av-Med Health Plan-High -Broward, Dade and Palm Beach	800/882-8633	ML1	ML2	17.67	56.31	NCQA
Av-Med Health Plan-Std - Broward, Dade and Palm Beach	800/882-8633	ML4	ML5	14.12	36.71	NCQA
Capital Health Plan - Tallahassee area	850/383-3311	EA1	EA2	18.34	79.92	NCQA
Humana Medical Plan - South Florida	888/393-6765	EE1	EE2	17.08	39.29	URAC
JMH Health Plan - Broward-Dade counties	800/721-2993	J81	J82	16.53	40.90	
Total Health Choice - Broward/Dade/Palm Beach Counties	800/213-1133	4A1	4A2	14.92	37.18	
Vista Healthplan - South Florida	866/847-8235	3N1	3N2	24.90	141.80	
Vista Healthplan - Gainesville	866/847-8235	UL1	UL2	17.73	68.75	
Vista Healthplan - Tallahassee	866/847-8235	Y91	Y92	14.87	39.71	
Vista Healthplan of South Florida - Southern Florida	800/441-5501	5E1	5E2	15.08	41.48	
Georgia						
Aetna - Atlanta and Athens Areas	800/537-9384	2U1	2U2	17.19	41.46	NCQA
Kaiser Permanente-High -Atlanta area	800/611-1811	F81	F82	15.86	40.26	NCQA
Kaiser Permanente-Std - Atlanta area	800/611-1811	F84	F85	11.94	30.31	NCQA
Guam						
PacifiCare Asia Pacific-High -Guam/N.Mariana Islands/Belau	671/647-3526	JK1	JK2	38.42	109.80	
PacifiCare Asia Pacific-Std - Guam/N.Mariana Islands/Belau	671/647-3526	JK4	JK5	15.40	40.66	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
District of Columbia											
Aetna Open Access-High	$15/$20	$150/day x 3	$10	$25/$40	No	○	◒	◒	◒	◒	◒
Aetna Open Access-Basic	$20/$30	$150/day x 5	$10	$25/$40	No	○	◒	◒	◒	◒	◒
CareFirst BlueChoice	$20/$30	$100 per adm	$10	$25/$40	Yes	○	○	○	◒	○	○
Kaiser Permanente-High	$10/$20	$100	$10/$20Net	$20/$55	Yes	◒	○	○	○	◒	◒
Kaiser Permanente-Std	$30/$30	$250/dayx3	$15	$25/$40	Yes	◒	○	○	○	◒	◒
M.D. IPA	$10/$20	$100	$8	$20/$35	No	◒	◒	○	◒	●	◒
Florida											
Av-Med Health Plan-High	$15/$25	$100/dayx5	$15	$30/$50	No	◒	○	○	○	◒	◒
Av-Med Health Plan-Std	$25/$40	$125/dayx5	$20	$40/$60	No	◒	○	○	○	◒	◒
Capital Health Plan	$15/$25	$250	$15	$30/$50	No	●	●	◒	●	●	●
Humana Medical Plan	$10/$20	$100/day x 3	$5/$20	$20/$40	No	◒	○	○	◒	◒	○
JMH Health Plan	$10/$10	None	$5	50%/50%	Yes						
Total Health Choice	$10/$10	$100	$5	$15/$15	No						
Vista Healthplan	$15/$25	$100/day x 3	$10	$25/$80	Yes	○	○	○	○	○	○
Vista Healthplan	$15/$25	$100/day x 3	$10	$25/$80	Yes	○	○	○	○	○	○
Vista Healthplan	$15/$25	$100/day x 3	$10	$25/$80	Yes	○	○	○	○	○	○
Vista Healthplan of South Florida	$20/$30	$200	$15	$30/$50	Yes	○	○	○	○	○	○
Georgia											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	○	○	○	○	○	○
Kaiser Permanente-High	$15/$15	$250	$10/$16 Com	$20/$26	No	●	◒	◒	◒	●	◒
Kaiser Permanente-Std	$20/$30	$250/dayx3	$15 /$21 Com	$25/$31	No	●	◒	◒	◒	●	◒
Guam											
PacifiCare Asia Pacific-High	$10/$25	$100	$5	$10/$20	No	●	○	◒	●	◒	◒
PacifiCare Asia Pacific-Std	$15/$25	$250	$10	$20/$30	No	●	○	◒	●	◒	◒

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 Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
Hawaii						
HMSA - All of Hawaii	808/948-6499	871	872	16.62	37.00	NCQA NCQA
Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu	808/432-5955	631	632	19.21	41.30	NCQA
Kaiser Permanente-Std - Islands of Hawaii/Maui/Oahu	808/432-5955	634	635	14.91	32.07	NCQA
Idaho						
Group Health Cooperative-High -Kootenai and Latah	888/901-4636	VR1	VR2	19.56	71.94	NCQA
Group Health Cooperative-Std - Kootenai and Latah	888/901-4636	VR4	VR5	16.55	38.07	NCQA
Illinois						
Aetna - Chicago Area	800/537-9384	IK1	IK2	17.11	42.23	NCQA
BlueCHOICE - Madison and St. Clair counties	800/634-4395	9G1	9G2	22.76	43.23	NCQA
Group Health Plan-High -Southern/Cental	800/755-3901	MM1	MM2	51.07	92.45	URAC
Health Alliance HMO - Central/E.Central/N.West/South/West IL	800/851-3379	FX1	FX2	26.62	71.17	NCQA
Humana Health Plan Inc.-High -Chicago area	888/393-6765	751	752	19.33	44.45	URAC
Humana Health Plan Inc.-Std - Chicago area	888/393-6765	754	755	13.71	31.52	URAC
John Deere Health Plan - Bloomingtn/Moline/Peoria/RockIsld	800/247-9110	YH1	YH2	17.04	41.76	NCQA
Mercy Health Plans/Premier Health Plans - Southwest Illinois	800/327-0763	7M1	7M2	62.03	116.15	
OSF HealthPlans-High -Central/Central-Northwestern Illinois	800/673-5222	9F1	9F2	18.50	80.44	NCQA
PersonalCare's HMO - Central Illinois	800/431-1211	GE1	GE2	14.89	38.28	NCQA
Unicare HMO - Chicagoland Area	888/234-8855	171	172	18.84	77.94	NCQA
Union Health Service - Chicago area	312/829-4224	761	762	14.76	36.60	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Hawaii											
HMSA - In-Network	$15/$15	None	$5	$20/50%	Yes	●	●	●	●	◒	●
HMSA - Out-of-Network	30% sch +/30% sch +	30% sch +	$5+20%+	$20+20%+/50%+	No	●	●	●	●	◒	●
Kaiser Permanente-High	$12/$12	None	$10	$10/$10	Yes	●	◒	◒	◒	◒	◒
Kaiser Permanente-Std	$20/$20	10%	$10	$10/$10	Yes	●	◒	◒	◒	◒	◒
Idaho											
Group Health Cooperative-High	$15/$15	$200/day x 3	$15	$25/$50	N/A	○	◒	◒	◒	◒	◒
Group Health Cooperative-Std	$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes	○	◒	◒	◒	◒	◒
Illinois											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
BlueCHOICE	$10/$10	None	$7	$12/$25	Yes	◒	●	●	●	◒	●
Group Health Plan-High	$10/$20	$100	$10	$20/$35	Yes	◒	●	●	●	◒	◒
Health Alliance HMO	$15/$15	$250	$10	$20/$40	No	●	●	●	●	◒	●
Humana Health Plan Inc.-High	$10/$20	$100/day x 3	$5/$15	$15/$35	No	○	◒	○	◒	○	○
Humana Health Plan Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	○	◒	○	◒	○	○
John Deere Health Plan	$15/$25	None	$10	$20/$35	Yes	●	●	●	◒	●	●
Mercy Health Plans/Premier Health Plans - In-Network	$10/$20	None	$10	$20/$35	Yes	◒	●	◒	◒	◒	●
Mercy Health Plans/Premier Health Plans - Out-of-Network	30%/30%	30%	N/A	N/A	N/A	◒	●	◒	◒	◒	●
OSF HealthPlans-High	$20/$20	$500	$10	$20/$40	Yes	●	●	●	●	●	●
PersonalCare's HMO	$20/$20	$100/day x 5	$10	$20/$50	No	◒	◒	●	◒	○	◒
Unicare HMO	$15/$15	None	$5	$15/$25	N/A	◒	◒	◒	◒	◒	○
Union Health Service	$10/$10	None	$15	$15/$15	No						

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

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Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
Indiana						
Advantage Health Solutions, Inc.-High -Most of Indiana	800/553-8933	6Y1	6Y2	28.94	79.20	NCQA
Aetna - Northern Indiana	800/537-9384	IK1	IK2	17.11	42.23	NCQA
Aetna - Southeastern Indiana	800/537-9384	RD1	RD2	18.23	44.30	NCQA
Arnett HMO - Lafayette area	765/448-7440	G21	G22	16.24	42.23	NCQA
Health Alliance HMO - Fountain/Vermillion/Warren Counties	800/851-3379	FX1	FX2	26.62	71.17	NCQA
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	44.14	105.34	NCQA
Humana Health Plan Inc.-High -Lake/Porter/LaPorte Counties	888/393-6765	751	752	19.33	44.45	URAC
Humana Health Plan Inc.-Std - Lake/Porter/LaPorte Counties	888/393-6765	754	755	13.71	31.52	URAC
Physicians Health Plan of Northern Indiana - Northeast Indiana	260/432-6690	DQ1	DQ2	61.35	133.15	
Unicare HMO - Lake/Porter Counties	888/234-8855	171	172	18.84	77.94	NCQA
Iowa						
Avera Health Plans - Northwestern Iowa	888/322-2115	AV1	AV2	40.00	102.70	JCAHO
Coventry Health Care of Iowa-High -Central Iowa/Cedar Rapids/Sioux City	800/257-4692	SV1	SV2	17.03	56.69	NCQA
Health Alliance HMO - Central and Eastern Iowa	800/851-3379	FX1	FX2	26.62	71.17	NCQA
John Deere Health Plan - Central/Eastern Iowa	800/247-9110	YH1	YH2	17.04	41.76	NCQA
Sioux Valley Health Plan-High -Northwestern Iowa	800/752-5863	AU1	AU2	67.47	159.25	NCQA NCQA
Sioux Valley Health Plan-Std - Northwestern Iowa	800/752-5863	AU4	AU5	44.72	106.44	NCQA NCQA
Kansas						
Aetna - Kansas City Area	800/537-9384	KS1	KS2	16.24	41.72	NCQA
Coventry Health Care of Kansas-Wichita/Salinas-High -Wichita/Salina areas	800/664-9251	7W1	7W2	17.67	48.37	
Coventry Health Care of Kansas-Wichita/Salinas-Std - Wichita/Salina areas	800/664-9251	7W4	7W5	16.73	42.66	
Coventry Health Care of Kansas-Kansas City-High -Kansas City area	800/969-3343	HA1	HA2	16.74	43.21	
Coventry Health Care of Kansas-Kansas City-Std - Kansas City area	800/969-3343	HA4	HA5	15.86	40.93	
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	38.11	91.47	NCQA
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	14.30	32.90	NCQA
Preferred Plus of Kansas - S. Central Area	800/660-8114	VA1	VA2	64.78	231.86	JCAHO

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Indiana											
Advantage Health Solutions, Inc.-High	$15/$30	$400x2/Yr	$10	$30/$50	Yes	○	◒	◒	◒	◒	○
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	○	◒	◒	◒	○	○
Arnett HMO	$10/$10	$100	$10	$20/$40	N/A	◒	◒	●	◒	◒	◒
Health Alliance HMO	$15/$15	$250	$10	$20/$40	No	●	●	●	●	◒	●
Humana Health Plan	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	◒	◒	◒	○	○
Humana Health Plan Inc.-High	$10/$20	$100/day x 3	$5/$15	$15/$35	No	○	◒	○	◒	○	○
Humana Health Plan Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	○	◒	○	◒	○	○
Physicians Health Plan of Northern Indiana	$15/$15	20%	$10	$20/$40	No	●	●	●	◒	●	●
Unicare HMO	$15/$15	None	$5	$15/$25	N/A	◒	◒	◒	◒	◒	○
Iowa											
Avera Health Plans	$10/$15	$100/dayx3	$10	$20	Yes						
Coventry Health Care of Iowa-High	$15/$15	$100/day x 3	$5	$15/$30	Yes	◒	●	●	●	◒	◒
Health Alliance HMO	$15/$15	$250	$10	$20/$40	No	●	●	●	●	◒	●
John Deere Health Plan	$15/$25	None	$10	$20/$35	Yes	●	●	●	◒	●	●
Sioux Valley Health Plan - In-Network	$20/$30	$100/day x 5	$15	$30/$50	$30	○	●	●	◒	◒	◒
Sioux Valley Health Plan - Out-of-Network	40%/40%	40%	N/A	N/A/N/A	No	○	●	●	◒	◒	◒
Sioux Valley Health Plan - In-Network	$25/$25	$100/day x 5	$15	$30/$50	No	○	●	●	◒	◒	◒
Sioux Valley Health Plan - Out-of-Network	40%/40%	40%	N/A	N/A/N/A	No	○	●	●	◒	◒	◒
Kansas											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
Coventry Health Care of Kansas-Wichita/Salinas-High	$15/$30	$100/day x 3	$10	$30/$55	Yes	○	●	◒	◒	◒	◒
Coventry Health Care of Kansas-Wichita/Salinas-Std	$20/$35	$300/day x 3	$10	$30/$55	Yes	○	●	◒	◒	◒	◒
Coventry Health Care of Kansas-Kansas City-High	$15/$30	$100/day x 3	$10	$30/$55	Yes	○	●	◒	◒	◒	◒
Coventry Health Care of Kansas-Kansas City-Std	$20/$35	$300/day x 3	$10	$30/$55	Yes	◒	●	◒	◒	◒	◒
Humana Health Plan, Inc.-High	$10/$20	$100/day x 3	$5/$20	$20/$40	No	◒	◒	◒	◒	◒	◒
Humana Health Plan, Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	◒	◒	◒	◒	◒
Preferred Plus of Kansas	$20/$25	$150 X 5 days per yr	$10	$30/$50	Yes						

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 Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
Kentucky						
Aetna - Northern Kentucky	800/537-9384	RD1	RD2	18.23	44.30	NCQA
Humana Health Plan - Louisville area	888/393-6765	D21	D22	44.14	105.34	NCQA
United Healthcare of Ohio, Inc.-High -Northern Kentucky	800/231-2918	3U1	3U2	96.53	202.82	NCQA
United Healthcare of Ohio, Inc.-Std - Northern Kentucky	800/231-2918	3U4	3U5	47.45	88.70	NCQA NCQA
Louisiana						
Coventry Healthcare Louisiana-High -New Orleans area	800/341-6613	BJ1	BJ2	17.45	40.53	
Coventry Healthcare Louisiana-High -Baton Rouge area	800/341-6613	JA1	JA2	18.29	42.48	
Vantage Health Plan - Monroe/Shreveport/Alexandria Areas	888/823-1910	MV1	MV2	32.81	79.30	
Maryland						
Aetna Open Access-High -Northern/Central/Southern Maryland	800/537-9384	JN1	JN2	21.26	44.35	NCQA
Aetna Open Access-Basic - Northern/Central/Southern Maryland	800/537-9384	JN4	JN5	13.04	30.51	NCQA
CareFirst BlueChoice - All of Maryland	866/520-6099	2G1	2G2	26.90	56.55	NCQA
Coventry Health Care of Delaware -High -Most of Maryland	800/833-7423	IG1	IG2	38.01	134.60	
Kaiser Permanente-High -Baltimore/Washington, DC areas	301/468-6000	E31	E32	17.91	42.63	NCQA
Kaiser Permanente-Std - Baltimore/Washington, DC areas	301/468-6000	E34	E35	14.42	34.31	NCQA
M.D. IPA - All of Maryland	800/251-0956	JP1	JP2	18.12	43.50	NCQA
Massachusetts						
BlueChip, Coordinated Health Partners, Inc. - Southeastern Massachusetts	401/459-5500	DA1	DA2	33.66	147.15	NCQA NCQA
ConnectiCare - Counties Hampden, Hampshire, Franklin	800/251-7722	TE1	TE2	18.93	73.71	NCQA
Fallon Community Health Plan-High -Central/Eastern Massachusetts	800/868-5200	JV1	JV2	33.31	104.98	NCQA
Fallon Community Health Plan-Std - Central/Eastern Massachusetts	800/868-5200	JV4	JV5	18.25	44.36	NCQA

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Kentucky											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
Humana Health Plan	$15/$25	$250/day x 3	$10/$25	$25/$45	No	◒	◒	◒	◒	○	○
United Healthcare of Ohio, Inc.-High	$15/$15	$250	$10	$15/$30	Yes	◒	●	●	◒	○	◒
United Healthcare of Ohio, Inc. - In-Network	$20/$20	$500	$10	$20/$40	Yes	◒	●	●	◒	○	◒
United Healthcare of Ohio, Inc. - Out-of-Network	30%/30%	30%	$10	$20/$40	Yes	◒	●	●	◒	○	◒
Louisiana											
Coventry Healthcare Louisiana-High	$15/$15	$100/day x 3	$10	$20/$45	Yes	◒	◒	○	●	◒	◒
Coventry Healthcare Louisiana-High	$15/$15	$100/day x 3	$10	$20/$45	Yes	◒	◒	○	●	◒	◒
Vantage Health Plan	$15/$15	$250	$10	$20/$35	Yes						
Maryland											
Aetna Open Access-High	$15/$20	$150/day x 3	$10	$25/$40	No	○	◒	◒	◒	◒	◒
Aetna Open Access-Basic	$20/$30	$150/day x 5	$10	$25/$40	No	○	◒	◒	◒	◒	◒
CareFirst BlueChoice	$20/$30	$100 per adm	$10	$25/$40	Yes	○	○	○	◒	○	○
Coventry Health Care of Delaware -High	$10/$20	None	$10	$20/$45	Yes						
Kaiser Permanente-High	$10/$20	$100	$10/$20Net	$20/$55	Yes	◒	○	○	○	◒	◒
Kaiser Permanente-Std	$30/$30	$250/dayx3	$15	$25/$40	Yes	◒	○	○	○	◒	◒
M.D. IPA	$10/$20	$100	$8	$20/$35	No	◒	◒	○	◒	●	◒
Massachusetts											
BlueChip, Coordinated Health Partners, Inc. - In-Network	$15/$25	$500	$7	$30/$50	Yes	○	●	●	◒	◒	◒
BlueChip, Coordinated Health Partners, Inc. - Out-of-Network	30%/30%	None	$40+20%	$50+20%	$50+20% N/A	○	●	●	◒	◒	◒
ConnectiCare	$15/$20	$50 per day/$250 max	$15	$20/$35	Yes	◒	◒	●	◒	●	◒
Fallon Community Health Plan-High	$15/$25	$250	$5	$25/$50	Yes	◒	●	●	●	●	◒
Fallon Community Health Plan-Std	$20/$20	Nothing after Deduct	$10	$30/$60	Yes	◒	●	●	●	●	◒

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 Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
Michigan						
Bluecare Network of MI - Midland County Area	800/662-6667	K51	K52	17.50	83.27	NCQA
Bluecare Network of MI - Kent County Area	800/662-6667	KR1	KR2	54.14	251.54	NCQA
Bluecare Network of MI - Mid Michigan	800/662-6667	LN1	LN2	57.72	159.55	NCQA
Bluecare Network of MI - Southeast MI	800/662-6667	LX1	LX2	14.73	44.08	NCQA
Grand Valley Health Plan - Grand Rapids area	616/949-2410	RL1	RL2	18.76	116.97	NCQA
Health Alliance Plan - Southeastern Michigan/Flint area	800/422-4641	521	522	15.85	41.99	NCQA
HealthPlus MI - Flint/Saginaw areas	800/332-9161	X51	X52	46.86	108.31	NCQA
M-Care - Southeastern Michigan and Flint area	800/658-8878	EG1	EG2	15.11	40.05	NCQA
Total Health Care - Greater Detroit/Flint areas	800/826-2862	N21	N22	13.94	34.24	JCAHO
Minnesota						
Avera Health Plans - Southwestern Minnesota	888/322-2115	AV1	AV2	40.00	102.70	JCAHO
HealthPartners Classic-High -Minneapolis/St. Paul/St.Cloud	952-883-5000	531	532	77.38	204.99	NCQA
HealthPartners Open Access Deductible - Minneapolis/St. Paul/St.Cloud	952-883-5000	534	535	25.62	80.77	NCQA
HealthPartners Primary Clinic Plan - Minneapolis/St. Paul/St. Cloud	952-883-5000	HQ1	HQ2	133.29	339.19	NCQA
Missouri						
Aetna - Kansas City Area	800/537-9384	KS1	KS2	16.24	41.72	NCQA
BlueCHOICE - StLouis/Central/SW areas	800/634-4395	9G1	9G2	22.76	43.23	NCQA
Community Health Plan - MISSOURI	800-990-9247	IC1	IC2	15.60	42.94	
Coventry Health Care of Kansas-Kansas City-High -Kansas City area	800/969-3343	HA1	HA2	16.74	43.21	
Coventry Health Care of Kansas-Kansas City-Std - Kansas City area	800/969-3343	HA4	HA5	76.36	197.05	35.24
Group Health Plan-High -St. Louis area	800/755-3901	MM1	MM2	51.07	92.45	URAC
Humana Health Plan, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	38.11	91.47	NCQA
Humana Health Plan, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	14.30	32.90	NCQA
Mercy Health Plans/Premier Health Plans - East/Central/Southwest Missouri	800/327-0763	7M1	7M2	62.03	116.15	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Michigan											
Bluecare Network of MI	$10/$10	Nothing	$5	$20/$20	Yes	◒	○	◒	◒	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20/$20	Yes	◒	○	◒	◒	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20/$20	Yes	◒	○	◒	◒	○	◒
Bluecare Network of MI	$10/$10	Nothing	$5	$20/$20	Yes	◒	○	◒	◒	○	◒
Grand Valley Health Plan	$10/$10	None	$5	$5/$5	No	●	◒	●	○	●	◒
Health Alliance Plan	$10/$10	None	$10	$20/$20	Yes	●	◒	◒	◒	◒	◒
HealthPlus MI	$10/$10	None	$10	$20/$20	Yes	●	◒	●	◒	●	●
M-Care	$10/$10	None	$10	$20/$30	No	●	◒	◒	◒	●	●
Total Health Care	$10/$10	None	Nothing	Nothing/Nothing	No	◒	○	○	○	◒	○
Minnesota											
Avera Health Plans	$10/$15	$100/dayx3	$10	$20	Yes						
HealthPartners Classic-High	$15/$15	$100	$12	$12/$24	No	◒	●	◒	◒	◒	◒
HealthPartners Open Access Deductible	$15/$15	$100	$10	$10/$35	No	◒	●	◒	◒	◒	◒
HealthPartners Primary Clinic Plan	$20/$20	$200	$12	$12/$24	No	◒	●	◒	◒	◒	◒
Missouri											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
BlueCHOICE	$10/$10	None	$7	$12/$25	Yes	◒	●	●	●	◒	●
Community Health Plan	$15/$30	$100/day x 4	$10	$25/$40	Yes						
Coventry Health Care of Kansas-Kansas City-High	$15/$30	$100/day x 3	$10	$30/$55	Yes	○	●	◒	◒	◒	○
Coventry Health Care of Kansas-Kansas City-Std											
Group Health Plan-High	$10/$20	$100	$10	$20/$35	Yes	◒	●	●	●	◒	◒
Humana Health Plan, Inc.-High	$10/$20	$100/day x 3	$5/$20	$20/$40	No	○	◒	◒	○	○	○
Humana Health Plan, Inc.-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	○	◒	◒	○	○	○
Mercy Health Plans/Premier Health Plans - In-Network	$10/$20	None	$10	$20/$35	Yes	◒	●	●	●	●	●
Mercy Health Plans/Premier Health Plans - Out-of-Network	30%/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 Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
Montana						
New West Health Services - Most of Montana	800/290-3657	NV1	NV2	18.98	40.53	
Nebraska						
Coventry Health Care of Nebraska - Omaha Metropolitan area	800/471-0240	IE1	IE2	19.01	73.10	
Nevada						
Aetna - Las Vegas Area	800/537-9384	Y11	Y12	17.40	43.33	NCQA
Health Plan of Nevada - Northern Area	702/871-0999	2L1	2L2	17.73	51.45	NCQA
Health Plan of Nevada - Las Vegas area	702/871-0999	NM1	NM2	10.42	26.68	NCQA
NevadaCare - Clark County	702/304-5500	IF1	IF2	18.61	50.66	
Pacificare of Nevada - Las Vegas/Clark County	800-531-3341	K91	K92	15.65	35.52	NCQA
New Jersey						
Aetna - All of New Jersey	800/537-9384	P31	P32	30.40	94.66	NCQA
AmeriHealth HMO - All of New Jersey	800/454-7651	FK1	FK2	18.54	44.25	NCQA
Coventry Health Care of Delaware -High -Southern New Jersey	800/833-7423	2J1	2J2	38.58	136.05	
GHI Health Plan-High -Northern New Jersey	212/501-4444	801	802	46.17	150.20	URAC URAC
New Mexico						
Lovelace Health Plan - All of New Mexico	800/808-7363	Q11	Q12	17.31	42.49	NCQA
Presbyterian Health Plan - All NM counties except Otero & S. Eddy	800/356-2219	P21	P22	18.74	82.42	NCQA

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Montana											
New West Health Services - In-Network	$15/$15	$100	$10	$20/$40	Yes						
New West Health Services - Out-of-Network	30%/30%	30%	N/A	N/A/N/A	N/A						
Nebraska											
Coventry Health Care of Nebraska	$20/$20	None	$10	$20/$45	Yes						
Nevada											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
Health Plan of Nevada	$10/$10	$100	$10	$25/$40	Yes						
Health Plan of Nevada	$10/$10	$100	$10	$25/$40	Yes	○	○	○	○	◒	◒
NevadaCare - In-Network	$20/$20	$250/day x 3	$15	$25/$60	Yes						
NevadaCare - Out-of-Network	$20+30%sch +/$20+30%sch	+ 30%sch +	N/A	N/A/N/A	N/A						
Pacificare of Nevada	$15/$30	$200/day x 5	$15	$35/$50	Yes	○	○	○	○	◒	◒
New Jersey											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	◒	◒	◒	◒	◒	◒
AmeriHealth HMO	$30/$35	$200/day x 3	$10	$40/50%	Yes	◒	◒	●	◒	◒	○
Coventry Health Care of Delaware -High	$10/$20	None	$10	$20/$45	Yes						
GHI Health Plan - In-Network	$15/$15	$100/adm x2	$15	$25/$75	Yes	◒	●	◒	○	○	○
GHI Health Plan - Out-of-Network	+ 50% of sch.	50%	N/A	N/A/N/A	N/A	◒	●	◒	○	○	○
New Mexico											
Lovelace Health Plan	$15/$25	$250	$7	$15/$35	Yes	◒	○	○	◒	○	○
Presbyterian Health Plan	$15/$25	$100	$10	$20/$40	Yes	◒	◒	○	◒	◒	◒

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

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Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
New York						
Aetna - NYC Area and Dutchess/Sullivan/Ulster	800/537-9384	JC1	JC2	22.91	85.22	NCQA
Blue Choice - Rochester area	800/462-0108	MK1	MK2	14.63	36.66	NCQA
Capital District Physician's Health Plan - Capital District area	800/777-2273	SG1	SG2	17.47	44.04	NCQA
GHI Health Plan-High -All of New York	212/501-4444	801	802	46.17	150.20	URAC URAC
GHI Health Plan-Std - All of New York	212/501-4444	804	805	19.14	45.12	URAC
GHI HMO Select-High -Brnx/Brklyn/Manhat/Queen/Richmon/Westche	877/244-4466	6V1	6V2	29.01	115.70	NCQA
GHI HMO Select-Std - Brnx/Brklyn/Manhat/Queen/Richmon/Westche	877/244-4466	6V4	6V5	17.74	49.38	NCQA
GHI HMO Select-High -Capital/Hudson Valley Regions	877/244-4466	X41	X42	19.10	85.41	NCQA
GHI HMO Select-Std - Capital/Hudson Valley Regions	877/244-4466	X44	X45	17.36	43.91	NCQA
HIP of Greater New York-High -New York City area	800/HIP-TALK	511	512	17.93	94.27	NCQA
HIP of Greater New York-Std - New York City area	800/HIP-TALK	514	515	14.79	41.43	NCQA
HMO Blue - Utica/Rome/Central New York areas	800/722-7884	AH1	AH2	19.57	90.37	NCQA
HMOBlue-CNY - Syracuse/Binghamton/Elmira areas	800/828-2887	EB1	EB2	19.41	89.15	NCQA
Independent Health Assoc - Western New York	800/453-1910	QA1	QA2	14.58	40.00	NCQA NCQA
MVP Health Care - Eastern Region	888/687-6277	GA1	GA2	16.65	43.01	NCQA
MVP Health Care - Central Region	888/687-6277	M91	M92	18.12	63.84	NCQA
MVP Health Care - Mid-Hudson Region	888/687-6277	MX1	MX2	18.68	76.72	NCQA
Preferred Care - Rochester area	800/950-3224	GV1	GV2	14.29	38.16	NCQA
Univera Healthcare - Western New York (Southern Counties)	(800) 427-8490	KQ1	KQ2	16.51	43.75	NCQA
Univera Healthcare - Western New York (Northern Counties)	(800) 427-8490	Q81	Q82	13.26	37.60	NCQA
Vytra Health Plans - Queens/Nassau/Suffolk Counties	800/406-0806	J61	J62	35.89	148.00	NCQA
North Dakota						
Heart of America Health Plan - Northcentral North Dakota	800-525-5661	RU1	RU2	14.08	36.19	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
New York											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	◒	◒	◒	◒	◒	◒
Blue Choice	$15/$15	None	$10	$25/$40	No	●	●	●	●	◒	●
Capital District Physician's Health Plan	$20/$20	$100dayX5	$10	$25/$40	NA	●	●	●	●	●	●
GHI Health Plan - In-Network	$15/$15	$100/adm x2	$15	$25/$75	Yes	◒	●	◒	○	○	○
GHI Health Plan - Out-of-Network	+ 50% of sch.	50%	N/A	N/A/N/A	N/A	◒	●	◒	○	○	○
GHI Health Plan-Std	$25/$25	$250/dayx3	$10	$25/$80	Yes	◒	●	◒	○	○	○
GHI HMO Select-High	$10/$10	None	$10	$20/$30	Yes	○	◒	◒	●	◒	○
GHI HMO Select-Std	$20/$20	None	$10	$20/$30	Yes	○	◒	◒	●	◒	○
GHI HMO Select-High	$10/$10	None	$10	$20/$30	Yes	○	◒	◒	●	◒	○
GHI HMO Select-Std	$20/$20	None	$10	$20/$30	Yes	○	◒	◒	●	◒	○
HIP of Greater New York-High	$10/$10	None	$10	$15/$40	Yes	◒	○	○	○	◒	○
HIP of Greater New York-Std	$10/$20	$500	$10	$20/$40	Yes	◒	○	○	○	◒	○
HMO Blue	$20/$20	$240	$10	$25/$40	No	◒	◒	●	◒	○	◒
HMOBlue-CNY	$20/$20	$240	$10	$25/$40	No	◒	◒	●	◒	○	◒
Independent Health Assoc - In-Network	$15/$15	None	$10	$20/$35	No	●	●	●	●	●	●
Independent Health Assoc - Out-of-Network	75%/75%	75%	N/A	N/A/N/A	No	●	●	●	●	●	●
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	◒	●	◒
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	◒	●	◒
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	◒	●	◒
Preferred Care	$15/$15	$100	$10	$25/$40	Yes	●	●	●	●	●	●
Univera Healthcare	$20/$20	None	$10	$20/$45	No	◒	●	●	◒	●	●
Univera Healthcare	$20/$20	None	$10	$20/$45	No	◒	●	●	◒	●	●
Vytra Health Plans	$10/$10	None	$10	$15/$15	Yes	●	◒	◒	◒	◒	◒
North Dakota											
Heart of America Health Plan	$10/Nothing	None	50%	50%/50%	None						

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 Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
Ohio						
Aetna - Cleveland and Toledo Areas	800/537-9384	7D1	7D2	16.69	39.72	NCQA
Aetna - Columbus Area	800/537-9384	ND1	ND2	18.52	78.04	NCQA
Aetna - Greater Cincinnati Area	800/537-9384	RD1	RD2	18.23	44.30	NCQA
AultCare HMO-High -Stark/Carroll/Holmes/Tuscarawas/Wayne Co	330/363-6360	3A1	3A2	18.17	44.59	
Blue HMO - Most of Ohio	800/228-4375	R51	R52	39.81	100.92	NCQA
HMO Health Ohio - Northeast Ohio	800/522-2066	L41	L42	18.66	72.31	NCQA
Hometown Health Plan - Massillon	800-426-9013	MZ1	MZ2	15.22	38.05	
Kaiser Permanente - Cleveland/Akron areas	800/686-7100	641	642	19.34	69.69	NCQA
Paramount Health Care - Northwest/North Central Ohio	800/462-3589	U21	U22	18.70	88.08	NCQA
SummaCare Health Plan - Cleveland, Akron areas	330/996-8700	5W1	5W2	27.79	67.76	NCQA
SuperMed HMO - Northeast Ohio	800/522-2066	5M1	5M2	69.29	220.98	NCQA
The Health Plan of the Upper Ohio Valley - Eastern Ohio	800/624-6961	U41	U42	16.35	37.60	NCQA
United Healthcare of Ohio, Inc.-High -Cincinnati/Dayton/Springfield areas	800/231-2918	3U1	3U2	96.53	202.82	NCQA
United Healthcare of Ohio, Inc.-Std - Cincinnati/Dayton/Springfield areas	800/231-2918	3U4	3U5	47.45	88.70	NCQA NCQA
Oklahoma						
Aetna - Oklahoma City/Tulsa Areas	800/537-9384	SL1	SL2	19.28	45.60	NCQA
Globalhealth, Inc. - OKLAHOMA	405-280-5600	IM1	IM2	16.88	40.67	
PacifiCare Southwest Region (OK & TX) - Central/Northeastern Oklahoma	800-531-3341	2N1	2N2	19.17	55.46	NCQA
Oregon						
Kaiser Permanente-High -Portland/Salem areas	800/813-2000	571	572	19.46	44.41	NCQA
Kaiser Permanente-Std - Portland/Salem areas	800/813-2000	574	575	17.88	40.79	NCQA
PacifiCare Northwest Region (Oregon/Washington) - Metro Portland/Salem/Corvalis/Eugene	800-531-3341	7Z1	7Z2	31.35	64.33	NCQA

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Ohio											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	○	◒	◒	◒	○	○
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	○	◒	◒	◒	○	○
AultCare HMO-High	$10/$10	None	$10	$20/$35	N/A	●	●	●	●	●	●
Blue HMO	$10/$10	None	$10	$20/$30	Yes	◒	●	●	◒	◒	◒
HMO Health Ohio	$15/$15	$250	$10	$20/$30	Yes	◒	◒	◒	◒	○	○
Hometown Health Plan	$15/$20	$250	$15	$25/$40	No	●	●	●	◒	●	●
Kaiser Permanente	$10/$10	$100	$10	$25/$25	No	●	●	●	◒	◒	◒
Paramount Health Care	$10/$20	$300	$5	$15/$25	No	◒	◒	◒	●	●	●
SummaCare Health Plan	$15/$20	None	$12	$30/$50	Yes	●	◒	◒	◒	◒	◒
SuperMed HMO	$15/$15	$250	$10	$20/$30	Yes	◒	◒	◒	◒	○	○
The Health Plan of the Upper Ohio Valley	$10/$20	$250	$15	$30/$50	Yes	●	●	●	●	●	●
United Healthcare of Ohio, Inc.-High	$15/$15	$250	$10	$15/$30	Yes	◒	●	●	◒	○	◒
United Healthcare of Ohio, Inc. - In-Network	$20/$20	$500	$10	$20/$40	Yes	◒	●	●	◒	○	◒
United Healthcare of Ohio, Inc. Out-of-Network	30%/30%	30%	$10	$20/$40	Yes	◒	●	●	◒	○	◒
Oklahoma											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	○	◒	◒	●	◒	◒
Globalhealth, Inc.	$15/$25	$250 per day/ 3 days	$10	$25/$40	Yes						
PacifiCare Southwest Region (OK & TX)	$20/$40	$400/day x 5	$10	$40/$50	Yes	◒	◒	◒	◒	◒	●
Oregon											
Kaiser Permanente-High	$15/$15	$100	$15	$30/$30	Yes	●	◒	○	○	●	◒
Kaiser Permanente-Std	$15/$15	$100	$15	$30/$30	Yes	●	◒	○	○	●	◒
PacifiCare Northwest Region (Oregon/Washington)	$15/$45	$250/day x 3	$10	$30/$50	Yes	○	○	◒	◒	○	◒

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 Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
Pennsylvania						
Aetna - Philadelphia and Southeastern PA	800/537-9384	P31	P32	30.40	94.66	NCQA
Aetna - Pittsburgh Area	800/537-9384	YE1	YE2	15.10	41.64	NCQA
Coventry Health Care of Delaware -High -Southeastern Pennsylvania	800/833-7423	2J1	2J2	38.58	136.05	
HealthAmerica Pennsylvania-High -Greater Pittsburgh area	866/351-5946	261	262	19.16	82.26	NCQA
HealthAmerica Pennsylvania-Std - Greater Pittsburgh area	866/351-5946	264	265	17.89	53.33	NCQA
HealthAmerica Pennsylvania-High -Northeast Pennsylvania	866/351-5946	4N1	4N2	83.32	195.46	NCQA
HealthAmerica Pennsylvania-Std - Northeast Pennsylvania	866/351-5946	4N4	4N5	56.31	133.34	NCQA
HealthAmerica Pennsylvania-High -Southeastern Pennsylvania	866/351-5946	PN1	PN2	78.86	184.29	NCQA
HealthAmerica Pennsylvania-Std - Southeastern Pennsylvania	866/351-5946	PN4	PN5	54.66	128.62	NCQA
HealthAmerica Pennsylvania-High -Central Pennsylvania	866/351-5946	SW1	SW2	47.99	114.20	NCQA
HealthAmerica Pennsylvania-Std - Central Pennsylvania	866/351-5946	SW4	SW5	31.72	76.78	NCQA
Keystone Health Plan Central - Harrisburg/Northern Region/Lehigh Valley	800/622-2843	S41	S42	53.47	144.71	NCQA
Keystone Health Plan East - Philadelphia area	800/227-3115	ED1	ED2	18.52	81.98	NCQA
UPMC Health Plan - Western Pennsylvania area	888/876-2756	8W1	8W2	19.23	83.99	NCQA
Puerto Rico						
Humana Health Plans of Puerto Rico - Puerto Rico	800/314-3121	ZJ1	ZJ2	10.52	24.20	
Triple-S - All of Puerto Rico	787/749-4777	891	892	13.34	28.65	
Rhode Island						
BlueChip, Coordinated Health Partners, Inc. - All of Rhode Island	401/459-5500	DA1	DA2	33.66	147.15	NCQA NCQA
South Carolina						
Carolina Care - South Carolina	800/868-6734	IB1	IB2	19.57	44.03	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Pennsylvania											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	◒	●	●	●	○	◒
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
Coventry Health Care of Delaware -High	$10/$20	None	$10	$20/$45	Yes						
HealthAmerica Pennsylvania-High	$10/$25	None	$8	$25/$40	Yes	◒	●	●	◒	◒	◒
HealthAmerica Pennsylvania-Std	$20/$30	$200/day x 3	$8	$35/$50	Yes	◒	●	●	◒	◒	◒
HealthAmerica Pennsylvania-High	$10/$25	None	$8	$25/$40	Yes	◒	●	●	◒	◒	◒
HealthAmerica Pennsylvania-Std	$20/$30	$200/day x 3	$8	$35/$50	Yes	◒	●	●	◒	◒	◒
HealthAmerica Pennsylvania-High	$10/$25	None	$8	$25/$40	Yes						
HealthAmerica Pennsylvania-Std	$20/$30	$200/day x 3	$8	$35/$50	Yes						
HealthAmerica Pennsylvania-High	$10/$25	None	$8	$25/$40	Yes	◒	●	●	◒	◒	◒
HealthAmerica Pennsylvania-Std	$20/$30	$200/day x 3	$8	$35/$50	Yes	◒	●	●	◒	◒	◒
Keystone Health Plan Central	$15/$20	$200 copay	$10	$25/$40	Yes	●	●	●	●	◒	●
Keystone Health Plan East	$15/$25	None	$15	$20/$35	Yes	◒	●	◒	●	◒	◒
UPMC Health Plan	$10/$10	None	$5	$15/$35	Yes	◒	●	◒	◒	◒	◒
Puerto Rico											
Humana Health Plans of Puerto Rico - In-Network	$5/$5	None	$2.50	$5/$5	No						
Humana Health Plans of Puerto Rico - Out-of-Network	$8/$8	$50	N/A	N/A/N/A	N/A						
Triple-S - In-Network	$7.50/$10	None	$5	$8/$12	Yes	●	●	○	◒	●	◒
Triple-S - Out-of-Network	$7.50 + 10%/$10 + 10%	None	25%	25%/25%	No	●	●	○	◒	●	◒
Rhode Island											
BlueChip, Coordinated Health Partners, Inc. - In-Network	$15/$25	$500	$7	$30/$50	Yes	○	●	●	◒	◒	◒
BlueChip, Coordinated Health Partners, Inc. - Out-of-Network	30%/30%	None	$40+20%	$50+20%/$50+20%	N/A	○	●	●	◒	◒	◒
South Carolina											
Carolina Care	$20/$30	$250	$10	$20/$50	Yes						

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

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Primary Care Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
South Dakota						
Avera Health Plans - Eastern and Central South Dakota	888/322-2115	AV1	AV2	40.00	102.70	NCQA
Sioux Valley Health Plan-High -Eastern/Central/Rapid City Areas	800/752-5863	AU1	AU2	67.47	159.25	NCQA NCQA
Sioux Valley Health Plan-Std - Eastern/Central/Rapid City Areas	800/752-5863	AU4	AU5	44.72	106.44	NCQA NCQA
Tennessee						
Aetna - Nashville Area	800/537-9384	6J1	6J2	23.22	53.70	NCQA
Aetna - Memphis Area	800/537-9384	UB1	UB2	16.73	42.66	NCQA
Texas						
Aetna - Houston Area	800/537-9384	8G1	8G2	19.30	76.26	NCQA
Aetna - Austin/San Antonio Areas	800/537-9384	P11	P12	17.40	43.83	NCQA
Aetna - Dallas/Ft Worth Areas	800/537-9384	PU1	PU2	23.42	85.01	NCQA
FirstCare - Waco area	800/884-4901	6U1	6U2	18.00	38.67	
FirstCare - West Texas	800/884-4901	CK1	CK2	57.60	104.03	
HMO Blue Texas - Houston	800/833-5318	YM1	YM2	28.72	97.00	NCQA
Humana Health Plan of Texas-High -San Antonio area	888/393-6765	UR1	UR2	51.84	123.06	URAC
Humana Health Plan of Texas-Std - San Antonio area	888/393-6765	UR4	UR5	16.69	38.38	URAC
Mercy Health Plans/Premier Health Plans - Webb/Zapata/Duval/Jim Hogg Counties	800/617-3433	HM1	HM2	19.59	83.21	
PacifiCare Southwest Region (OK & TX) - San Antonio/Dallas/Ft.Worth	800-531-3341	GF1	GF2	20.67	50.74	NCQA
Utah						
Altius Health Plans - Wasatch Front	800/377-4161	9K1	9K2	38.46	72.98	
Vermont						
MVP Health Care - All of Vermont	888/687-6277	VW1	VW2	45.99	166.41	NCQA

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

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Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
South Dakota											
Avera Health Plans	$10/$15	$100/dayx3	$10	$20	Yes						
Sioux Valley Health Plan - In-Network	$20/$30	$100/day x 5	$15	$30/$50	$30	○	●	●	◒	◒	○
Sioux Valley Health Plan - Out-of-Network	40%/40%	40%	N/A	N/A/N/A	No	○	●	●	◒	◒	○
Sioux Valley Health Plan - In-Network	$25/$25	$100/day x 5	$15	$30/$50	No	○	●	●	◒	◒	○
Sioux Valley Health Plan - Out-of-Network	40%/40%	40%	N/A	N/A/N/A	No	○	●	●	◒	◒	○
Tennessee											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	◒	◒	○	◒	◒	◒
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	◒	◒	○	◒	◒	◒
Texas											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes						
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	◒	◒	◒	◒	◒	◒
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	◒	○	○	◒	◒	◒
FirstCare	$20/$20	$100/day x 5	$10	$20/$40	Yes	◒	●	◒	●	●	●
FirstCare	$20/$20	$100/day x 5	$10	$20/$40	Yes	◒	●	◒	◒	◒	●
HMO Blue Texas	$20/$20	$100/dayx4	$10	$25/$40	Yes	○	○	○	○	◒	○
Humana Health Plan of Texas-High	$10/$20	$100/day x 3	$5/$20	$20/$40	No	●	◒	◒	◒	◒	◒
Humana Health Plan of Texas-Std	$15/$25	$250/day x 3	$10/$25	$25/$45	No	●	◒	◒	◒	◒	◒
Mercy Health Plans/Premier Health Plans - In-Network	$10	None	$7	$12/$25	Yes	●	◒	○	●	●	◒
Mercy Health Plans/Premier Health Plans - Out-of-Network	40%/40%	40%	N/A	N/A	N/A	●	◒	○	●	●	◒
PacifiCare Southwest Region (OK & TX)	$20/$40	$400/day x 5	$10	$40/$50	Yes	◒	◒	◒	◒	◒	
Utah											
Altius Health Plans	$10/$15	None	$10	$20/$40	Yes	◒	◒	◒	◒	◒	◒
Vermont											
MVP Health Care	$15/$15	$240	$5	$20/$40	Yes	●	●	●	◒	●	◒

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

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Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
Virginia						
Aetna Open Access-High -Northern/Central/Richmond, Virginia Area	800/537-9384	JN1	JN2	21.26	44.35	NCQA
Aetna Open Access-Basic - Northern/Central/Richmond, Virginia Area	800/537-9384	JN4	JN5	13.04	30.51	NCQA
CareFirst BlueChoice - Northern Virginia	866/520-6099	2G1	2G2	26.90	56.55	NCQA
Kaiser Permanente-High -Washington, DC area	301/468-6000	E31	E32	17.91	42.63	NCQA
Kaiser Permanente-Std - Washington, DC area	301/468-6000	E34	E35	14.42	34.31	NCQA
M.D. IPA - N.VA/Cntrl VA/Richmond/Tidewater/Roanoke	800/251-0956	JP1	JP2	18.12	43.50	NCQA
Optima Health Plan - Peninsula/Southside Hampton Roads	800/206-1060	9R1	9R2	24.86	72.87	NCQA
Piedmont Community Healthcare - Lynchburg area	888/674-3368	2C1	2C2	18.42	42.19	
Washington						
Aetna - Seattle/Puget Sound Areas	800/537-9384	8J1	8J2	15.65	39.81	NCQA
Group Health Cooperative-High -Most of Western Washington	888/901-4636	541	542	23.88	51.16	NCQA
Group Health Cooperative-Std - Most of Western Washington	888/901-4636	544	545	15.91	35.93	NCQA
Group Health Cooperative-High -Central WA/Spokane/Pullman	888/901-4636	VR1	VR2	19.56	71.94	NCQA
Group Health Cooperative-Std - Central WA/Spokane/Pullman	888/901-4636	VR4	VR5	16.55	38.07	NCQA
Kaiser Permanente-High -Vancouver/Longview	800/813-2000	571	572	19.46	44.41	NCQA
Kaiser Permanente-Std - Vancouver/Longview	800/813-2000	574	575	17.88	40.79	NCQA
KPS Health Plans - High -All of Washington	800/552-7114	VT1	VT2	33.18	58.54	
KPS Health Plans - Std - All of Washington	800/552-7114	L11	L12	17.31	37.37	
PacifiCare Northwest Region (Oregon/Washington) - Clark County	800-531-3341	7Z1	7Z2	31.35	64.33	NCQA
PacifiCare Northwest Region (Oregon/Washington) - Washington	800-531-3341	SA1	SA2	14.43	33.73	NCQA

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Virginia											
Aetna Open Access-High	$15/$20	$150/day x 3	$10	$25/$40	No	○	◒	◒	◒	◒	◒
Aetna Open Access-Basic	$20/$30	$150/day x 5	$10	$25/$40	No	○	◒	◒	◒	◒	◒
CareFirst BlueChoice	$20/$30	$100 per adm	$10	$25/$40	Yes	○	○	○	◒	○	○
Kaiser Permanente-High	$10/$20	$100	$10/$20Net	$20/$55	Yes	◒	○	○	○	◒	◒
Kaiser Permanente-Std	$30/$30	$250/dayx3	$15	$25/$40	Yes	◒	○	○	○	◒	◒
M.D. IPA	$10/$20	$100	$8	$20/$35	No	◒	◒	○	◒	●	◒
Optima Health Plan	$10/$10	$250	$10	$20/$40	Yes	●	●	◒	◒	●	●
Piedmont Community Healthcare - In-Network	$25/$25	None	$15	$30/$30	Yes						
Piedmont Community Healthcare - Out-of-Network	40%/30%	None	$15	$30/$30	N/A						
Washington											
Aetna	$20/$30	$150/day x 5	$10	$25/$40	Yes	○	○	◒	○	○	○
Group Health Cooperative-High	$15/$15	$200/day x 3	$15	$25/$50	N/A	○	◒	◒	◒	◒	◒
Group Health Cooperative-Std	$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes	○	◒	◒	◒	◒	◒
Group Health Cooperative-High	$15/$15	$200/day x 3	$15	$25/$50	N/A	○	◒	◒	◒	◒	◒
Group Health Cooperative-Std	$20+20%/$20+20%	$200/day x 3	$20	$30/$60	Yes	○	◒	◒	◒	◒	◒
Kaiser Permanente-High	$15/$15	$100	$15	$30/$30	Yes	●	◒	○	○	●	◒
Kaiser Permanente-Std	$15/$15	$100	$15	$30/$30	Yes	●	◒	○	○	●	◒
KPS Health Plans - High - In-Network	$20/$20	None	$5	$20/50%	Yes	●	●	●	◒	●	●
KPS Health Plans - High - Out-of-Network	$15+45%/$25+45%	None	N/A	N/A/N/A	N/A	●	●	●	◒	●	●
KPS Health Plans - Std - In-Network	$15/x3 or 20%/20%	$100/day x 5	$10	$30/50%	Yes	●	●	●	◒	●	●
KPS Health Plans - Std - Out-of-Network	$15/x3 or 45%/45%	$100/day x 5	N/A	N/A/N/A	No	●	●	●	◒	●	●
PacifiCare Northwest Region (Oregon/Washington)	$15/$45	$250/day x 3	$10	$30/$50	Yes	○	○	◒	◒	○	◒
PacifiCare Northwest Region (Oregon/Washington)	$15/$45	$250/day x 3	$10	$30/$50	Yes						

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 Specialist/Office Copay shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

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

Plan Name – Location	Telephone Number	Enrollment Code		Biweekly Premium Your Share		Accredited
		Self Only	Self & family	Self Only	Self & family	
West Virginia						
The Health Plan of the Upper Ohio Valley - Northern/Central West Virginia	800/624-6961	U41	U42	16.35	37.60	NCQA
Wisconsin						
Dean Health Plan - South Central Wisconsin	800/279-1301	WD1	WD2	17.66	63.91	NCQA
Group Health Cooperative - South Central Wisconsin	608/828-4827	WJ1	WJ2	15.40	41.63	NCQA
HealthPartners Classic-High -West Central Wisconsin	952-883-5000	531	532	77.38	204.99	NCQA
HealthPartners Open Access Deductible - West Central Wisconsin	952-883-5000	534	535	25.62	80.77	NCQA
HealthPartners Primary Clinic Plan - West Central Wisconsin	952-883-5000	HQ1	HQ2	133.29	339.19	NCQA
Prevea Health Plan - Wisconsin	888/711-1444	ID1	ID2	18.80	63.77	
Wyoming						
WINhealth Partners - Wyoming	307/638-7700	PV1	PV2	18.83	101.72	

Prescription Drugs — Generic, Brand Name, and Non-formulary shows what you pay for prescriptions when you use a plan pharmacy. You pay the Brand name amount if you or your doctor request the Brand name or if a Generic is not available. The figure in the Brand name/Non-formulary column is the copayment or coinsurance most commonly paid by members of this health plan for a Brand name formulary drug. If a non-formulary drug is prescribed and the cost to you is different than the Brand name, you pay the second amount if listed.

Mail Order Discounts. If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results — See page 3 for a description.
Accredited — The National Committee for Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and/or URAC (URAC). See page 3 for details.

Plan Name	Primary care / Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results ● above average, ◒ average, ○ below average					
			Generic	Brand name/ Non-formulary	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
West Virginia											
The Health Plan of the Upper Ohio Valley	$10/$20	$250	$15	$30/$50	Yes	●	●	●	●	●	●
Wisconsin											
Dean Health Plan	$10/$10	None	$10	30%/30%	No	●	●	◒	◒	◒	●
Group Health Cooperative	$10/$10	None	$5	$20/$20	No	●	●	●	●	◒	◒
HealthPartners Classic-High	$15/$15	$100	$12	$12/$24	No	◒	●	◒	◒	◒	◒
HealthPartners Open Access Deductible	$15/$15	$100	$10	$10/$35	No	◒	●	◒	◒	◒	◒
HealthPartners Primary Clinic Plan	$20/$20	$200	$12	$12/$24	No	◒	●	◒	◒	◒	◒
Prevea Health Plan	$15/$15	$100	$10	$20/$40							
Wyoming											
WINhealth Partners	$10/$10	None	$10	$15/$40	Yes						

High Deductible and Consumer-Driven Health Plans

Nationwide and Regional High Deductible Health Plans with a Health Savings Account or Health Reimbursement Arrangement and Consumer-Driven Plans

(Pages 68 through 89)

A **High Deductible Health Plan** (HDHP) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The HDHP gives you greater flexibility and discretion over how you use your health care benefits.

When you enroll, your health plan establishes for you either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The plan automatically deposits the monthly "premium pass through" into your HSA. The plan credits an amount into the HRA. (This is the "Premium Contribution to HSA/HRA" column in the following charts.)

Preventive care is often covered in full, usually with no or only a small deductible or copayment. Preventive care expenses may also be payable up to an annual maximum dollar amount (up to $300 for instance). As you receive other non-preventive medical care, you must meet the plan deductible before the health plan pays benefits. You can choose to pay your deductible with funds from your HSA or you can choose instead to pay for your deductible out-of-pocket, allowing your savings to continue to grow.

The HDHP features higher annual deductibles (a minimum of $1,050 for Self and $2,100 for Family coverage) and annual out-of-pocket limits (not to exceed $5,000 for Self and $10,000 for Family coverage) than other insurance plans. Depending on the HDHP you choose, you may have the choice of using in-network and out-of-network providers. There may be higher deductibles and out-of-pocket limits when you use out-of-network providers. Using in-network providers will save you money.

Health Savings Account (HSA)

Health Savings Accounts are available to members who do not have Medicare or another health plan. The amount of the "premium pass through" is based on whether you have a Self Only or Self and Family enrollment. You have the option to make tax-free contributions to your account, provided the total contributions do not exceed the limits established by law, which are typically not more than the plan deductible. If you are over 55, you can make an additional "catch up" contribution. You can use funds in your account to help pay your health plan deductible. However, if you enroll in an HDHP with an HSA, you are not eligible to participate in a Health Care Flexible Spending Account.

Features of an HSA include:

- Tax-deductible deposits you make to the HSA.
- Tax-deferred interest earned on the account.
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused funds and interest from year to year.
- Portability; the account is owned by you and is yours to keep – even when you retire.

Health Reimbursement Arrangement (HRA)

For members who are not eligible for an HSA, have Medicare or another non-High Deductible Health Plan, the HDHP will provide and administer a Health Reimbursement Arrangement.

The plan will credit the HRA different amounts depending on whether you have a Self Only or a Self and Family enrollment. You can use funds in your account to help pay your health plan deductible.

Features of an HRA include:

- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused credits from year to year.
- Credits in an HRA do not earn interest.
- Credits in the HRA are forfeited if you leave federal employment or switch health insurance plans.

High Deductible and Consumer-Driven Health Plans

	Health Savings Account (HSA)	**Health Reimbursement Arrangement (HRA)**
ELIGIBILITY	You must enroll in a High Deductible Health Plan. No other general medical insurance coverage permitted. You cannot be enrolled in Medicare Part A or Part B.	You must enroll in a High Deductible Health Plan.
FUNDING	The plan deposits a monthly "premium pass through" into your account.	The plan deposits the credit amount directly into your HRA.
CONTRIBUTIONS	The maximum allowed is a combination of the health plan "premium pass through" and the member contribution up to the amount of the plan deductible.	Only that portion of the premium specified by the health plan will be contributed. You cannot add your own money to an HRA.
DISTRIBUTIONS	May be used to pay the out-of-pocket medical expenses for yourself, your spouse, or your dependents, or to pay the plan's deductible. See IRS Publication 502 for a complete list of eligible expenses.	May be used to pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the health plan, or to pay the plan's deductible. See IRS Publication 502 for a complete list of eligible expenses.
PORTABLE	Yes, you can take this account with you when you terminate employment or retire.	If you retire and remain in your health plan you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under that health plan will be eligible for reimbursement, subject to timely filing requirements. Unused credits are forfeited.
ANNUAL ROLLOVER	Yes, funds accumulate without a maximum cap.	Yes, credits accumulate without a maximum cap.

IMPORTANT REMINDER: This is only a summary of the features of the HDHP/HSA or HRA. Refer to the specific Plan brochure for the complete details covering Plan design, operation, and administration as each Plan will have differences.

Consumer-Driven Plans – A Consumer-Driven plan provides you with greater freedom in spending health care dollars the way you want. The typical plan has common components: Member responsibility for certain up-front medical costs, an employer-funded account that you may use to pay these up-front costs, and catastrophic coverage with a high deductible. You and your family members receive full coverage for in-network preventive care.

High Deductible and Consumer-Driven Health Plans

How to read this chart

Premium Contribution to HSA/HRA shows the amount your health plan automatically deposits into your account.

Calendar Year (CY) Deductible Self/Family shows the amount of expenses an individual or family must pay before the plan begins to pay benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance or copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days), a coinsurance amount such as 20%, or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
APWU Health Plan Consumer Driven Plan (CDHP)	866/833-3463	474	475	18.40	42.85
GEHA High Deductible Health Plan (HDHP)	800/821-6136	341	342	21.02	49.36
Mail Handlers High Deductible Health Plan (HDHP)	800/410-7778	481	482	19.01	43.09

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
APWU (CDHP)	PPO	N/A	$600/$1,200	$4,500/$4,500	15%	None	15%	Nothing	25%/25%/25%
	Non-PPO	N/A	$600/$1,200	$9,000/$9,000	40%	None	40%	Nothing up to $1200/$2400	N/A
GEHA (HDHP)	PPO	$60/$120	$1,100/$2,200	$5,000/$10,000	15%	15%	15%	Nothing up to $300	30%/30%/N/A
	Non-PPO	$60/$120	$1,100/$2,200	$5,000/$10,000	30%	30%	30%	Nothing up to $300	30%/30%/N/A
Mail Handlers (HDHP)	PPO	$83/$166	$2,250/$4,500	$5,000/$10,000	$15	$75day-$750	$150	Nothing	$10/$25/$40
	Non-PPO	$83/$166	$2,250/$4,500	$7,500/$15,000	40%	40%	40%	Not covered	Not Covered

High Deductible and Consumer-Driven Health Plans

Premium Contribution to HSA/HRA shows the amount your health plan automatically deposits into your account.

Calendar Year (CY) Deductible Self/Family shows the amount of expenses an individual or family must pay before the plan begins to pay benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance or copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days) or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
Alabama					
Aetna HealthFund CDHP -Lamar and Pickens Counties	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Lamar and Pickens Counties	800/537-9384	224	225	17.29	39.78
Alaska					
Aetna HealthFund CDHP -Anchorage and Fairbanks Areas	800/537/9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Anchorage and Fairbanks Areas	800/537/9384	224	225	17.29	39.78
Arizona					
Aetna HealthFund CDHP -Phoenix and Tucson Areas	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Phoenix and Tucson Areas	800/537-9384	224	225	17.29	39.78
Humana CoverageFirst CDHP - Phoenix	888/393-6765	DB1	DB2	10.49	24.13
Arkansas					
Aetna HealthFund CDHP -Eastern Arkansas	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Eastern Arkansas	800/537-9384	224	225	17.29	39.78
California					
Aetna HealthFund CDHP -Northern/Central Valley/Southern CA	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Northern/Central Valley/Southern CA	800/537-9384	224	225	17.29	39.78

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Alaska									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Arizona									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Arkansas									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
California									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%

High Deductible and Consumer-Driven Health Plans

Premium Contribution to HSA/HRA shows the amount your health plan automatically deposits into your account.

Calendar Year (CY) Deductible Self/Family shows the amount of expenses an individual or family must pay before the plan begins to pay benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance or copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days) or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
Colorado					
Aetna HealthFund CDHP -Denver Area	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Denver Area	800/537-9384	224	225	17.29	39.78
Humana CoverageFirst CDHP - Denver	888/393-6765	7T1	7T2	12.15	27.94
Connecticut					
Aetna HealthFund CDHP -All of Connecticut	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - All of Connecticut	800/537-9384	224	225	17.29	39.78
Delaware					
Aetna HealthFund CDHP -All of Delaware	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - All of Delaware	800/537-9384	224	225	17.29	39.78
Coventry Health Care of Delaware HDHP -Delaware	800/833-7423	2J4	2J5	17.93	44.09
District of Columbia					
Aetna HealthFund CDHP -All of Washington D.C.	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - All of Washington D.C.	800/537-9384	224	225	17.29	39.78

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
Colorado									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%*
Connecticut									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Delaware									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Coventry Health Care of Delaware-HDHP		$41.66/$83.33	$1,050/$2,100	$5,000/$10,000	$15	15%	15%	$15/$25/15%	$10/$20/$45
District of Columbia									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%

High Deductible and Consumer-Driven Health Plans

Premium Contribution to HSA/HRA shows the amount your health plan automatically deposits into your account.

Calendar Year (CY) Deductible Self/Family shows the amount of expenses an individual or family must pay before the plan begins to pay benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance or copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days) or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
Florida					
Aetna HealthFund CDHP -Jacksonville/Miami/Orlando/Tampa Areas	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Jacksonville/Miami/Orlando/Tampa Areas	800/537-9384	224	225	17.29	39.78
Humana CoverageFirst CDHP- Tampa	888/393-6765	MJ1	MJ2	11.60	26.67
Humana CoverageFirst CDHP - Jacksonville	888/393-6765	MQ1	MQ2	12.15	27.94
Humana CoverageFirst CDHP - South Florida	888/393-6765	QP1	QP2	11.05	25.40
Humana CoverageFirst CDHP - Orlando	888/393-6765	YG1	YG2	12.70	29.21
Georgia					
Aetna HealthFund CDHP -Atlanta Area	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Atlanta Area	800/537-9384	224	225	17.29	39.78
Coventry Health Care of Georgia HDHP - GEORGIA	800/395-2545	L51	L52	12.67	29.13
Illinois					
Aetna HealthFund CDHP -Chicago Area	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Chicago Area	800/537-9384	224	225	17.29	39.78
Group Health Plan, Inc. HDHP - Southern/Central	800/755-3901	MM4	MM5	19.16	41.02
Humana CoverageFirst CDHP - Chicago	888/393-6765	MW1	MW2	8.84	20.32
OSF HealthPlans HDHP -Central/Central-Northwestern Illinois	800/673-5222	9F4	9F5	16.68	41.47

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
Florida									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%*
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%*
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%*
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%*
Georgia									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Coventry Health Care of Georgia- HDHP		$41.66/$83.33	$1,500/$3,000	$5,000/$10,000	$20	15%	15%	$20/$40/15%	$10/$25/$50
Illinois									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Group Health Plan, Inc.	- In-of-Network	$41.33/$83.33	$1,500/$2,500	$5,000/$10,000	$15	10%	10%	$15/$25	$15/$25/$50
Group Health Plan, Inc.	- Out-of-Network	$41.33/$41.33	$3,000/$5,000	$10,000/$20,000	30%	30%	30%	30% + Deduct.	N/A
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	30%*
OSF HealthPlans-HDHP	-In-Network	$42/$83	$1,050/$2,100	$3,000/$6,000	20%+Ded	20% + Ded	20%+Ded	$20	20%+Ded
OSF HealthPlans-HDHP	-Out-of-Network	$42/$83	$4,000/$8,000	$12,000/$24,000	40%	40% + Ded	40%	40%	All

High Deductible and Consumer-Driven Health Plans

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Calendar Year (CY) Deductible Self/Family shows the amount of expenses an individual or family must pay before the plan begins to pay benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance or copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days) or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
Indiana					
Advantage Health Solutions, Inc.HDHP -Most of Indiana	800/553-8933	6Y4	6Y5	19.71	44.61
Aetna HealthFund CDHP -Lake and Porter Counties	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Lake and Porter Counties	800/537-9384	224	225	17.29	39.78
Humana CoverageFirst CDHP - Southern Indiana	888/393-6765	BM1	BM2	13.25	30.48
Humana CoverageFirst CDHP - Indiana	888/393-6765	L81	L82	11.05	25.40
Humana CoverageFirst CDHP - Lake/Porter/LaPorte Counties	888/393-6765	MW1	MW2	8.84	20.32
Iowa					
Coventry Health Care of Iowa HDHP -Central Iowa/Cedar Rapids/Sioux City	800/257-4692	SV4	SV5	13.70	35.40
Kansas					
Aetna HealthFund CDHP -Kansas City Area	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Kansas City Area	800/537-9384	224	225	17.29	39.78
Coventry Health Care of Kansas, Inc. HDHP - Wichita/Salina areas	800/664-9251	7G1	7G2	13.62	33.63
Coventry Health Care of Kansas - Kansas City-HDHP -Kansas City area	800/969-3343	9H1	9H2	14.50	37.41
Humana CoverageFirst CDHP Plan - Kansas City	888/393-6765	PH1	PH2	8.84	20.32

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
Indiana									
Advantage Health Plan, Inc.-HDHP		$45.83/$93.33	$1050/$2100	$3000/$6000	20%	20%	20%	20% + deduct.	$10/$20/$50
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%*
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%*
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Iowa									
Coventry Health Care of Iowa-HDHP		$41.66/$83.33	$1,050/$2,100	$5,000/$10,000	$20	10%	10%	$20/$30/10%	$10/$20/$45
Kansas									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Coventry Health Care of Kansas, Inc. (HDHP Plan)		$41.66/$83.33	$1,050/$2,100	$5,000/$10,000	$20	20%	20%	$20/$35/20%	$15/$25/$50
Coventry Health Care of Kansas - Kansas City-HDHP		$41.66/$83.33	$1,050/$2,100	$5,000/$10,000	$20	20%	20%	$20/$35/20%	$15/$25/$50
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%

High Deductible and Consumer-Driven Health Plans

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Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days) or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
Kentucky					
Aetna HealthFund CDHP -Northern KY/Fulton and Lewis Counties	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Northern KY/Fulton and Lewis Counties	800/537-9384	224	225	17.29	39.78
Humana CoverageFirst CDHP - Lexington	888/393-6765	6N1	6N2	13.80	31.75
Humana CoverageFirst CDHPlan - Louisville	888/393-6765	BM1	BM2	13.25	30.48
Humana CoverageFirst CDHP - Northern Kentucky	888/393-6765	L81	L82	11.05	25.40
Louisiana					
Coventry Healthcare Louisiana-HDHP - New Orleans area	800/341-6613	BJ4	BJ5	13.86	32.19
Coventry Healthcare Louisiana-HDHP -Baton Rouge area	800/341-6613	JA4	JA5	14.68	34.11
Humana CoverageFirst CDHP - New Orleans	888/393-6765	9J1	9J2	10.49	24.13
Humana CoverageFirst (CDHP) - Baton Rouge	888/393-6765	9L1	9L2	12.70	29.21
Humana CoverageFirst (CDHP) - Shreveport	888/393-6765	9S1	9S2	14.36	33.02
Maryland					
Aetna HealthFund CDHP -All of Maryland	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - All of Maryland	800/537-9384	224	225	17.29	39.78
Coventry Health Care of Delaware HDHP -Maryland	800/833-7423	IG4	IG5	17.26	42.40

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
Kentucky									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Louisiana									
Coventry Healthcare Louisiana-HDHP	-In-Network	$41.66/$83.33	$1,050/$2,100	$4,000/$8,000	20%	20%	20%	20%	10$/$35/$60
Coventry Healthcare Louisiana-HDHP	-Out -of-Network	$41.66/$83.33	$2,000/$4,000	$6,000/$12,000	30%	30%	30%	30%	N/A
Coventry Healthcare Louisiana-HDHP	-In-Network	$41.66/$83.33	$1,050/$2,100	$4,000/$8,000	20%	20%	20%	20%	10$/$35/$60
Coventry Healthcare Louisiana-HDHP	-Out -of-Network	$41.66/$83.33	$2,000/$4,000	$6,000/$12,000	30%	30%	30%	30%	N/A
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Maryland									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Coventry Health Care of Delaware -HDHP	-In-Network	$41.66/$83.33	$1,050/$2,100	$5,000/$10,000	$15	15%	15%	$15/$25/15%	$10/$20/$45

High Deductible and Consumer-Driven Health Plans

Premium Contribution to HSA/HRA shows the amount your health plan automatically deposits into your account.

Calendar Year (CY) Deductible Self/Family shows the amount of expenses an individual or family must pay before the plan begins to pay benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance or copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days) or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
Massachusetts					
Aetna HealthFund Consumer Driven Plan -Boston Area	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP- Boston Area	800/537-9384	224	225	17.29	39.78
Michigan					
Aetna HealthFund CDHP -Detroit Area	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Detroit Area	800/537-9384	224	225	17.29	39.78
Mississippi					
Aetna HealthFund CDHP -Northern Mississippi	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Northern Mississippi	800/537-9384	224	225	17.29	39.78
Missouri					
Aetna HealthFund CDHP -Kansas City and St. Louis Areas	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Kansas City and St. Louis Areas	800/537-9384	224	225	17.29	39.78
Coventry Health Care of Kansas - Kansas City-HDHP -Kansas City area	800-969-3343	9H1	9H2	14.50	37.41
Group Health Plan, Inc. - St. Louis Area	800/755-3901	MM4	MM5	19.16	41.02
Humana CoverageFirst Consumer Driven Plan - Kansas City	888/393-6765	PH1	PH2	8.84	20.32

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
Massachusetts									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Michigan									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Mississippi									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Missouri									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Coventry Health Care of Kansas - Kansas City-HDHP		$41.66/$83.33	$1,050/$2,100	$5,000/$10,000	$20	20%	20%	$20/$35/20%	$15/$25/$50
Group Health Plan, Inc.	- In-of-Network	$41.33/$83.33	$1,500/$2,500	$5,000/$10,000	$15	10%	10%	$15/$25	$15/$25/$50
Group Health Plan, Inc.	- Out-of-Network	$41.33/$41.33	$3,000/$5,000	$10,000/$20,000	30%	30%	30%	30% + Deduct.	N/A
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%

High Deductible and Consumer-Driven Health Plans

Premium Contribution to HSA/HRA shows the amount your health plan automatically deposits into your account.

Calendar Year (CY) Deductible Self/Family shows the amount of expenses an individual or family must pay before the plan begins to pay benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance or copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days) or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
Nevada					
Aetna HealthFund CDHP -Las Vegas/Clark and Nye Counties	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Las Vegas/Clark and Nye Counties	800/537-9384	224	225	17.29	39.78
New Hampshire					
Aetna HealthFund CDHP -Most of New Hampshire	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Most of New Hampshire	800/537-9384	224	225	17.29	39.78
New Jersey					
Aetna HealthFund CDHP -All of New Jersey	800/537-9382	221	222	15.39	35.40
Aetna HealthFund HDHP - All of New Jersey	800/537-9382	224	225	17.29	39.78
Coventry Health Care of Delaware HDHP -Southern New JerseyDelaware	800/833-7423	2J4	2J5	17.93	44.09
New York					
Aetna HealthFund CDHP -NY City Area/Upstate NY (Syr. & Roch.)	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - NY City Area/Upstate NY (Syr. & Roch.)	800/537-9384	224	225	17.29	39.78
North Carolina					
Aetna HealthFund CDHP -Charlotte/Central/Raleigh/Durham Areas	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Charlotte/Central/Raleigh/Durham Areas	800/537-9384	224	225	17.29	39.78

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
Nevada									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
New Hampshire									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
New Jersey									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Coventry Health Care of Delaware-HDHP		$41.66/$83.33	$1,050/$2,100	$5,000/$10,000	$15	15%	15%	$15/$25/15%	$10/$20/$45
New York									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
North Carolina									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%

High Deductible and Consumer-Driven Health Plans

Premium Contribution to HSA/HRA shows the amount your health plan automatically deposits into your account.

Calendar Year (CY) Deductible Self/Family shows the amount of expenses an individual or family must pay before the plan begins to pay benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance or copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days) or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
Ohio					
Aetna HealthFund CDHP -Cincinnati/Cleveland/Columbus/Toledo	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Cincinnati/Cleveland/Columbus/Toledo	800/537-9384	224	225	17.29	39.78
AultCare HMO-HDHP -Stark/Carroll/Holmes/Tuscarawas/Wayne Co	330/363-6360	3A4	3A5	18.96	37.99
Humana CoverageFirst Consumer Driven Plan - Cincinnati	888/393-6765	L81	L82	11.05	25.40
Oklahoma					
Aetna HealthFund CDHP -Oklahoma City and Tulsa Areas	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Oklahoma City and Tulsa Areas	800/537-9384	224	225	17.29	39.78
Pennsylvania					
Aetna HealthFund CDHP -Philadelphia/Pittsburgh/Southeastern PA	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Philadelphia/Pittsburgh/Southeastern PA	800/537-9384	224	225	17.29	39.78
Coventry Health Care of Delaware HDHP -South eastern Pennsylvania	800/833-7423	2J4	2J5	17.93	44.09
HealthAmerica Pennsylvania-HDHP -Souteatern Pennsylvania	866/351-5946	9N1	9N2	29.02	62.37
HealthAmerica Pennsylvania-HDHP - Greater Pittsburgh area	866/351-5946	Y61	Y62	17.09	42.01
HealthAmerica Pennsylvania-HDHP -Northeast Pennsylvania	866/351-5946	YN1	YN2	36.02	79.08
HealthAmerica Pennsylvania-HDHP - Central Pennsylvania	866/351-5946	YW1	YW2	19.30	43.55

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
Ohio									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
AultCare HDHP	- In-Network	$166.67/$333.33	$2,000/$4,000	$4,000/$8,000	20%	20%	20%	Nothing	20%/20%20%
AultCare HDHP	- Out-of-Network	$166.67/$333.33	$4,000/$8,000	$8,000/$16,000	40%	40%	40%	50% UCR	40%/40%/40%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Oklahoma									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Pennsylvania									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Coventry Health Care of Delaware -HDHP		$41.66/$83.33	$1,050/$2,100	$5,000/$10,000	$15	15%	15%	$15/$25/15%	$10/$20/$45
HealthAmerica Pennsylvania-HDHP		$52.08/$208.33	$1,250/$2,500	$4,000/$8,000	$15	None	Nothing	$15/$25	$5/$35/$50
HealthAmerica Pennsylvania-HDHP		$52.08/$208.33	$1,250/$2,500	$4,000/$8,000	$15	None	Nothing	$15/$25	$5/$35/$50
HealthAmerica Pennsylvania-HDHP		$52.08/$208.33	$1,250/$2,500	$4,000/$8,000	$15	None	Nothing	$15/$25	$5/$35/$50
HealthAmerica Pennsylvania-HDHP		$52.08/$208.33	$1,250/$2,500	$4,000/$8,000	$15	None	Nothing	$15/$25	$5/$35/$50

High Deductible and Consumer-Driven Health Plans

Premium Contribution to HSA/HRA shows the amount your health plan automatically deposits into your account.

Calendar Year (CY) Deductible Self/Family shows the amount of expenses an individual or family must pay before the plan begins to pay benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance or copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician.

Hospital Inpatient when admitted to a hospital. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days) or a flat deductible amount (e.g., $200 per admission).

Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
South Carolina					
Aetna HealthFund CDHP -York County	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - York County	800/537-9384	224	225	17.29	39.78
Tennessee					
Aetna HealthFund CDHP - Memphis and Nashville Areas	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Memphis and Nashville Areas	800/537-9384	224	225	17.29	39.78
Humana CoverageFirst Consumer Driven Plan - Memphis	888/393-6765	L61	L62	11.05	25.40
Texas					
Aetna HealthFund CDHP -Austin/Dallas/FtWorth/Houston/SanAntonio	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Austin/Dallas/FtWorth/Houston/SanAntonio	800/537-9384	224	225	17.29	39.78
Humana CoverageFirst Consumer Driven Plan - Houston	888/393-6765	T21	T22	13.25	30.48
Humana CoverageFirst Consumer Driven Plan - Dallas/Ft. Worth	888/393-6765	T81	T82	12.70	29.21
Humana CoverageFirst Consumer Driven Plan - Corpus Christi	888/393-6765	TP1	TP2	11.60	26.67
Humana CoverageFirst Consumer Driven Plan - San Antonio	888/393-6765	TU1	TU2	11.05	25.40
Humana CoverageFirst Consumer Driven Plan - Austin	888/393-6765	TV1	TV2	12.15	27.94

High Deductible and Consumer-Driven Health Plans

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive care services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per year).

Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
South Carolina									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Tennessee									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Texas									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
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Outpatient Surgery shows what the member pays to the doctor for surgery performed on an outpatient basis.

Plan Name	Telephone Number	Enrollment Code		Your Share of Premium	
		Self Only	Self & Family	Self Only	Self &Family
Virginia					
Aetna HealthFund CDHP -Northern/Central/Richmond VA Areas	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Northern/Central/Richmond VA Areas	800/537-9384	224	225	17.29	39.78
Washington					
Aetna HealthFund CDHP -Seattle/Puget Sound Areas	800/537-9384	221	222	15.39	35.40
Aetna HealthFund HDHP - Seattle/Puget Sound Areas	800/537-9384	224	225	17.29	39.78
Wisconsin					
Humana CoverageFirst Consumer Driven Plan - Milwaukee	888/393-6765	FB1	FB2	12.15	27.94

High Deductible and Consumer-Driven Health Plans

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Prescription Drugs shows the amount most commonly paid by members for a manufacturer's Generic drug (if available) and Brand name drug when purchased at a local pharmacy and when on the health plan's formulary. If a third figure is listed this is what you pay for a non-formulary drug when the cost to you is different than the Brand name.

High Deductible Health Plans and Consumer-Driven Health Plans are much different from the other types of plans shown in this Guide. This chart is a broad outline of what you are expected to pay under each plan for the services listed. These plans may be a good value for you. You can use in-network providers to save money. By using out-of-network providers, however, you not only pay a higher copayment but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (You receive a bill for $100, but the plan's allowance is $85. You pay the higher copayment for out-of-network care plus the $15 difference between $100 (the billed amount) and $85 (the plan's allowance.) This chart is not a complete statement of your out-of-pocket obligations in every individual circumstance. ***You must read a plan's brochure for details.***

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Surgery	Outpatient Surgery	Preventive Services	Prescription Drugs
Virginia									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Washington									
Aetna HealthFund CDHP	- In-Network	N/A	$1,000/$2,000	$3,000/$6,000	15%	15%	15%	N/A	$10/$25/$40
Aetna HealthFund CDHP	- Out-of-Network	N/A	$1,000/$2,000	$3,000/$6,000	40%	40%	40%	N/A	40%/40%/40%
Aetna HealthFund HDHP	- In-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$25/$40
Aetna HealthFund HDHP	- Out-of-Network	$104/$208*	$2,500/$5,000	$4,000/$8,000	30%	30%	30%	All	30%/30%/30%
Wisconsin									
Humana CoverageFirst (CDHP)	- In-Network	N/A	$1,050/$3,000	Stated copays	$20	$100/day x 5	Nothing	$20/$35	($10/$25)/$25/50%
Humana CoverageFirst (CDHP)	- Out-of-Network	N/A	$2,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	Copay + 30%*


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