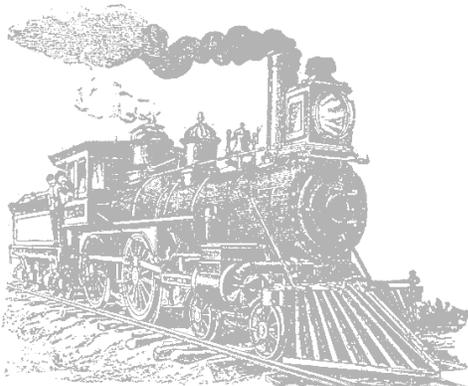


The 2001 Guide to

Federal Employees Health Benefits Plans



*All
Aboard for
Health!*

FOR UNITED STATES POSTAL SERVICE EMPLOYEES

*Be sure to visit our web site at www.opm.gov/insure
and U.S. Postal Service's Intranet web site at blue.usps.gov/hrisp/comp*



UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT

RETIREMENT AND INSURANCE
SERVICE

RI 70-2
Revised November 2000

Program Features

- **No Waiting Periods.** You can use your benefits as soon as your coverage becomes effective.
- **A Choice of Coverage.** Choose between self only or self and family.
- **A Choice of Plans and Options.** Select from Fee-for-Service, Health Maintenance Organization, or Point of Service plans.
- **A Postal Service Contribution.** The Postal Service pays 85 percent of the weighted average premium toward the total cost of your premium, but not more than 88.75 percent of the total premium for any plan.
- **Salary Deduction.** You pay your share of the premium through a payroll deduction.
- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enrollment.
- **Continued Group Coverage.** Eligible participants can continue coverage following retirement, divorce, death, or changes in employment status. See your local personnel 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. See your human resource office for more information.



**BETTER INFORMATION
BETTER CHOICES
BETTER HEALTH**

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Things to Remember

- A number of plans withdrew from the FEHB Program. Make sure your plan will be offered in 2001.
- Be aware of benefit changes for 2001.
- Check the premium for 2001.
- Paying your premium contributions on a pre-tax basis may restrict your ability to reduce or cancel coverage outside of FEHB open season unless you have one of the qualified life status changes and your election is in keeping with the change. See page 9 of this guide.



The information in the 2001 Guide to Federal Employees Health Benefits (FEHB) Plans gives you an overview of the FEHB Program and its participating plans. Before you make any final decisions about health plans, read the plan brochures.

FEHB and You

The Federal Employees Health Benefits (FEHB) Program began operation in July 1960. It is the nation's largest employer-sponsored health insurance program. Almost 9 million people, including 2.3 million federal employees, 1.9 million retirees, and eligible family members, are members of the Program.

Of Note for 2001

- Beginning in 2001, all FEHB plans must offer coverage for mental health and substance abuse that is identical to medical coverage deductibles, coinsurance, copays, and day and visit limitations. Check OPM's web site at www.opm.gov/insure and your plan's brochure for details.
- Patient Safety: See page 5 for five important steps you can take to prevent medical error and improve your healthcare safety.
- Patients' Bill of Rights and Responsibilities: The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommended consumer protections and quality initiatives that are now fully implemented by all FEHB plans. OPM's web site at www.opm.gov/insure lists the specific types of information that your health plan must make available to you. You may also contact your health plan directly for this information.

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 Insurance Programs. FEHB 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 2001 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 or from your local personnel office. OPM's web site, www.opm.gov/insure, also provides this guide, various plan brochures, and other helpful information.

You may choose from among Fee-for-Service (FFS) plans regardless of where you live (see pages 14 through 16); or plans offering a Point of Service (POS) Product, and Health Maintenance Organizations (HMOs) if you live (or sometimes if you work) within the area serviced by the plan (see pages 22 through 57).

While FEHB eligibility, enrollment requirements, and the plans available for 2001 are the same for federal and USPS employees alike, there are some important differences in premium costs and withholding of premium contributions that apply to postal employees only. Career postal employees premium rates are calculated using the "Fair Share Formula", which covers non-postal employees and annuitants as well. The difference is that the Postal Service pays a higher percentage contribution than the rest of the federal government, which makes health benefits more affordable for postal employees.

Coverage

New employees have the opportunity to select a health plan when hired and current employees have an opportunity to select or change plans when certain life events occur and during an open season that occurs each fall. There are time limits for making these elections, so when a life event occurs, immediately check with your local personnel office to determine the effect on your eligibility and coverage and the action you must take.

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). Further information for determining family members' eligibility appears on page 2 of the Health Benefits Election Form, SF 2809 (July 1999 edition).

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

- Separation
- Retirement
- Divorce
- Death
- Relocation
- Leave without pay
- Child reaching age 22.

It is your responsibility to understand and report life events that may cause you or your family member to lose eligibility. Certain rules about coverage, timelines, and premium amounts apply. 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 plans during an open season. The 2000 Open Season is from November 13 through close of business December 11. 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 option
- Change from Self Only to Self and Family
- Change from Self and Family to Self Only
- Cancel enrollment

If you decide to do any of the above actions, you must submit an election form (Standard Form 2809) to your local personnel office by close of business on **December 11, 2000**.

Your new enrollment or any changes that you make to your existing coverage will take effect on **January 13, 2001**. If you decide NOT to change your enrollment, DO NOTHING, and your present enrollment will continue automatically unless your plan is not participating in 2001. If your plan is not participating in 2001, 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 2000 plan year.

If you decide to cancel your coverage, you must submit a Standard Form 2809 that clearly reflects your acceptance of the consequences of cancellation. A cancellation generally is effective at the end of the pay period in which it is received by the local personnel office. However, if cancellation is elected during open season, it will become effective on January 12, 2001. If during the plan year you pay premium contributions on a pre-tax basis you will not be able to cancel or reduce (change from Self and Family to Self Only) coverage unless you experience a qualified life status change and your election is in keeping with the change. See pages 9 and 10.

FEHB and You

Should you cancel coverage, you may not enroll again until the next open season unless an event occurs that permits enrollment, for example, a change in marital status.

Note to those considering retirement: In deciding whether to enroll in or cancel FEHB insurance, remember that you will not be eligible for FEHB coverage when you retire if you have not been continuously covered, either as an enrollee or eligible family member, for the 5 years 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 to 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 begins on page 9.

After referring to these sources, if you still have questions regarding eligibility, enrollment criteria, continued coverage after certain life events, or if you need an election form (SF 2809), contact your local personnel office.

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

Selecting a Health Plan

Before selecting a plan you should do the following:

- **Compare benefits in the brochures,**
- **Review costs,**
- **Consider quality, and**
- **Understand how the plan works.**

FEHB and You

Benefits —

Check to see if the plan offers the type of services you think you might need. Does it offer a prenatal program? Can you get preventative care? If you have other insurance coverage, how does the FEHB plan coordinate benefits with the other plan? Given the trend toward reducing hospital stays, will your plan pay for home health care? Because health care is expensive, pay attention to the plan's annual out-of-pocket maximum to see how you are protected. See if there are limits on the number of visits for the services you need. Don't assume benefits will be the same as they were last year. Check the plan brochure for details.

- ✓ **Read plan brochures carefully.**
- ✓ **Know what services are covered.**
- ✓ **Know what services are not covered.**

Cost —

The premium you pay is an important consideration. When thinking about premiums, what can you afford biweekly or monthly? Should you enroll in a High Option — and pay High Option premiums — if a Standard Option would do?

You also need to consider other costs. If you need to go to the hospital, how much will you have to pay? What will you pay for an emergency room visit? If you have children, what will you pay for a well-child visit? What will you pay for a prescription?

Do you have to pay a deductible for the services you want? You share medical expenses by paying a coinsurance (a percentage of the bill) or a copayment (a fixed dollar amount). Which option do you prefer? Does the plan limit the dollar amount it will pay for certain services, making you pay the rest?

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

F E H B a n d Y o u

Quality —

Reviewing the quality data in this Guide is like reading about the repair history of different car models before buying one. The model's repair record may or may not predict what your actual experience will be. However, it gives an indication of how the models compare to one another. You can then be fairly confident that a car that requires fewer repairs is a less risky purchase. The quality information in this Guide can help you avoid an uninformed decision.

What is quality health care? Most experts agree that quality varies at every level of the health care system, from one plan to another and even from one physician's office to another. Quality is just as much a matter of concern in fee-for-service plans as in HMOs. However, there are fewer opportunities to measure how they actually deliver care.

Poor quality can mean too much care (e.g., unnecessary surgery), too little care (e.g., not providing an indicated diagnostic test), or the wrong care (e.g., improper dose of a medication). Health plans can affect the quality of care in the ways they influence the physician's behavior and in the ways in which care is delivered.

Review the survey information in this guide to help you in making an informed decision.

Enrollee survey results in this Guide are not provided by the health plans. *They are solely based on the responses of enrolled individuals like you.* An independent company surveyed a statistically valid sample of each plan's members. A plan's ratings show how well the plan scored based on the responses of its surveyed members.

The complete questionnaire is on OPM's web site at www.opm.gov/insure.

These are summarized findings in key areas:

- **Getting Needed Care.** Did you have problems getting a referral to a specialist or did you experience delays in obtaining care?
- **Getting Care Quickly.** When you called during the doctor's regular office hours, did you get the advice or help you needed? Could you get an appointment for regular or routine care as soon as you wanted?
- **How Well Doctors Communicate.** Did your doctor listen carefully to you and explain things in a way you could understand? Did he spend enough time with you?
- **Courteous and Helpful Office Staff.** Was the doctor's staff as helpful as you thought they should be?

FEHB and You

- **Customer Service.** When you called your plan's customer service department, were they helpful? Did you have paperwork problems? Were the plan's written materials understandable?
- **Claims Processing.** Did your plan pay your claims correctly and in a reasonable time?
- **Overall plan satisfaction.** How would you rate your overall experience with your health plan?

A plan may not be rated for one of three reasons:

1. It is new to the FEHB Program,
2. It has fewer than 500 Federal enrollees, or
3. It failed to administer the survey as we asked. These plans are identified with an **X**.

Accreditation is another quality indicator. It is a rigorous and comprehensive evaluation by independent organizations that assess the quality of the key systems and processes that health care organizations use. It also includes an assessment of the care and service health plans deliver in areas such as immunization rates, mammography rates, and member satisfaction. The National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and the American Accreditation Healthcare Commission/URAC are independent, private, not-for-profit organizations dedicated to assessing and reporting on the quality of health care organizations. For further details, visit their web sites at www.ncqa.org, www.jcaho.org and www.urac.org.



**Call the
FEHB Fraud Hot Line
(202) 418-3300**

**if a provider has billed you for services
you did not receive.**

Patient Safety

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

- 1 Speak up if you have questions or concerns.** Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.
- 2 Keep a list of all medicines you take.** Tell your doctor and pharmacist about the medicines you take, including over-the-counter medicines such as aspirin and ibuprofen, and dietary supplements such as vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.
- 3 Make sure you get the results of any test or procedure.** Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected — in person, on the phone, or in the mail — don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.
- 4 Talk with your doctor and health care team about your options if you need hospital care.** If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.
- 5 Make sure you understand what will happen if you need surgery.** Ask your doctor and surgeon: Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

Prescription errors occur much more frequently than they should, often with serious consequences. Keep a record of your medicines; share this information with all of your doctors.

List all prescriptions and over-the-counter drugs, such as aspirin and ibuprofen, and dietary supplements, such as vitamins and herbals. Update this form whenever you have changes.	
MEDICATION	DOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

 Cut out this card and keep it with you.

How the Plan Works

Different types of plans have different methods for getting and paying for care.

- **Fee-for-Service** — This is a traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse you once you have paid the bill and filed an insurance claim for each covered medical expense. You select the doctor or hospital of your choice, but you usually must pay a deductible and coinsurance or copayment. Most fee-for-service plans have preferred provider organizations (PPO). You save money and avoid paperwork when you use preferred providers.
 - **Health Maintenance Organization** — This type of health plan gives you coordinated care through a network of physicians and hospitals in particular areas. You usually must get all your care from the providers that are part of the plan. You pay copayments for most services and rarely pay a deductible or coinsurance.
 - **Point of Service** — This type of plan also has rules about what benefits are covered, doctor choice, and access to specialists, but you can choose any doctor you like and see specialists without referrals if you agree to pay more.
- There are things you can do to make a plan work best for you.
- When you need care, use your brochure to find out about the plan's rules and coverage for the care you need. Know what services require precertification, prior approval, or referral before you use them.
 - Use your plan's mail order drug program if it has one. You get the convenience of a 90-day supply instead of a 30-day supply.
 - Request generic drugs instead of brand name drugs. A generic medication is a copy of a brand name drug. It has the same active ingredients but costs less.
 - Get a second or even third opinion before undergoing treatment for a serious illness or injury.
 - If you're in a fee-for-service plan, use the plan's PPO if it has one. (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, will probably be covered under non-PPO benefits.)
 - Ask questions. You deserve a voice in your own health care!

5 Steps to Safer Health Care:

1. Speak up if you have questions or concerns.
2. Keep a list of all the medicines you take.
3. Make sure you get the results of any test or procedure.
4. Talk with your doctor and health care team about your options if you need hospital care.
5. Make sure you understand what will happen if you need surgery.

Learn more at www.opm.gov/insure



Cut out this card and keep it with you.

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. Beginning October 1 this year all other federal employees were afforded this feature as well. Payment of premiums on a pre-tax basis prohibits postal enrollees from reducing coverage at any time. Read the "Reducing Coverage" section for details.

Pre-Tax Withholding

If you are a career USPS 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 Qualified Life Status Change, 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), 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 your coverage outside FEHB Open Season that apply if you pay your premium contributions with pre-tax money. These are explained 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 to waive the pre-tax treatment. For more information, see the section, How to Waive Pre-Tax Payments on page 10.

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 one of the following qualified life status changes occur.

Qualified Life Status Changes

1. You marry, divorce, legally separate, or your marriage is annulled.
2. You add a qualified dependent (for example, by birth, or you adopt a child, or your dependent now satisfies eligibility requirements).
3. You lose a qualified dependent (for example, by death, or your child is placed for adoption, or your dependent now ceases to satisfy eligibility requirements).
4. You, your spouse, or your dependent has a change in work site or residence.

FEHB and You

5. Your spouse or your dependent starts or ends employment, or an unpaid leave of absence, or a strike or lock-out; or has a change in employment status making that person eligible or ineligible for a benefit plan.
6. A court order, judgment or decree (resulting from a change in marital status or legal custody) requires you to begin providing coverage for your child or requires another person to do so.
7. You, your spouse or your dependent becomes or ceases to be eligible for Medicare or Medicaid.
8. You begin or end an unpaid leave of absence.
9. Your spouse or your dependent elects to change health coverage under another employer's plan, either based upon a qualified life status change or for a period of coverage that is different from USPS--you may then eliminate any duplicate coverage.

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

A qualified life status change does not allow you the opportunity to change plans or options.

To reduce your FEHB coverage outside of FEHB Open Season, submit Standard Form (SF) 2809, Health Benefits Election Form, to your local personnel office no later than 60 days after a qualified life status change has occurred. 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 SF 2809 is received. The effective date of a cancellation will be the last day of the pay period in which your SF 2809 is received.

If you are the only person left in your Self and Family enrollment as a result of a change in marital or family status (divorce, legal separation, annulment, or loss of a qualified dependent, for example, through death or because your child reaches age 22), you must elect to reduce the enrollment (elect Self Only coverage, or cancel coverage) WITHIN 60 DAYS of the qualified life status change. Otherwise, your self and family enrollment will continue until another event (that is, a qualified life status change or FEHB Open Season) occurs that allows you to elect to reduce coverage. The election cannot become effective retroactively, therefore, there will be no retroactive premium adjustment.

Retirement is NOT a qualified life status change that allows cancellation prior to separation. 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 premiums contributions are not withheld as a pre-tax payment, thus 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 Pre-tax Payments

If you wish to pay your premiums with after-tax money, you should contact your local personnel office and ask for Postal Service (PS) Form 8201, Pre-tax Health Insurance Premium Waiver/Restoration Form. Complete the form and return it to your local personnel office by close of business December 11, 2000.

FEHB and You

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 in the event of a qualified life status change.

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 qualified life status change.

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

WWW.OPM.GOV/INSURE

Opm now has two FEHB web pages to make your search for information easier. There is the FEHB Home Page that has information on the FEHB Program and important information on health care. There is also the Plan Comparison Page that has all the information you'll need to make an informed health insurance election.

Here's what you can find on the two pages:

FEHB Home Page

- The FEHB Handbook for Enrollees and Employing Offices — detailed and in-depth information about the FEHB Program
- The FEHB law and regulations
- Information on Disputed Claims, Patients' Bill of Rights and Mental Health Parity
- Frequently Asked Questions
- Monthly highlights about different health care issues and programs
- Information on Medicare and FEHB
- FEHB Facts — a program overview

Plan Comparison Page

- 2001 Plan Comparison — gives you general information about plans, plan quality, and information about how to choose a plan
- A link to PlanSmartChoice — an interactive decision support tool to help you select a plan
- Links to Guides and Brochures — view them on the web or download them and print them to keep
- Links to other web sites where you can find more about health care quality
- Links to on-line enrollment information — Employee Express, Annuitant Open Season Express

Plan Comparisons

2001 Plan Year List of Health Plans with Biweekly Premium Rates for USPS Employees

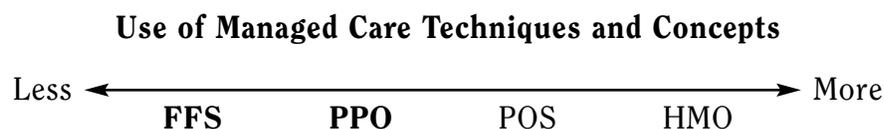
Nationwide Fee-for-Service Plans Open to All

(Pages 14 through 16)

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

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

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



Important: Some FFS plans also offer a Point of Service product.
Check pages 21–57 for details.

Nationwide Fee-for-Service Plans Open to All

How to read this chart:

The table below highlights selected features that may help you narrow your choice of health plans. An (*) in any column means an exception to the general rule for that particular plan. See the applicable column description for details. Always consult plan brochures before making your final decision.

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. Check the plan brochure for details.

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. Check the plan brochure for details.

Plan name	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Alliance Health Plan	202/939-6325	1R1	1R2	38.92	68.05
APWU Health Plan [◇]	800/222-2798	471	472	31.15	61.52
Blue Cross and Blue Shield-High	local phone #	101	102	54.51	103.97
Blue Cross and Blue Shield-Std [◇]	local phone #	104	105	18.63	45.56
GEHA Benefit Plan-High	800/821-6136	311	312	34.79	67.01
GEHA Benefit Plan-Std	800/821-6136	314	315	12.37	28.12
Mail Handlers-High	800/410-7778	451	452	31.36	50.59
Mail Handlers-Std	800/410-7778	454	455	9.87	21.42
NALC	703/729-4677	321	322	33.38	58.57
Postmasters-High	703/683-5585	361	362	159.06	332.56
Postmasters-Std	703/683-5585	364	365	42.26	81.36

◇ Offers a Point of Service product.

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

The **Annual Out-of-pocket Maximum** is the amount of certain covered charges the plan will require you to pay during the year. Some plans (*) require each family member to pay the maximum.

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

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

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

Finally, what you pay for **Generic** and **Brand name** drugs purchased through **Mail Order** is shown. In some cases you pay the greater of either the copayment or coinsurance shown. If you pay more for non-preferred drugs, that amount is shown on the non-PPO line.

Plan name	Benefit type	Medical-Surgical — You pay										
		Deductible			Annual Out-of-pocket Maximum	Copay (\$)/Coinsurance (%)						
		Per person		Per stay hospital inpatient		Doctors	Outpatient tests	Hospital			Mail order prescription drugs	
		Calendar year	Prescription drug					Inpatient	Outpatient other	Generic	Brand Name	
						R&B	Other					
Alliance Health Plan	PPO	\$100	\$200*	\$150	\$2,000*	10%	10%	10%	10%	10%	20%	20%
	Non-PPO	\$300	\$200*	\$250	\$3,000*	30%	30%	30%	30%	30%	20%	20%
APWU Health Plan	PPO	\$250	None	None	\$4,000	10%	10%	10%	10%	10%	\$5/20%	\$5/20%
	Non-PPO	\$250	None	\$200	\$6,000	30%	30%	30%	30%	30%	\$5/20%	\$5/20%
Blue Cross and Blue Shield-High	PPO	\$150	None	None	\$1,000	5%	5%	Nothing	Nothing	5%	\$8	\$14
	Non-PPO	\$150	None	\$100	\$2,700	20%	20%	30%	30%	\$100/d	\$8	\$14
Blue Cross and Blue Shield-Std	PPO	\$250	None	\$100	\$3,000	10%	10%	Nothing	Nothing	10%	\$12	\$20
	Non-PPO	\$250	None	\$300	\$5,000	25%	25%	30%	30%	\$150/d	\$12	\$20
GEHA Benefit Plan-High	PPO	\$300	None	None	\$2,500	10%	10%	Nothing	10%	10%	\$10	\$30
	Non-PPO	\$300	None	None	\$3,500	25%	25%	Nothing	25%	25%	\$10	\$30
GEHA Benefit Plan-Std	PPO	\$450	None	None	\$3,000	15%	15%	15%	15%	15%	\$15	50%
	Non-PPO	\$450	None	None	\$4,000	35%	35%	35%	35%	35%	\$15	50%
Mail Handlers-High	PPO	\$150	\$250*	None	\$2,500	10%	10%	Nothing	Nothing	10%	\$10	\$30
	Non-PPO	\$150	\$250*	\$250	\$4,000	30%	30%	Nothing	Nothing	30%	\$10	\$45
Mail Handlers-Std	PPO	\$200	\$600*	\$150	\$4,000	10%	10%	Nothing	Nothing	10%	\$10	\$40
	Non-PPO	\$200	\$600*	\$300	\$4,000	30%	30%	Nothing	Nothing	30%	\$10	\$55
NALC	PPO	\$250	None	None	\$3,000	15%	15%	Nothing	Nothing	15%	\$12	\$25
	Non-PPO	\$300	\$25	\$100	\$3,500	30%	30%	20%	20%	30%	\$12	\$25
Postmasters-High	PPO	\$200	\$100	None	\$3,000	10%	10%	10%	10%	10%	\$10	\$25
	Non-PPO	\$400	\$150	\$150	\$3,500	20%	20%	25%	25%	20%	\$10	\$25
Postmasters-Std	PPO	\$250	\$100	None	\$3,500	10%	10%	10%	10%	10%	\$15/20%	\$30/20%
	Non-PPO	\$500	\$150	\$250	\$5,000	30%	30%	30%	30%	30%	\$15/20%	\$30/20%

Nationwide Fee-for-Service Plans Open to All

Enrollee Survey Results — See page 5 for a description.

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

Plan Comparisons

2001 Plan Year List of Health Plans with Biweekly Premium Rates for USPS Employees

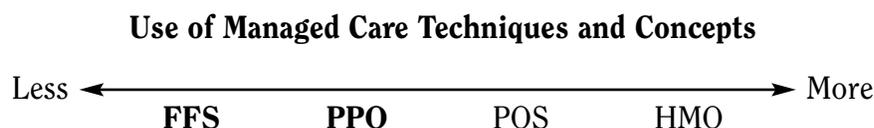
Nationwide Fee-for-Service Plans Open Only to Specific Groups

(Pages 18 through 20)

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

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

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



Important: Some FFS plans also offer a Point of Service product.
Check pages 21-57 for details.

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. An (*) in any column means an exception to the general rule for that particular plan. See the applicable column description for details. Always consult plan brochures before making your final decision.

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. Check the plan brochure for details.

Some plans apply **Prescription Drug** purchases to the Calendar Year deductible (CY).

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

Plan name	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Association Benefit Plan	800/634-0069	421	422	†	†
Foreign Service	202/833-4910	401	402	19.13	63.53
Panama Canal Area [◇]	732/222-2229	431	432	22.06	38.36
Rural Carrier Benefit Plan	800/638-8432	381	382	35.18	48.70
SAMBA	301/984-4101	441	442	41.11	106.37
Secret Service	800/424-7474	Y71	Y72	12.47	31.57

[◇] Offers a Point of Service product.

[†] See your personnel office.

The **Annual Out-of-pocket Maximum** is the amount of certain covered charges the plan will require you to pay during the year. Some plans (*) apply the limit to inpatient charges other than room and board.

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

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

Your share of **Hospital Inpatient Room and Board** and **Other** (e.g., nursing, supplies, and medications) covered charges are shown, usually after any per stay deductible. Some plans require this for your first admission only (*). Services provided and billed by the hospital for outpatient care (other than surgery) are shown as **Hospital Outpatient Other** expenses.

Finally, what you pay for **Generic** and **Brand name** drugs purchased through **Mail Order** is shown. In some cases you pay the greater of either the copayment or coinsurance shown. If you pay more for non-preferred drugs, that amount is shown on the non-PPO line.

Plan name	Benefit type	Medical-Surgical — You pay										
		Deductible			Annual Out-of-pocket Maximum	Copay (\$)/Coinsurance (%)						
		Per person		Per stay hospital inpatient		Doctors	Outpatient tests	Hospital			Mail order prescription drugs	
		Calendar year	Prescription drug					R&B	Other	Outpatient other	Generic	Brand Name
Association Benefit Plan	PPO	\$250	CY	None	\$2,000	10%	10%	Nothing	Nothing	10%	\$15	\$30
	Non-PPO	\$250	CY	\$100	\$3,000	25%	25%	25%	25%	25%	\$15	\$45
Foreign Service	PPO	\$300	None	None	\$3,000	Nothing	10%	Nothing	Nothing	10%	\$15	\$25
	Non-PPO	\$300	CY	\$200	\$4,000	20%	20%	20%	20%	20%	\$15	\$25
Panama Canal Area	No PPO	None	\$400	\$125	\$2,500*	50%	50%	50%	50%	50%	N/A	N/A
Rural Carrier Benefit Plan	PPO	\$250	CY	None	\$2,000	15%	15%	Nothing	Nothing	Nothing	\$13	\$18
	Non-PPO	\$250	CY	\$200*	\$2,500	15%	25%	\$200*	20%	Nothing	\$13	\$18
SAMBA	PPO	\$300	None	\$200	\$2,500	10%	10%	Nothing	10%	10%	\$15	\$20
	Non-PPO	\$300	None	\$200	\$2,500	30%	30%	30%	30%	30%	\$15	\$25
Secret Service	No PPO	\$200	None	\$100	\$1,000	20%	20%	Nothing	Nothing	Nothing	\$5	\$12

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

Enrollee Survey Results — See page 5 for a description.

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

Plan Comparisons

2001 Plan Year List of Health Plans with Biweekly Premium Rates for USPS Employees

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

(Pages 22 through 57)

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

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

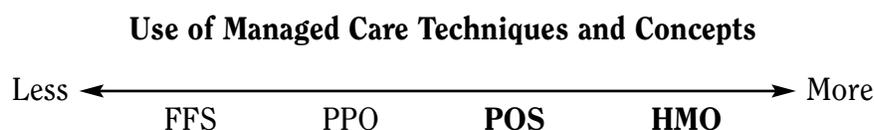
Plans Offering a Point of Service (POS) Product — A product offered by an HMO or FFS plan that has features of both.

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

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

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

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



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.

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Alabama					
Health Partners of Alabama - Birmingham/Other areas	800/947-5093	DF1	DF2	25.17	94.95
PrimeHealth of Alabama, Inc. - Central/Southern Alabama	800/236-9421	AA1	AA2	11.55	31.78
Arizona					
Aetna U.S. Healthcare - Phoenix/Tucson areas	800/537-9384	WQ1	WQ2	9.78	27.52
CIGNA HealthCare of AZ-Phoenix - Phoenix area	800/572-9990	161	162	14.59	37.48
InterGroup of Arizona, Inc. - Maricopa/Pima/Other AZ counties	800/289-2818	A71	A72	10.80	29.14
PacifiCare Health Plans - Most of Arizona	800/347-8600	A31	A32	10.00	28.01
California					
Aetna U.S. Healthcare - Southern California area	800/537-9384	2X1	2X2	9.59	22.38
Aetna U.S. Healthcare - Northern California area	800/537-9384	BU1	BU2	22.00	46.57
Blue Cross- HMO - Most of California	800/235-8631	M51	M52	10.58	27.00
Blue Shield of CA Access+ - Most of California	800/334-5847	SJ1	SJ2	10.14	25.16
CIGNA HealthCare of California - Northern/Southern California	800/832-3211	9T1	9T2	10.95	24.10
Health Net - Most of California	800/522-0088	LB1	LB2	10.46	24.77
Kaiser Permanente - Northern California	800/464-4000	591	592	10.16	24.25
Kaiser Permanente - Southern California	800/464-4000	621	622	10.62	24.54
Maxicare Southern California - Southern California	800/234-6294	CM1	CM2	8.67	22.03
National HMO Health Plan - Northern/Central/Southern California	800/468-8600	MN1	MN2	8.47	22.24
PacifiCare Health Plans - Most of California	800/624-8822	CY1	CY2	9.03	23.55
UHP HEALTHCARE - LA/Orange/San Bernardino Counties	800/544-0088	C41	C42	8.46	18.03
Universal Care - Southern California	800/257-3087	6Q1	6Q2	8.60	22.72
Western Health Advantage - Northern California	888/563-2250	5Z1	5Z2	10.10	24.23

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See page 5 for a description. An (X) means the plan did not conduct the survey as we asked. **Accredited** — A (✓) means the plan is accredited by the National Committee for Quality Assurance; the Joint Commission on Accreditation of Healthcare Organizations; and/or the American Accreditation Healthcare Commission/URAC.

Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
Alabama												
Health Partners of Alabama	\$15	\$100	\$5	\$15/\$25	○	○	◐	●	●	◐	◐	
PrimeHealth of Alabama, Inc.	\$10	None	\$7	\$12/\$30	◐	◐	◐	●	●	◐	◐	
Arizona												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	◐	○	○	◐	◐	◐	◐	✓
CIGNA HealthCare of AZ-Phoenix	\$10	None	\$5	\$15	○	○	○	○	○	◐	◐	✓
InterGroup of Arizona, Inc.	\$10	None	\$5	\$10	○	○	○	○	○	◐	◐	✓
PacifiCare Health Plans	\$10	None	\$5	\$15	○	○	○	○	○	◐	◐	✓
California												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	◐	○	○	○	○	◐	◐	✓
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	○	○	◐	○	○	○	✓
Blue Cross- HMO	\$10	None	\$5	\$10	◐	○	○	○	○	◐	◐	✓
Blue Shield of CA Access+	\$10	None	\$6	\$6	○	◐	○	○	○	◐	◐	✓
CIGNA HealthCare of California	\$10	None	\$5	\$10	○	○	○	○	○	○	○	✓
Health Net	\$10	None	\$5	\$10/\$15	◐	○	◐	◐	◐	◐	◐	✓
Kaiser Permanente	\$10	None	\$10	\$10	●	◐	○	○	○	●	◐	✓
Kaiser Permanente	\$10	None	\$10	\$10	◐	◐	○	○	○	●	◐	✓
Maxicare Southern California	\$10	None	\$5	\$10/\$25	◐	○	○	◐	○	◐	○	
National HMO Health Plan	\$10	\$25	\$5	\$10/50%	●	○	○	◐	◐	◐	●	✓
PacifiCare Health Plans	\$10	None	\$5	\$15	◐	○	○	○	○	◐	◐	✓
UHP HEALTHCARE	\$10	None	\$5	\$5								
Universal Care	\$10	None	\$5	\$5								✓
Western Health Advantage	\$10	None	\$5	\$10/\$20								✓

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.

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Colorado					
Aetna U.S. Healthcare - The Front Range	800/537-9384	6F1	6F2	11.68	43.12
Kaiser Permanente - Denver/Colorado Springs areas	888/681-7878	651	652	9.77	24.90
PacifiCare of Colorado-High -Denver/Pueblo/Col.Sprgs/FtColins/LaPlata	800/877-9777	D61	D62	11.52	33.81
PacifiCare of Colorado-Std - Denver/Pueblo/Col.Sprgs/FtColins/LaPlata	800/877-9777	D64	D65	8.70	22.52
Rocky Mountain HMO - Most of Colorado	800/346-4643	XJ1	XJ2	34.60	88.83
Connecticut					
Aetna U.S. Healthcare - All of Connecticut	800/537-9384	H11	H12	26.06	111.89
Blue Cross and Blue Shield-Std - All of Connecticut	800/438-5356	104	105	18.63	45.56
ConnectiCare - All of Connecticut	800/251-7722	TE1	TE2	11.06	28.96
Health New England - Northern Connecticut	413/787-4004	DJ1	DJ2	20.05	73.55
Physicians Health Services/CT - All of Connecticut	877/747-9585	DP1	DP2	35.47	153.59
Delaware					
Aetna U.S. Healthcare-High -All of Delaware	800/537-9384	SU1	SU2	20.66	83.94
Aetna U.S. Healthcare-Std - All of Delaware	800/537-9384	SU4	SU5	12.15	47.60

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See page 5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — A (✓) means the plan is accredited by the National Committee for Quality Assurance; the Joint Commission on Accreditation of Healthcare Organizations; and/or the American Accreditation Healthcare Commission/URAC.

Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
Colorado												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	○	◐	◐	◐	○	○	
Kaiser Permanente	\$10	None	\$5	\$15	◐	◐	○	○	○	●	◐	✓
PacifiCare of Colorado-High	\$10	None	\$5	\$10/\$20	○	○	◐	◐	◐	○	○	✓
PacifiCare of Colorado-Std	\$15	\$300	\$10	\$20/\$30	○	○	◐	◐	◐	○	○	✓
Rocky Mountain HMO	\$10	None	\$10	\$15	◐	●	●	●	●	◐	●	✓
Connecticut												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	◐	●	◐	◐	○	○	✓
Blue Cross and Blue Shield-Std - In-Network	\$15	None	\$10	\$20	◐	●	●	◐	◐	◐	●	✓
Blue Cross and Blue Shield-Std - Out-of-Network	25%	\$300	45%	45%	◐	●	●	◐	◐	◐	●	✓
ConnectiCare	\$10	None	\$10	\$20/\$35	◐	●	◐	◐	◐	○	●	✓
Health New England	\$10	None	\$7	\$15	◐	●	○	◐	◐	◐	●	✓
Physicians Health Services/CT	\$10	None	\$10	\$20	●	●	●	●	●	◐	●	✓
Delaware												
Aetna U.S. Healthcare-High	\$10	None	\$5	\$10/\$25								
Aetna U.S. Healthcare-Std	\$15	\$240	\$10	\$15/\$30								

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.

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
District of Columbia					
Aetna U.S. Healthcare-High -Washington, DC area	800/537-9384	JN1	JN2	12.85	33.08
Aetna U.S. Healthcare-Std - Washington, DC area	800/537-9384	JN4	JN5	9.36	21.89
CapitalCare - Washington, DC area	800/680-9495	2G1	2G2	16.79	42.55
Free State Health Plan - Washington, DC area	800/445-6036	LD1	LD2	17.16	40.97
George Washington Univ HP - Washington, DC area	301/941-2000	E51	E52	11.52	28.24
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	11.90	30.05
MD-IPA - Washington, DC area	800/251-0956	JP1	JP2	12.25	30.24
Florida					
Av-Med Health Plan - Broward/Dade/Palm Beach Counties	800/882-8633	EM1	EM2	13.07	85.96
Av-Med Health Plan - Orlando area	800/882-8633	GP1	GP2	19.25	102.90
Av-Med Health Plan - Tampa Bay area	800/882-8633	H51	H52	25.93	121.23
Av-Med Health Plan - Jacksonville area	800/882-8633	HW1	HW2	12.84	82.68
Av-Med Health Plan - Gainesville area	800/882-8633	JF1	JF2	14.59	90.02
Beacon Health Plans - Dade/Broward/Palm Beach Counties	800/850-0979	4K1	4K2	9.79	27.59
Capital Health Plan - Tallahassee area	850/383-3311	EA1	EA2	10.56	28.19
Foundation Health - Central Florida	800/441-5501	5D1	5D2	10.56	33.31
Foundation Health - Southern Florida	800/441-5501	5E1	5E2	8.43	23.20
HIP Health Plan of FL - South Florida	800/447-8255	3N1	3N2	12.15	67.43
HIP Health Plan of FL - Tampa area	800/447-8255	K71	K72	34.51	146.84
Humana Medical Plan - South Florida	888/393-6765	EE1	EE2	11.41	28.54
Prudential HealthCare HMO - Jacksonville area	800/856-0764	EC1	EC2	11.53	50.65
Prudential HealthCare HMO - Central Florida area	800/856-0764	EH1	EH2	10.73	35.63
Total Health Choice - Broward/Dade/Palm Beach Counties	305/408-5823	4A1	4A2	10.16	25.30

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Accredited — A (✓) means the plan is accredited by the National Committee for Quality Assurance; the Joint Commission on Accreditation of Healthcare Organizations; and/or the American Accreditation Healthcare Commission/URAC.

Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
District of Columbia												
Aetna U.S. Healthcare-High	\$10	None	\$5	\$10/\$25	○	○	◐	◐	◐	○	○	✓
Aetna U.S. Healthcare-Std	\$15	\$240	\$10	\$15/\$30	○	○	◐	◐	◐	○	○	✓
CapitalCare	\$10	None	\$8	\$15/\$30	◐	◐	○	◐	○	◐	◐	✓
Free State Health Plan	- In-Network	\$10	None	\$10	\$20/\$35	◐	◐	◐	◐	◐	◐	✓
	- Out-of-Network	20%	\$200#	\$10	\$20/\$35							
George Washington Univ HP	\$10	None	\$5	\$15/\$25	○	◐	○	◐	○	○	○	✓
Kaiser Permanente	\$10	None	\$7	\$7	◐	◐	○	○	○	●	◐	✓
MD-IPA	\$10	None	\$5	\$10/\$25	●	●	◐	◐	◐	●	◐	✓
Florida												
Av-Med Health Plan	\$10	None	\$5	\$5	◐	○	○	◐	◐	●	◐	✓
Av-Med Health Plan	\$10	None	\$5	\$5	◐	○	○	◐	◐	●	◐	✓
Av-Med Health Plan	\$10	None	\$5	\$5	◐	○	○	◐	◐	●	◐	✓
Av-Med Health Plan	\$10	None	\$5	\$5	◐	○	○	◐	◐	●	◐	✓
Av-Med Health Plan	\$10	None	\$5	\$5	◐	○	○	◐	◐	●	◐	✓
Beacon Health Plans	\$10	None	\$5	\$15								
Capital Health Plan	\$10	\$100	\$7	\$20/\$35	●	●	◐	◐	◐	●	●	✓
Foundation Health	\$10	None	\$5	\$15/\$30	○	○	○	○	○	◐	◐	✓
Foundation Health	\$10	None	\$5	\$15/\$30	○	○	○	○	○	◐	◐	✓
HIP Health Plan of FL	\$10	\$100	\$5	\$10	○	◐	○	○	◐	◐	○	✓
HIP Health Plan of FL	\$10	\$100	\$5	\$10	○	◐	○	○	◐	◐	○	✓
Humana Medical Plan	\$10	None	\$5	\$10/\$25	◐	○	○	○	○	◐	◐	✓
Prudential HealthCare HMO	\$10	None	\$5	\$10/\$20	◐	◐	○	◐	◐	◐	◐	✓
Prudential HealthCare HMO	\$10	None	\$5	\$10/\$20	◐	○	○	○	○	◐	◐	✓
Total Health Choice	\$10	\$100	\$5	\$15								

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.

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Georgia					
Aetna U.S. Healthcare - Atlanta, Athens and Augusta areas	800/537-9384	2U1	2U2	10.81	28.41
Blue Cross and Blue Shield-Std - Athens/Atl/Augusta/Col/Macon/Savannah	800/282-2473	104	105	18.63	45.56
Kaiser Permanente - Atlanta area	800/611-1811	F81	F82	10.89	27.63
Guam					
PacifiCare Asia Pacific-High -Guam/N. Mariana Islands/Palau	671/647-3526	JK1	JK2	12.27	55.43
PacifiCare Asia Pacific-Std - Guam/N. Mariana Islands/Palau	671/647-3526	JK4	JK5	8.08	21.33
Hawaii					
HMSA - All of Hawaii	808/948-6499	871	872	11.10	24.71
Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu/Kauai	808/597-5955	631	632	17.23	28.89
Kaiser Permanente-Std - Islands of Hawaii/Maui/Oahu/Kauai	808/597-5955	634	635	10.22	21.98
Idaho					
Group Health Cooperative - Kootenai and Latah	800/497-2210	VR1	VR2	17.26	76.30
Premera HealthPlus - Washington border counties	800/527-6675	8F1	8F2	16.46	55.63

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See page 5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — A (✓) means the plan is accredited by the National Committee for Quality Assurance; the Joint Commission on Accreditation of Healthcare Organizations; and/or the American Accreditation Healthcare Commission/URAC.

Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
Georgia												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	○	◐	◐	◐	○	○	
Blue Cross and Blue Shield-Std	\$15	None	\$10	\$20	◐	○	○	◐	◐	◐	●	✓
	25%	\$300	45%	45%								
Kaiser Permanente	\$10	None	\$11	\$11	●	●	●	◐	●	●	◐	✓
Guam												
PacifiCare Asia Pacific-High	\$10	None	\$5	\$5/\$20	●	◐	○	◐	○	●	◐	
PacifiCare Asia Pacific-Std	\$15	\$150	\$5	\$5/\$20	●	◐	○	◐	○	●	◐	
Hawaii												
HMSA	20%	None	\$5	\$10/50%**	●	●	●	●	●	●	●	
	30%	30%	\$5***	\$10***								
Kaiser Permanente-High	\$10	None	\$7	\$7	●	●	◐	◐	◐	●	●	✓
Kaiser Permanente-Std	\$15	None#	\$7	\$7	●	●	◐	◐	◐	●	●	✓
Idaho												
Group Health Cooperative	\$10	\$100/day*	\$10	\$10	●	◐	●	●	●	●	●	✓
Premera HealthPlus	\$10	\$100	\$10	\$20/\$30	○	◐	◐	◐	◐	○	◐	✓

* For up to 3 days

** Based on fee schedule

*** Plan pays non-plan pharmacy only what it would have paid a plan pharmacy; you pay the difference.

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.

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Illinois					
Aetna U.S. Healthcare - Metro St. Louis area	800/537-9384	D41	D42	9.14	24.31
Aetna U.S. Healthcare - Chicago area	800/537-9384	XC1	XC2	8.06	25.65
Group Health Plan - Southern/Metro East/Central	800/743-3901	MM1	MM2	25.36	45.69
Health Alliance HMO - Central/E.Central/N.West/South/West IL	800/851-3379	FX1	FX2	19.58	53.13
Health Partners of the Midwest - St. Louis area	800/338-4123	RN1	RN2	25.70	46.41
Humana Health Plan Inc. - Chicago area	888/393-6765	751	752	12.59	37.19
John Deere Health Plan - Bloomington/Joliet/Moline/Peoria/RockIsld	800/247-9110	YH1	YH2	12.80	75.98
Mercy Health Plans/Premier - Southwest Illinois	800/327-0763	7M1	7M2	11.66	27.12
OSF HealthPlans - Central/Northern Illinois	800/673-5222	9F1	9F2	10.89	28.65
PersonalCare's HMO - East Central Illinois	800/431-1211	GE1	GE2	8.82	22.68
Prudential HealthCare HMO - Southern Illinois	800/856-0764	VZ1	VZ2	9.65	24.36
UNICARE Health Plans of the Mid-West - Chicago area	312/234-7747	171	172	9.34	24.25
Union Health Service - Chicago area	312/829-4224	761	762	10.10	25.04
Indiana					
Aetna U.S. Healthcare - Southern Indiana	800/537-9384	7L1	7L2	11.16	27.58
Aetna U.S. Healthcare - Southeastern Indiana	800/537-9384	RD1	RD2	12.66	53.53
Aetna U.S. Healthcare - Lake/Porter Counties	800/537-9384	XC1	XC2	8.06	25.65
Arnett HMO - Lafayette area	765/448-7440	G21	G22	18.98	83.97
Health Alliance HMO - Fountain/Vermillion/Warren Counties	800/851-3379	FX1	FX2	19.58	53.13
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	12.95	56.56
Humana Health Plan Inc. - Lake/Porter/LaPorte Counties	888/393-6765	751	752	12.59	37.19
M*Plan - Central/Northeast/Southwest Indiana	317/571-5320	IN1	IN2	18.40	38.08
Maxicare Indiana - Most of Indiana	800/752-5866	GK1	GK2	11.99	28.19
Physicians HP of N. Indiana - Northern Indiana	219/432-6690	DQ1	DQ2	21.28	46.87
Sagamore Advantage HMO, Inc. - Most of Indiana	800/553-8933	6Y1	6Y2	11.94	28.03
UNICARE Health Plans of the Mid-West - Lake/Porter Counties	888/234-7747	171	172	9.34	24.25
Welborn HMO - Evansville area	812/426-6600	H31	H32	15.51	73.15

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See page 5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — A (✓) means the plan is accredited by the National Committee for Quality Assurance; the Joint Commission on Accreditation of Healthcare Organizations; and/or the American Accreditation Healthcare Commission/URAC.

Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average								Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing		
Illinois													
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25									
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	○	◐	◐	○	○	○		✓
Group Health Plan	\$10	None	\$8	\$15/\$30	◐	◐	○	◐	○	◐	◐		✓
Health Alliance HMO	\$10	\$100	\$7	\$14	●	●	●	●	●	●	●		
Health Partners of the Midwest	\$10	None	\$7	\$12/\$25	◐	◐	◐	◐	◐	◐	◐		
Humana Health Plan Inc.	\$10	None	\$3	\$7/\$20	○	◐	○	◐	○	◐	○		✓
John Deere Health Plan	\$10	\$100	\$5	\$15/\$30	●	●	●	◐	●	◐	●		✓
Mercy Health - In-Network	\$10	None	\$7	\$12	●	●	●	◐	◐	●	●		
Mercy Health - Out-of-Network	30%	None#	\$7	\$12									
OSF HealthPlans	\$10	\$100*	\$7	\$15/\$25	●	●	●	●	●	●	●		
PersonalCare’s HMO	\$10	\$100	\$10	\$20/\$35	●	●	●	◐	●	●	●		✓
Prudential HealthCare HMO	\$10	None	\$5	\$15/\$25	○	○	◐	◐	◐	○	○		✓
UNICARE Health Plans of the Mid-West	\$10	None	\$5	\$10	○	◐	◐	○	◐	◐	○		✓
Union Health Service	\$10	None	\$5	\$5									
Indiana													
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25									
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	◐	●	●	●	○	○		
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	○	◐	◐	○	○	○		✓
Arnett HMO	\$10	None	\$5	\$15/\$30	●	●	●	◐	●	●	●		
Health Alliance HMO	\$10	\$100	\$7	\$14	●	●	●	●	●	●	●		
Humana Health Plan	\$10	None	\$5	\$10/\$25	◐	◐	◐	◐	◐	○	◐		
Humana Health Plan Inc.	\$10	None	\$3	\$7/\$20	○	◐	○	◐	○	◐	○		
M*Plan	\$10	None	\$5	\$10/\$30	●	●	●	◐	●	◐	◐		✓
Maxicare Indiana	\$10	None	\$5	\$10/\$25	◐	◐	◐	◐	◐	○	○		✓
Physicians HP of N. Indiana	\$10	20%**	\$10	\$10/\$25	●	●	●	●	●	●	●		
Sagamore Advantage HMO, Inc.	\$10	\$100	\$5	\$10									
UNICARE Health Plans of the Mid-West	\$10	None	\$5	\$10	○	◐	◐	○	◐	◐	○		✓
Welborn HMO	\$10	None	\$5	\$15	●	●	●	◐	●	●	●		✓

* For up to 3 days
 ** Of the first \$2,500

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

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Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Iowa					
Coventry Health Care of Iowa - Des Moines/Central Iowa/Waterloo	800/257-4692	SV1	SV2	9.45	25.51
Health Alliance HMO - Central Iowa	888/536-5300	7X1	7X2	11.21	27.20
John Deere Health Plan - Central/Eastern Iowa	800/247-9110	YH1	YH2	12.80	75.98
SecureCare of Iowa - Central/Eastern Iowa	888/881-8820	3Q1	3Q2	11.31	32.18
Kansas					
Blue Cross and Blue Shield-Std - Most of Kansas	800/432-0379	104	105	18.63	45.56
Coventry Health Care of Kansas - Wichita/Salinas areas	800/969-3343	7W1	7W2	11.13	28.38
Humana Kansas City, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	12.76	40.96
Humana Kansas City, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	9.89	23.73
Kaiser Permanente - Kansas City area	913/642-2662	HA1	HA2	9.54	24.62
Preferred Plus of Kansas - S. Central & Jefferson/Shawnee Counties	800/660-8114	VA1	VA2	12.79	71.28
Kentucky					
Advantage Care, Inc. - Central/Eastern Kentucky	800/850-8585	XW1	XW2	11.96	45.11
Aetna U.S. Healthcare - Lexington/Louisville areas	800/537-9384	7L1	7L2	11.16	27.58
Aetna U.S. Healthcare - Northern Kentucky area	800/537-9384	RD1	RD2	12.66	53.53
Bluegrass Family Health - Central/Eastern Kentucky	606/269-4475	2B1	2B2	19.21	84.54
Bluegrass Family Health - Southern Kentucky	606/269-4475	BD1	BD2	23.99	96.98
Bluegrass Family Health - Western Kentucky	606/269-4475	BH1	BH2	26.39	103.20
Humana Health Plan - Louisville area	888/393-6765	D21	D22	12.95	56.56
United Health Care of Ohio, Inc. - Northern Kentucky	800/231-2918	3U1	3U2	19.23	48.16

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average								Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing		
Iowa													
Coventry Health Care of Iowa	\$10	None	\$5 or 25%*	\$5 or 25%*	◐	●	●	◐	◐	◐	◐	✓	
Health Alliance HMO	\$10	\$100	\$7	\$14	●	●	●	●	●	●	●		
John Deere Health Plan	\$10	\$100	\$5	\$15/\$30	●	●	●	◐	●	◐	●	✓	
SecureCare of Iowa	\$10	\$100	25%	25%									
Kansas													
Blue Cross and Blue Shield-Std - In-Network	\$15	None	\$10	\$20	◐	●	●	●	●	◐	●		
- Out-of-Network	25%	\$300	45%	45%									
Coventry Health Care of Kansas	\$10	None	\$5	\$10/\$20	○	○	◐	◐	◐	◐	●	✓	
Humana Kansas City, Inc.-High	\$10	None	\$5	\$10/\$25	○	◐	◐	◐	○	◐	◐	✓	
Humana Kansas City, Inc.-Std	\$15	\$100	\$10	\$20/\$35	○	◐	◐	◐	○	◐	◐	✓	
Kaiser Permanente	\$10	None	\$5	\$5	◐	◐	◐	○	◐	●	◐	✓	
Preferred Plus of Kansas	\$10	None	\$5	\$15									
Kentucky													
Advantage Care, Inc.	\$10	\$100	\$7	\$14/\$30	◐	◐	◐	◐	◐	●	●	✓	
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25									
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	◐	●	●	●	○	○		
Bluegrass Family Health - In-Network	\$10	\$100	\$5	\$10/\$25	◐	◐	◐	●	●	◐	●		
- Out-of-Network	30%	30%	30%	30%									
Bluegrass Family Health - In-Network	\$10	\$100	\$5	\$10/\$25									
- Out-of-Network	30%	30%	30%	30%									
Bluegrass Family Health - In-Network	\$10	\$100	\$5	\$10/\$25									
- Out-of-Network	30%	30%	30%	30%									
Humana Health Plan	\$10	None	\$5	\$10/\$25	◐	◐	◐	◐	◐	○	◐		
United Health Care of Ohio, Inc.	\$10	\$100	\$10	\$15	◐	●	●	◐	●	●	◐	✓	

* You pay the greater amount

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

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Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Louisiana					
Aetna U.S. Healthcare - Baton Rouge/Lafayette/New Orleans areas	800/537-9384	NG1	NG2	10.38	30.07
Amcare Health Plans - New Orleans area	800/772-2995	ZH1	ZH2	9.46	24.59
Amcare Health Plans - Baton Rouge/Alexandria/Shreveport areas	800/772-2995	ZQ1	ZQ2	10.70	27.81
Blue Cross and Blue Shield-Std - New Orleans area	800/272-3029	104	105	18.63	45.56
Maxicare Louisiana - Baton Rouge/New Orleans areas	800/933-6294	JA1	JA2	10.56	24.53
Maryland					
Aetna U.S. Healthcare-High -North/Central/Southern Maryland	800/537-9384	JN1	JN2	12.85	33.08
Aetna U.S. Healthcare-Std - North/Central/Southern Maryland	800/537-9384	JN4	JN5	9.36	21.89
CapitalCare - South/Central Maryland	800/680-9495	2G1	2G2	16.79	42.55
Free State Health Plan - All of Maryland	800/445-6036	LD1	LD2	17.16	40.97
George Washington Univ HP - Central/Southern Maryland	301/941-2000	E51	E52	11.52	28.24
Kaiser Permanente - Baltimore/Washington, DC areas	301/468-6000	E31	E32	11.90	30.05
MD-IPA - All of Maryland	800/251-0956	JP1	JP2	12.25	30.24
Massachusetts					
Aetna U.S. Healthcare - Central/Eastern MA/Hampden	800/537-9384	NE1	NE2	27.80	111.04
Blue Chip, Coord Hlth Partners - Southeastern Massachusetts	401/459-5500	DA1	DA2	16.55	72.95
Blue Cross and Blue Shield-Std - All of Massachusetts	800/433-7766	104	105	18.63	45.56
Fallon Community Health Plan - Central/Eastern Massachusetts	800/868-5200	JV1	JV2	11.84	39.70
Health New England - Western Massachusetts	413/787-4004	DJ1	DJ2	20.05	73.55

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
Louisiana												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	◐	◐	○	◐	◐	●	○	
Amcare Health Plans	\$10	None	\$5	\$15/50%								
Amcare Health Plans	\$10	None	\$5	\$15/50%								
Blue Cross and Blue Shield-Std - In-Network	\$15	None	\$10	\$20	●	◐	○	◐	○	●	●	✓
- Out-of-Network	25%	\$300	45%	45%								
Maxicare Louisiana - In-Network	\$10	None	\$7	\$12/\$25	◐	○	○	◐	○	○	○	
- Out-of-Network	20%	20%	N/A	N/A								
Maryland												
Aetna U.S. Healthcare-High	\$10	None	\$5	\$10/\$25	○	○	◐	◐	◐	○	○	✓
Aetna U.S. Healthcare-Std	\$15	\$240	\$10	\$15/\$30	○	○	◐	◐	◐	○	○	✓
CapitalCare	\$10	None	\$8	\$15/\$30	◐	◐	○	◐	○	◐	◐	✓
Free State Health Plan - In-Network	\$10	None	\$10	\$20/\$35	◐	◐	◐	◐	◐	◐	◐	✓
- Out-of-Network	20%	\$200#	\$10	\$20/\$35								
George Washington Univ HP	\$10	None	\$5	\$15/\$25	○	◐	○	◐	○	○	○	✓
Kaiser Permanente	\$10	None	\$7	\$7	◐	◐	○	○	○	●	◐	✓
MD-IPA	\$10	None	\$5	\$10/\$25	●	●	◐	◐	◐	●	◐	✓
Massachusetts												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	◐	●	●	●	○	○	✓
Blue Chip, Coord Hlth Partners - In-Network	\$10	None	\$5	\$15/\$30	◐	●	●	●	●	◐	◐	✓
- Out-of-Network	20%	None#	\$5	\$15/\$30								
Blue Cross and Blue Shield-Std - In-Network	\$15	None	\$10	\$20	●	●	●	◐	◐	●	●	✓
- Out-of-Network	25%	\$300	45%	45%								
Fallon Community Health Plan	\$10	None	\$5	\$10	●	●	●	●	●	◐	◐	✓
Health New England	\$10	None	\$7	\$15	◐	●	○	◐	◐	◐	●	✓

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.

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Michigan					
Aetna U.S. Healthcare - Greater Detroit Metro area	800/537-9384	8Z1	8Z2	10.12	26.18
Blue Care Network West MI - Western Michigan	800/662-6667	G71	G72	46.29	144.17
Blue Care Network West MI - East Michigan Region	800/662-6667	K51	K52	12.33	74.79
Blue Care Network West MI - Western Michigan	800/662-6667	KF1	KF2	13.84	88.03
Blue Care Network West MI - East Michigan Region	800/662-6667	KN1	KN2	12.91	89.40
Blue Care Network West MI - Western Michigan	800/662-6667	KR1	KR2	18.51	117.12
Blue Care Network West MI - Mid Michigan	800/662-6667	LN1	LN2	33.52	95.55
Blue Care Network West MI - Southeast MI	800/662-6667	LX1	LX2	8.86	29.14
Grand Valley Health Plan - Grand Rapids area	616/949-2410	RL1	RL2	11.71	31.22
Health Alliance - Southeastern Michigan/Flint area	800/422-4641	521	522	10.76	28.51
HealthPlus MI - Flint/Saginaw areas	800/332-9161	X51	X52	12.25	35.81
M-Care - Mid/Southeastern Michigan	800/658-8878	EG1	EG2	10.73	28.44
OmniCare - Southeastern Michigan	800/477-6664	KA1	KA2	10.21	25.64
SelectCare HMO - Southeast Michigan	800/332-2365	K61	K62	10.27	28.76
SelectCare HMO - Flint area	800/332-2365	KP1	KP2	12.32	75.57
The Wellness Plan - Southeastern Michigan	800/875-9355	K31	K32	10.51	28.77
Total Health Care - Greater Detroit/Flint areas	800/826-2862	N21	N22	9.96	25.21
Minnesota					
APWU Health Plan - Minneapolis/St Paul area	800/222-2798	471	472	31.15	61.52
Blue Cross and Blue Shield-Std - All of Minnesota	800/859-2128	104	105	18.63	45.56
HealthPartners Classic-High -Minneapolis/St. Paul areas	612/883-5000	531	532	27.88	81.08
HealthPartners Classic-Std - Minneapolis/St. Paul areas	612/883-5000	534	535	12.29	31.01
HealthPartners Health Plan - Minneapolis/St. Paul/St. Cloud areas	612/883-5000	HQ1	HQ2	43.01	117.37

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average								Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing		
Michigan													
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25									
Blue Care Network West MI	\$10	None	\$5	\$5	◐	◐	●	◐	◐	◐	◐	◐	✓
Blue Care Network West MI	\$10	None	\$5	\$5	◐	◐	●	◐	◐	◐	◐	◐	✓
Blue Care Network West MI	\$10	None	\$5	\$5	◐	◐	●	◐	◐	◐	◐	◐	✓
Blue Care Network West MI	\$10	None	\$5	\$5	◐	◐	●	◐	◐	◐	◐	◐	✓
Blue Care Network West MI	\$10	None	\$5	\$5	◐	◐	●	◐	◐	◐	◐	◐	✓
Blue Care Network West MI	\$10	None	\$5	\$5	◐	◐	●	◐	◐	◐	◐	◐	✓
Blue Care Network West MI	\$10	None	\$5	\$5	◐	◐	●	◐	◐	◐	◐	◐	✓
Grand Valley Health Plan	\$10	None	\$5	\$5									✓
Health Alliance	\$10	None	\$2	\$2	●	●	◐	◐	◐	◐	◐	◐	✓
HealthPlus MI	\$10	None	\$5	\$5	●	○	◐	◐	◐	●	●	●	✓
M-Care	\$10	None	\$5	\$10	◐	◐	◐	●	◐	◐	◐	◐	✓
OmniCare	\$10	None	\$2	\$2	○	○	○	○	○	○	○	○	✓
SelectCare HMO	\$10	None	\$2	\$2	○	○	○	○	○	◐	○	○	✓
SelectCare HMO	\$10	None	\$2	\$2									
The Wellness Plan	\$10	None	\$5	\$5	○	○	○	◐	○	○	○	○	✓
Total Health Care	\$10	None	Nothing	Nothing									
Minnesota													
APWU Health Plan													
- In-Network	\$10	None	\$5 or 25%*	\$5 or 25%*									
- Out-of-Network	30%	\$200	\$5 or 45%*	\$5 or 45%*									
Blue Cross and Blue Shield-Std													
- In-Network	\$15	None	\$10	\$20	●	●	●	◐	●	◐	●	●	
- Out-of-Network	25%	\$300	45%	45%									
HealthPartners Classic-High	\$10	None	\$8	\$8	◐	◐	◐	◐	◐	●	◐	◐	✓
HealthPartners Classic-Std	\$15	\$200	\$10	\$10	◐	◐	◐	◐	◐	●	◐	◐	✓
HealthPartners Health Plan	\$10	None	\$8	\$8	◐	◐	◐	◐	◐	●	◐	◐	✓

* You pay the greater amount. See plan brochure for details.

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.

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Mississippi					
Prudential HealthCare HMO - Desoto/Marshall/Tate/Tunica Cos.	800/856-0764	UB1	UB2	8.65	26.37
Missouri					
Aetna U.S. Healthcare - Kansas City Metro area	800/537-9384	7K1	7K2	9.93	26.06
Aetna U.S. Healthcare - Metro St. Louis area	800/537-9384	D41	D42	9.14	24.31
BlueCHOICE - StLouis/Central/SW/Poplar Bluff area	800/634-4395	9G1	9G2	12.55	27.16
Group Health Plan - St. Louis area	800/743-3901	MM1	MM2	25.36	45.69
Health Partners of the Midwest - St. Louis and Columbia areas	800/338-4123	RN1	RN2	25.70	46.41
Humana Kansas City, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	12.76	40.96
Humana Kansas City, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	9.89	23.73
Kaiser Permanente - Kansas City area	913/642-2662	HA1	HA2	9.54	24.62
Mercy Health Plans/Premier - East/Central/Southwest Missouri	800/327-0763	7M1	7M2	11.66	27.12
Prudential HealthCare HMO - St. Louis area	800/856-0764	VZ1	VZ2	9.65	24.36
Nevada					
Aetna U.S. Healthcare - Southern Nevada/Las Vegas area	800/537-9384	8L1	8L2	10.41	27.26
Health Plan of Nevada - Las Vegas/Reno areas	702/871-0999	NM1	NM2	10.19	26.09
PacifiCare Health Plans - LasVegas/Carson City/Reno areas	800/811-7305	K91	K92	10.15	25.72
PacifiCare Health Plans		\$10	None	\$5	\$15

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			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
Mississippi												
Prudential HealthCare HMO	\$10	None	\$5	\$15/\$25	◐	○	○	◐	◐	○	○	✓
Missouri												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25								
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25								
BlueCHOICE	\$10	None	\$5	\$10/\$15	○	●	◐	◐	◐	○	◐	✓
Group Health Plan	\$10	None	\$8	\$15/\$30	◐	◐	○	◐	○	◐	◐	✓
Health Partners of the Midwest	\$10	None	\$7	\$12/\$25	◐	◐	◐	◐	◐	◐	◐	✓
Humana Kansas City, Inc.-High	\$10	None	\$5	\$10/\$25	○	◐	◐	◐	○	◐	◐	✓
Humana Kansas City, Inc.-Std	\$15	\$100	\$10	\$20/\$35	○	◐	◐	◐	○	◐	◐	✓
Kaiser Permanente	\$10	None	\$5	\$5	◐	◐	◐	○	◐	●	◐	✓
Mercy Health - In-Network	\$10	None	\$7	\$12	●	●	●	◐	◐	●	●	
Plans/Premier - Out-of-Network	30%	None#	\$7	\$12								
Prudential HealthCare HMO	\$10	None	\$5	\$15/\$25	○	○	◐	◐	◐	○	○	✓
Nevada												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25								✓
Health Plan of Nevada - In-Network	\$10	\$100/day*	\$5	\$20	○	○	○	○	○	○	○	✓
- Out-of-Network	20%	CY#**	\$5	\$20								

* Up to the annual out-of-pocket maximum
 ** Applied to calendar year deductible

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Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
New Jersey					
Aetna U.S. Healthcare-High -All of New Jersey	800/537-9384	P31	P32	34.26	120.85
Aetna U.S. Healthcare-Std - All of New Jersey	800/537-9384	P34	P35	18.54	86.51
AmeriHealth HMO - All of New Jersey	800/454-7651	FK1	FK2	59.26	127.18
Blue Cross and Blue Shield-Std - All of New Jersey	800/624-5078	104	105	18.63	45.56
CIGNA CoMED HealthCare - All of New Jersey	800/462-6633	P41	P42	59.58	108.65
GHI Health Plan - Northern New Jersey	201/623-6000	801	802	14.97	61.79
Physicians Health Services of NJ - All of New Jersey	877/747-9585	2F1	2F2	10.94	26.25
QualMed Plans for Health - Burlington/Camden/Gloucester Counties	800/998-2840	271	272	37.98	94.77
New Mexico					
Lovelace Health Plan - All of New Mexico	505/262-7363	Q11	Q12	12.37	54.69
Presbyterian Health Plan - All NM counties except Otero & S. Eddy	505/923-5678	P21	P22	10.97	28.62
Cimarron Health Plan - All of New Mexico	800/365-0009	PX1	PX2	8.97	23.68

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
New Jersey												
Aetna U.S. Healthcare-High	\$10	None	\$5	\$10/\$25	●	●	●	●	●	◐	◐	✓
Aetna U.S. Healthcare-Std	\$15	\$240	\$10	\$15/\$30	●	●	●	●	●	◐	◐	✓
AmeriHealth HMO	\$10	None	\$5	\$5	○	◐	◐	●	◐	○	○	✓
Blue Cross and Blue Shield-Std	\$15	None	\$10	\$20	○	◐	○	◐	○	○	○	✓
- In-Network	25%	\$300	45%	45%								
- Out-of-Network												
CIGNA CoMED HealthCare	\$10	None	\$10	\$20	○	○	○	○	○	○	○	✓
GHI Health Plan	\$10	None	\$5	\$15/\$30	◐	●	◐	◐	◐	◐	◐	
- In-Network												
- Out-of-Network	50%*	50%*	\$5	N/A								
Physicians Health Services of NJ	\$10	None	\$10	\$20	◐	◐	◐	◐	◐	◐	○	
QualMed Plans for Health	\$10	None	\$4	\$4	○	○	●	◐	◐	○	○	✓
New Mexico												
Lovelace Health Plan	\$10	None	\$5	\$10	◐	◐	○	○	○	○	○	✓
Presbyterian Health Plan	\$10	None	\$5	\$15	○	○	○	◐	○	◐	◐	
Cimarron Health Plan	\$10	None	\$5	\$8	◐	◐	○	◐	◐	◐	●	

* Non-plan doctors and hospitals paid based on fee schedule

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Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
New York					
Aetna U.S. Healthcare - NYC area and Dutchess/Sullivan/Ulster	800/537-9384	JC1	JC2	11.96	34.90
Aetna U.S. Healthcare - Syracuse area	800/537-9384	TG1	TG2	11.67	29.27
Blue Choice - Rochester area	716/238-4300	MK1	MK2	12.30	42.51
Blue Cross and Blue Shield-Std - NYC/LI/Rocklnd/Wstchstr/Mid-Hudson	800/522-5566	104	105	18.63	45.56
C.D.P.H.P. - Albany/Cooperstown areas	800/777-2273	PW1	PW2	11.76	35.43
C.D.P.H.P. - Hudson Valley area	800/777-2273	QB1	QB2	14.16	67.82
C.D.P.H.P. - Capital District area	518/862-3750	SG1	SG2	11.70	35.25
CIGNA HealthCare of NY - New York City area	800/345-9458	HU1	HU2	24.26	103.99
GHI Health Plan - All of New York	212/501-4444	801	802	14.97	61.79
GHI HMO Select - Bronx/Brklyn/Manhattan/Queens/Westchster	877/244-4466	6V1	6V2	48.95	101.05
GHI HMO Select - Capital/Hudson Valley Regions	877/244-4466	X41	X42	11.70	28.94
Health First New York - New York City area	888/232-5415	7N1	7N2	11.95	35.36
HealthCarePlan - Western New York	716/847-0881	Q81	Q82	9.18	26.02
HIP of Greater New York - New York City area	800/HIP-TALK	511	512	10.49	48.64
HMO Blue - Utica/Rome/Central New York areas	800/722-7884	AH1	AH2	18.76	76.12
HMO-CNY - Syracuse/Binghamton/Elmira areas	800/828-2887	EB1	EB2	12.47	62.66
Independent Health Assoc - Western New York	800/453-1910	QA1	QA2	8.58	24.08
MVP Health Plan - Eastern Region	888/687-6277	GA1	GA2	11.46	31.48
MVP Health Plan - Central Region	888/687-6277	M91	M92	11.41	30.35
MVP Health Plan - Mid-Hudson Region	888/687-6277	MX1	MX2	12.81	62.38
PHP/Mohawk Valley Region - Utica area	315/797-7019	SH1	SH2	12.02	52.28
Physicians Health Svcs of NY - NYC/LI/Dtchs/Orng/Putnm/Rklnd/Wschs	877/747-9585	PD1	PD2	19.24	82.81
Preferred Care - Rochester area	716/325-3113	GV1	GV2	11.44	29.03
Prepaid Health Plan - Syracuse/Southern Tier areas	315/638-2133	QE1	QE2	12.21	56.62
Vytra Health Plans - Queens/Nassau/Suffolk Counties	800/406-0806	J61	J62	23.71	98.83

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
New York												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	◐	○	◐	◐	◐	○	✓
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25								
Blue Choice	\$10	None	\$8	\$8	●	●	●	●	●	●	●	✓
Blue Cross and Blue Shield-Std	\$15	None	\$10	\$20	◐	◐	◐	◐	◐	◐	○	✓
	25%	\$300	45%	45%								
C.D.P.H.P.	\$10	None	\$5	\$20								✓
C.D.P.H.P.	\$10	None	\$5	\$20								✓
C.D.P.H.P.	\$10	None	\$5	\$20	●	●	●	●	●	●	●	✓
CIGNA HealthCare of NY	\$10	None	\$7	\$14	○	○	○	○	○	○	○	
GHI Health Plan	\$10	None	\$5	\$15/\$30	◐	●	◐	◐	◐	◐	◐	
	50%*	50%*	\$5	N/A								
GHI HMO Select	\$10	None	\$10	\$10								✓
GHI HMO Select	\$10	None	\$10	\$10								✓
Health First New York	\$10	\$100	\$5	\$10								
HealthCarePlan	\$10	None	\$5	\$5	●	●	●	●	●	●	●	✓
HIP of Greater New York	\$10	None	\$10	\$10	◐	◐	○	○	○	◐	○	✓
HMO Blue	\$10	None	\$5	\$20/\$35	◐	●	●	●	●	◐	◐	✓
HMO-CNY	\$10	None	\$5	\$20/\$35	◐	●	●	◐	◐	◐	◐	✓
Independent Health Assoc	\$10	None	\$5	\$10/\$25	●	●	●	●	●	●	●	✓
MVP Health Plan	\$10	None	\$5	\$20	●	●	●	●	●	●	●	✓
MVP Health Plan	\$10	None	\$5	\$20	●	●	●	●	●	●	●	✓
MVP Health Plan	\$10	None	\$5	\$20	●	●	●	●	●	●	●	✓
PHP/Mohawk Valley Region	\$10	None	\$5	\$10								
Physicians Health Svcs of NY	\$10	None	\$10	\$20	●	●	◐	◐	◐	●	◐	✓
Preferred Care	\$10	None	\$10	\$20/\$35	●	●	●	●	●	●	●	✓
Prepaid Health Plan	\$10	None	\$5	\$10	●	●	●	◐	●	●	●	
Vytra Health Plans	\$10	None	\$5	\$5	◐	●	◐	◐	○	◐	○	

* Non-plan doctors and hospitals paid based on fee schedule

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

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
North Carolina					
Aetna U.S. Healthcare - Charlotte/Metrolina and Raleigh/Durham	800/537-9384	3G1	3G2	10.06	26.04
Doctors Health Plan, Inc. - Greater Tri/Char/Up-Low Cape Fear areas	800/476-2303	6D1	6D2	11.14	26.51
Generations Family Health Plan - Triangle area:Raleigh/Durham/Chapel Hill	888/256-5563	8B1	8B2	11.01	27.70
PARTNERS NHP of NC - Most of North Carolina	800/942-5695	EQ1	EQ2	13.99	30.32
QualChoice of North Carolina - Northwestern North Carolina	800/816-0911	7Q1	7Q2	19.90	66.08
UHC of North Carolina - Central/Eastern/Western areas	800/999-1147	XM1	XM2	24.90	54.86
North Dakota					
Blue Cross and Blue Shield-Std - Fargo/Moorehead area	800/548-4026	104	105	18.63	45.56
Heart of America HMO - Northcentral North Dakota	701/776-5848	RU1	RU2	11.89	28.62
Ohio					
Aetna U.S. Healthcare - Cleveland and Toledo areas	800/537-9384	7D1	7D2	15.04	58.63
Aetna U.S. Healthcare - Columbus area	800/537-9384	7J1	7J2	23.43	79.38
Aetna U.S. Healthcare - Greater Cincinnati area	800/537-9384	RD1	RD2	12.66	53.53
AultCare HMO - Stark/Carroll/Holmes/Tuscarawas/Wayne Co	330/438-6360	3A1	3A2	11.31	30.15
CHP of Ohio - Lick'g/Ottawa/Sandusky/Seneca Cos	740/348-1449	MG1	MG2	11.19	60.02
Health Maintenance Plan(HMP) - Most of Ohio	800/228-4375	R51	R52	12.92	29.19
Health Plan Upper OH Valley - Eastern Ohio	800/624-6961	U41	U42	11.50	49.99
HMO Health Ohio - Northeast Ohio	800/522-2066	L41	L42	11.50	30.28
Kaiser Permanente - Akron/Cleveland areas	800/686-7100	641	642	11.27	27.67
Paramount Health Care - Northwest/North Central Ohio	800/462-3589	U21	U22	12.52	64.01
SummaCare Health Plan - Northern Ohio	330/996-8410	5W1	5W2	10.09	27.74
SuperMed HMO - Northeast Ohio	800/522-2066	5M1	5M2	10.97	28.05
United Health Care of Ohio, Inc. - Cincinnati/Dayton/Springfield/Toledo	800/231-2918	3U1	3U2	19.23	48.16
Vantage Health Plan - North Central Ohio	800/878-4394	6A1	6A2	11.78	29.20

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
North Carolina												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	○	◐	◐	◐	○	○	
Doctors Health Plan, Inc.	\$10	\$100	\$10	\$20/\$30	◐	○	◐	●	◐	○	○	
Generations Family Health Plan	\$10	None	\$5	\$15/\$25	◐	○	◐	●	◐	●	◐	
PARTNERS NHP of NC	\$10	\$250	\$10	\$10	●	◐	◐	◐	◐	●	●	✓
QualChoice of North Carolina - In-Network	\$10	None	\$6	\$12	◐	●	◐	●	◐	◐	◐	
QualChoice of North Carolina - Out-of-Network	\$10	None	\$6	\$12								
UHC of North Carolina	\$10	None	\$10	\$15	●	●	●	●	●	●	●	✓
North Dakota												
Blue Cross and Blue Shield-Std - In-Network	\$15	None	\$10	\$20	◐	●	●	◐	●	●	●	
Blue Cross and Blue Shield-Std - Out-of-Network	25%	\$300	45%	45%								
Heart of America HMO	\$10	None	50%	50%								
Ohio												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25								
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25								
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	◐	●	●	●	○	○	✓
AultCare HMO	\$10	None	\$5	\$10	●	●	●	●	●	●	●	
CHP of Ohio	\$10	\$50/day*	\$10	\$15	●	◐	●	◐	●	●	●	
Health Maintenance Plan(HMP)	\$10	None	\$5	\$12	○	◐	●	◐	◐	◐	◐	✓
Health Plan Upper OH Valley	\$10	None	\$5	\$10	●	●	●	●	●	●	●	✓
HMO Health Ohio	\$10	None	\$5	\$5	○	◐	◐	◐	◐	○	○	✓
Kaiser Permanente	\$10	None	\$5	\$5	◐	●	◐	◐	●	●	◐	✓
Paramount Health Care	\$10	None	\$5	\$10	●	●	●	◐	◐	●	●	✓
SummaCare Health Plan	\$10	None	\$5	\$10								
SuperMed HMO	\$10	None	\$5	\$5	○	◐	◐	◐	◐	○	○	✓
United Health Care of Ohio, Inc.	\$10	\$100	\$10	\$15	◐	●	●	◐	●	●	◐	✓
Vantage Health Plan	\$10	\$100	\$10	30%								

* For up to 5 days

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

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Oklahoma					
Aetna U.S. Healthcare - N. E. Oklahoma and Oklahoma City areas	800/537-9384	8V1	8V2	9.93	26.03
Amcare Health Plans - Oklahoma City/Tulsa areas	800/772-2993	ZX1	ZX2	10.00	25.99
Blue Cross and Blue Shield-Std - Lawton/OK City/Tulsa/Other areas	800/722-3130	104	105	18.63	45.56
Healthcare Oklahoma - Oklahoma City/Lawton/Tulsa/Enid areas	800/535-2244	6W1	6W2	8.83	22.94
PacifiCare Health Plans - Oklahoma City/Tulsa areas	800/825-9355	2N1	2N2	10.00	26.12
Prudential HealthCare HMO - Central/Western/Southern Oklahoma	800/856-0764	RR1	RR2	10.75	28.62
Prudential HealthCare HMO - Tulsa area	800/856-0764	RS1	RS2	11.69	25.89
Oregon					
Kaiser Permanente-High -Portland/Salem areas	800/813-2000	571	572	19.83	48.93
Kaiser Permanente-Std - Portland/Salem areas	800/813-2000	574	575	12.05	27.66
PacifiCare Health Plans - Counties along I-5 Corridor	800/932-3004	7Z1	7Z2	24.50	49.60
Panama					
Panama Canal Area - Republic of Panama	732/222-2229	431	432	22.06	38.36

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited	
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing		
Oklahoma													
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25									✓
Amcare Health Plans	\$10	None	\$5	\$15/50%									
Blue Cross and Blue Shield-Std	- In-Network - Out-of-Network	\$15 25%	None \$300	\$10 45%	\$20 45%	◐	◐	●	●	●	○	◐	
Healthcare Oklahoma	\$10	None	\$5	\$10	◐	○	◐	◐	◐	◐	◐	◐	✓
PacifiCare Health Plans	\$10	None	\$5	\$15	○	○	○	◐	◐	◐	●	●	✓
Prudential HealthCare HMO	\$10	None	\$5	\$15/\$25	X	X	X	X	X	X	X	X	✓
Prudential HealthCare HMO	\$10	None	\$5	\$15/\$25	X	X	X	X	X	X	X	X	✓
Oregon													
Kaiser Permanente-High	\$10	None	\$10	\$10	◐	●	○	○	◐	●	●	●	✓
Kaiser Permanente-Std	\$12	None	\$15	\$15	◐	●	○	○	◐	●	●	●	✓
PacifiCare Health Plans	\$10	None	\$5	\$15	○	○	◐	○	◐	◐	●	●	
Panama													
Panama Canal Area	- In-Network - Out-of-Network	\$10 50%	\$75 \$125	50%	50%								

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	
		Self only	Self & family	Self only	Self & family
Pennsylvania					
Aetna U.S. Healthcare-High -Southwestern/Central/NE PA	800/537-9384	KL1	KL2	10.30	27.26
Aetna U.S. Healthcare-Std - Southwestern/Central/NE PA	800/537-9384	KL4	KL5	8.94	23.80
Aetna U.S. Healthcare-High -Southeastern PA	800/537-9384	SU1	SU2	20.66	83.94
Aetna U.S. Healthcare-Std - Southeastern PA	800/537-9384	SU4	SU5	12.15	47.60
First Priority Hlth - Northeastern Pennsylvania	800/822-8753	C81	C82	38.27	131.00
Free State Health Plan - Southern Pennsylvania	800/445-6036	LD1	LD2	17.16	40.97
Geisinger Health Plan - Central/Northeastern/South Central PA	800/447-4000	N91	N92	10.25	40.20
HealthAmerica Pennsylvania - Greater Pittsburgh area	800/735-4404	261	262	10.46	27.19
HealthAmerica Pennsylvania - Central Pennsylvania	800/788-8445	SW1	SW2	11.17	29.03
HealthGuard - Berks/Cmbrlnd/Dauphine/Lanc/Lebanon/York	800/822-0350	NQ1	NQ2	10.38	27.08
Keystone Health Plan Central - Harrisburg/Norther Region/Lehigh Valley	800/622-2843	S41	S42	13.72	49.43
Keystone Health Plan East - Philadelphia area	800/227-3115	ED1	ED2	12.04	50.83
KeystoneBlue - Pittsburgh/Altoona/Erie areas	800/421-0959	EF1	EF2	12.47	97.65
QualMed Plans for Health - Southern Pennsylvania	800/998-2840	271	272	37.98	94.77
QualMed Plans for Health - Scranton/Wilkes Barre areas	800/998-2840	2K1	2K2	14.06	51.15
UPMC Health Plan - Pittsburgh Area	412/454-7652	8W1	8W2	9.15	23.34
Puerto Rico					
Triple-S - All of Puerto Rico	787/749-4777	891	892	10.25	22.02

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average								Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing		
Pennsylvania													
Aetna U.S. Healthcare-High	\$10	None	\$5	\$10/\$25	◐	◐	●	●	●	◐	◐	✓	
Aetna U.S. Healthcare-Std	\$15	\$240	\$10	\$15/\$30	◐	◐	●	●	●	◐	◐	✓	
Aetna U.S. Healthcare-High	\$10	None	\$5	\$10/\$25	◐	●	●	●	●	◐	◐	✓	
Aetna U.S. Healthcare-Std	\$15	\$240	\$10	\$15/\$30	◐	●	●	●	●	◐	◐	✓	
First Priority Hlth	\$10	None	\$8	\$8/\$23	●	●	●	●	●	●	●	✓	
Free State Health Plan - In-Network	\$10	None	\$10	\$20/\$35	◐	◐	◐	◐	◐	◐	◐	✓	
Free State Health Plan - Out-of-Network	20%	\$200#	\$10	\$20/\$35									
Geisinger Health Plan - In-Network	\$10	None	\$8	\$8	●	●	●	●	●	●	●	✓	
Geisinger Health Plan - Out-of-Network	20%	20%	N/A	N/A									
HealthAmerica Pennsylvania	\$10	None	\$8	\$14/\$35	●	●	●	◐	◐	◐	◐	✓	
HealthAmerica Pennsylvania	\$10	None	\$8	\$14/\$35	●	●	●	◐	◐	◐	◐		
HealthGuard	\$10	None	\$10	\$20	●	●	●	●	●	●	●	✓	
Keystone Health Plan Central	\$10	None	\$10	\$10	●	●	●	●	◐	◐	●	✓	
Keystone Health Plan East	\$10	None	\$5	\$5	◐	●	◐	●	◐	◐	●	✓	
KeystoneBlue	\$10	\$100	\$8	\$14	●	●	●	◐	◐	◐	●	✓	
QualMed Plans for Health	\$10	None	\$4	\$4	○	○	●	◐	◐	○	○	✓	
QualMed Plans for Health	\$10	None	\$4	\$4								✓	
UPMC Health Plan	\$10	None	\$5	\$15									
Puerto Rico													
Triple-S - In-Network	\$7.50	None	\$2	\$10	●	●	○	●	◐	●	◐		
Triple-S - Out-of-Network	\$7.50	None#	\$2	\$10									

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Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Rhode Island					
Aetna U.S. Healthcare - All of Rhode Island	800/537-9384	5U1	5U2	9.80	26.35
Blue Chip, Coord Hlth Partners - All of Rhode Island	401/459-5500	DA1	DA2	16.55	72.95
South Carolina					
Doctors Health Plan, Inc. - York County	800/476-2303	6D1	6D2	11.14	26.51
PARTNERS NHP of NC - Upstate South Carolina	800/942-5695	EQ1	EQ2	13.99	30.32
Tennessee					
Aetna U.S. Healthcare - Nashville/Middle Tennessee areas	800/537-9384	6J1	6J2	11.75	59.96
Prudential HealthCare HMO - Nashville area	800/856-0764	UA1	UA2	11.88	66.57
Prudential HealthCare HMO - Memphis area	800/856-0764	UB1	UB2	8.65	26.37

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
Rhode Island												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	○	●	◐	◐	○	○	
Blue Chip, Coord - In-Network	\$10	None	\$5	\$15/\$30	◐	●	●	●	●	◐	◐	✓
Hlth Partners - Out-of-Network	20%	None#	\$5	\$15/\$30								
South Carolina												
Doctors Health Plan, Inc.	\$10	\$100	\$10	\$20/\$30	◐	○	◐	●	◐	○	○	
PARTNERS NHP of NC	\$10	\$250	\$10	\$10	●	◐	◐	◐	◐	●	●	✓
Tennessee												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	○	◐	●	◐	○	○	
Prudential HealthCare HMO	\$10	None	\$5	\$15/\$25	○	◐	◐	●	●	○	◐	✓
Prudential HealthCare HMO	\$10	None	\$5	\$15/\$25	◐	○	○	◐	◐	○	○	✓

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

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Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Texas					
Aetna U.S. Healthcare - Houston area	800/537-9384	5B1	5B2	10.31	35.71
Aetna U.S. Healthcare - San Antonio area	800/537-9384	8X1	8X2	11.47	33.75
Amcare Health Plans - Houston/El Paso areas	800/782-8373	2V1	2V2	10.26	26.68
Amcare Health Plans - Austin/San Antonio areas	800/782-8373	ZG1	ZG2	9.46	24.59
APWU Health Plan - Eastern and Central Texas	800/222-2798	471	472	31.15	61.52
FIRSTCARE - Waco area	800/884-4901	6U1	6U2	14.87	28.30
FIRSTCARE - West Texas	800/884-4901	CK1	CK2	51.67	99.38
Humana Health Plan of Texas - San Antonio area	888/393-6765	UR1	UR2	10.65	27.39
Mercy Health Plans/Premier - Webb/Zapata/Duval/Jim Hogg Counties	800/617-3433	HM1	HM2	12.71	51.25
HMO Blue Texas - Dallas/Ft. Worth/Amarillo/East & West Texas	800/486-3040	YX1	YX2	14.56	52.06
HMO Blue Texas - Houston/Austin/S.Antonio/C.Christi/Beau/Victoria	800/833-5318	YM1	YM2	11.35	27.78
PacifiCare Health Plans - S Ant/Hstn/Glvston/Da/Ft Wor/Glf Coast	800/825-9355	GF1	GF2	9.88	25.80
Texas Health Choice, L. C. - Dallas/Ft. Worth areas	972/458-5000	UK1	UK2	10.68	27.33
Utah					
Altius Health Plans - Wasatch Front	800/377-4161	9K1	9K2	29.95	59.61
Vermont					
MVP Health Plan - Bennington/Chittenden/Rutland/Wash. Cos.	888/687-6277	VW1	VW2	26.93	101.92

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
Texas												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	◐	○	○	◐	◐	◐	◐	
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	◐	○	◐	◐	◐	◐	○	
Amcare Health Plans	\$10	None	\$5	\$15/50%								
Amcare Health Plans	\$10	None	\$5	\$15/50%								
APWU Health Plan - In-Network	\$10	None	\$5 or 25%*	\$5 or 25%*								
APWU Health Plan - Out-of-Network	30%	\$200	\$5 or 45%*	\$5 or 45%*								
FIRSTCARE	\$10	None	\$10	\$20/\$30	◐	◐	◐	●	●	◐	◐	
FIRSTCARE	\$10	None	\$10	\$20/\$30	●	◐	●	●	●	●	●	
Humana Health Plan of Texas	\$10	None	\$5	\$10/\$25	◐	○	○	◐	◐	◐	◐	✓
Mercy Health Plans/Premier - In-Network	\$10	None	\$7	\$12								
Mercy Health Plans/Premier - Out-of-Network	30%	None#	\$7	\$12								
HMO Blue Texas	\$10	\$100	\$5	\$10/\$25	○	○	○	◐	◐	◐	○	✓
HMO Blue Texas	\$10	\$100	\$5	\$10/\$25	○	○	○	◐	◐	○	○	✓
PacifiCare Health Plans	\$10	None	\$5	\$15	○	○	○	◐	◐	○	○	
Texas Health Choice, L. C.	\$10	None	\$6	\$12	○	○	○	○	○	○	○	✓
Utah												
Altius Health Plans	\$10	None	\$10	\$15/\$30	○	○	◐	◐	◐	○	○	✓
Vermont												
MVP Health Plan	\$10	None	\$5	\$20	●	●	●	●	●	●	●	✓

* You pay the greater amount. See plan brochure for details.

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.

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Virginia					
Aetna U.S. Healthcare-High -N.VA/Fredericksburg areas	800/537-9384	JN1	JN2	12.85	33.08
Aetna U.S. Healthcare-Std - N.VA/Fredericksburg areas	800/537-9384	JN4	JN5	9.36	21.89
Aetna U.S. Healthcare-High -Richmond VA area	800/537-9384	XE1	XE2	10.99	28.52
Aetna U.S. Healthcare-Std - Richmond VA area	800/537-9384	XE4	XE5	9.78	25.42
CapitalCare - Northern Virginia	800/680-9495	2G1	2G2	16.79	42.55
CIGNA HealthCare of VA - Southeastern Virginia	800/533-1708	W21	W22	11.09	24.86
CIGNA HealthCare of VA - Central Virginia	800/533-1708	W31	W32	10.36	23.43
George Washington Univ HP - Northern Virginia	301/941-2000	E51	E52	11.52	28.24
HealthKeepers - Eastern,Central,F'burg,Western,SW areas	800/421-1880	X81	X82	11.75	34.04
Kaiser Permanente - Washington, DC area	301/468-6000	E31	E32	11.90	30.05
MD-IPA - N.VA/Cntrl VA/Richmond/Tidewater/Roanoke	800/251-0956	JP1	JP2	12.25	30.24
OPTIMA Health Plan - Peninsula/Southside Hampton Roads	757/552-7500	9R1	9R2	19.96	57.93
PARTNERS NHP of NC - Southwest Virginia	800/942-5695	EQ1	EQ2	13.99	30.32
Piedmont Community Healthcare - Lynchburg area	888/674-3368	2C1	2C2	12.55	29.20
Washington					
Aetna U.S. Healthcare - Western/Southeast Washington	800/537-9384	8J1	8J2	9.97	25.83
First Choice Health Plan - Greater Seattle area	800/783-7312	5G1	5G2	16.84	78.37
Group Health Cooperative - Most of Western Washington	206/448-4140	541	542	13.11	29.27
Group Health Cooperative - Central WA/Spokane/Colville/Pullman	800/497-2210	VR1	VR2	17.26	76.30
Kaiser Permanente-High -Vancouver/Longview	800/813-2000	571	572	19.83	48.93
Kaiser Permanente-Std - Vancouver/Longview	800/813-2000	574	575	12.05	27.66
Kitsap Physicians Service-High -Kitsap/Mason/Jefferson Counties	800/552-7114	VT1	VT2	62.90	122.01
Kitsap Physicians Service-Std - Kitsap/Mason/Jefferson Counties	800/552-7114	VT4	VT5	21.89	40.04
PacifiCare Health Plans - Clark County	800/932-3004	7Z1	7Z2	24.50	49.60
PacifiCare Health Plans - Puget Sound/Most West WA/Walla Walla	800/932-3004	WB1	WB2	10.60	27.68
Premera HealthPlus - Most of Washington	800/527-6675	8F1	8F2	16.46	55.63

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

Enrollee Survey Results — See page 5 for a description. An (X) means the plan did not conduct the survey as we asked.

Accredited — A (✓) means the plan is accredited by the National Committee for Quality Assurance; the Joint Commission on Accreditation of Healthcare Organizations; and/or the American Accreditation Healthcare Commission/URAC.

Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
Virginia												
Aetna U.S. Healthcare-High	\$10	None	\$5	\$10/\$25	○	○	◐	◐	◐	○	○	✓
Aetna U.S. Healthcare-Std	\$15	\$240	\$10	\$15/\$30	○	○	◐	◐	◐	○	○	✓
Aetna U.S. Healthcare-High	\$10	None	\$5	\$10/\$25								
Aetna U.S. Healthcare-Std	\$15	\$240	\$10	\$15/\$30								
CapitalCare	\$10	None	\$8	\$15/\$30	◐	◐	○	◐	○	◐	◐	✓
CIGNA HealthCare of VA	\$10	None	\$5	\$15/\$35	◐	◐	◐	○	○	◐	◐	✓
CIGNA HealthCare of VA	\$10	None	\$5	\$15/\$35	◐	◐	◐	○	○	◐	◐	✓
George Washington Univ HP	\$10	None	\$5	\$15/\$25	○	◐	○	◐	○	○	○	✓
HealthKeepers	\$10	\$100	\$5	\$10/\$25	◐	◐	◐	◐	○	●	●	✓
Kaiser Permanente	\$10	None	\$7	\$7	◐	◐	○	○	○	●	◐	✓
MD-IPA	\$10	None	\$5	\$10/\$25	●	●	◐	◐	◐	●	◐	✓
OPTIMA Health Plan	\$10	None	\$8	\$15/\$40	●	●	◐	●	●	●	●	✓
PARTNERS NHP of NC	\$10	\$250	\$10	\$10	●	◐	◐	◐	◐	●	●	✓
Piedmont Community Healthcare - In-Network	\$10	None#	\$5	\$15								
Piedmont Community Healthcare - Out-of-Network	30%	None#	\$5	\$15								
Washington												
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25	○	◐	◐	◐	◐	○	○	
First Choice Health Plan	\$10	None	\$5	\$10/\$25								
Group Health Cooperative	\$10	\$100/day*	\$10	\$10	●	●	●	◐	◐	●	●	✓
Group Health Cooperative	\$10	\$100/day*	\$10	\$10	●	◐	●	●	●	●	●	✓
Kaiser Permanente-High	\$10	None	\$10	\$10	◐	●	○	○	◐	●	●	✓
Kaiser Permanente-Std	\$12	None	\$15	\$15	◐	●	○	○	◐	●	●	✓
Kitsap Physicians Service-High	\$10	\$200	50%	50%	●	●	●	●	●	●	●	
Kitsap Physicians Service-Std	20%	None#	20%	20%	●	●	●	●	●	●	●	
PacifiCare Health Plans	\$10	None	\$5	\$15	○	○	◐	○	◐	◐	●	✓
PacifiCare Health Plans	\$10	None	\$5	\$15	○	○	◐	◐	◐	◐	○	
Premera HealthPlus	\$10	\$100	\$10	\$20/\$30	○	◐	◐	◐	◐	○	◐	✓

* For up to 3 days

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.

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

Hospital per Stay Deductible/Copay is the amount you pay when you are admitted into a hospital. A (#) means you also pay a share of the room and board charges; check with the plan.

Plan name – location	Telephone number	Enrollment code		Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
West Virginia					
Carelink Health Plans - Northern/Central/Southern West Virginia	800/348-2922	4C1	4C2	12.18	87.90
Free State Health Plan - Northeastern West Virginia	800/445-6036	LD1	LD2	17.16	40.97
Health Plan Upper OH Valley - Northern/Central West Virginia	800/624-6961	U41	U42	11.50	49.99
Wisconsin					
Compcare Health Services - Southeastern Wisconsin	414/226-6744	691	692	33.34	119.69
Compcare Health Services - Northcentral/Northwest Wisconsin	800/242-9635	6X1	6X2	26.44	90.55
Dean Health Plan - South Central Wisconsin	800/279-1301	WD1	WD2	12.41	66.72
Family Health Plan - Milwaukee area	414/256-0040	WH1	WH2	20.65	87.21
Group Health Coop - South Central Wisconsin	608/251-3356	WJ1	WJ2	11.19	34.41
Group Hlth Coop/Eau Claire - West Central Wisconsin	715/552-4300	WT1	WT2	33.00	117.77
HealthPartners Classic-High -Pierce/St. Croix Counties	612/883-5000	531	532	27.88	81.08
HealthPartners Classic-Std - Pierce/St. Croix Counties	612/883-5000	534	535	12.29	31.01
HealthPartners Health Plan - West Central Wisconsin	612/883-5000	HQ1	HQ2	43.01	117.37
Unity Health Plans - Southern/Central Wisconsin	800/362-3310	W41	W42	12.26	57.71
Valley Health Plan - Western Wisconsin	715/832-3235	VH1	VH2	47.90	153.14

Prescription Drugs, Generic, Brand Name shows what you pay for prescriptions when you use a plan pharmacy. If two brand name amounts are listed, the first is what you pay for “formulary” drugs (drugs on the plan’s preferred list); the second is what you pay for non-formulary drugs. Some plans charge different amounts for some drugs and for mail orders. In many plans, if you get the brand name instead of the generic drug, you also pay the difference between the two.

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Plan name	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs		Enrollee Survey Results ● above average, ◐ average, ○ below average							Accredited
			Generic	Brand name	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Courteous and helpful office staff	Customer service	Claims processing	
West Virginia												
Carelink Health Plans	\$10	\$100	\$10	\$20								
Free State Health Plan - In-Network	\$10	None	\$10	\$20/\$35	◐	◐	◐	◐	◐	◐	◐	✓
- Out-of-Network	20%	\$200#	\$10	\$20/\$35								
Health Plan Upper OH Valley	\$10	None	\$5	\$10	●	●	●	●	●	●	●	✓
Wisconsin												
Compcare Health Services	\$10	\$100/day*	\$7	\$12	○	●	●	◐	◐	○	○	✓
Compcare Health Services	\$10	\$100/day*	\$7	\$12	○	●	●	◐	◐	○	○	✓
Dean Health Plan	\$10	None	\$6	\$10	●	●	●	◐	●	●	●	✓
Family Health Plan	\$10	None	Nothing	Nothing	○	◐	○	○	○	○	○	
Group Health Coop	\$10	None	Nothing	Nothing	●	●	●	●	●	●	●	✓
Group Hlth Coop/Eau Claire	\$10	None	\$7.50	\$7.50								
HealthPartners Classic-High	\$10	None	\$8	\$8	◐	◐	◐	◐	◐	●	◐	✓
HealthPartners Classic-Std	\$15	\$200	\$10	\$10	◐	◐	◐	◐	◐	●	◐	✓
HealthPartners Health Plan	\$10	None	\$8	\$8	◐	◐	◐	◐	◐	●	◐	✓
Unity Health Plans	\$10	None	\$5	\$10	●	●	●	◐	◐	●	●	
Valley Health Plan	\$10	None	\$5	\$10	●	●	●	●	●	●	●	

* For up to 2 days

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