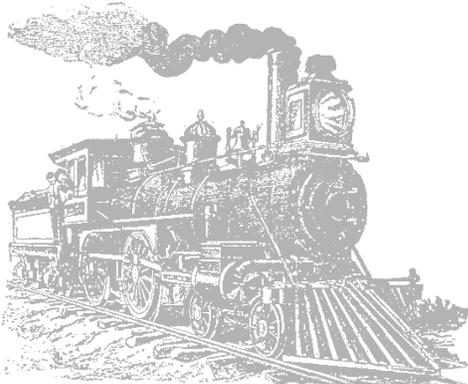


The 2001 Guide to

Federal Employees Health Benefits Plans



*All
Aboard for
Health!*

**PARTICIPATING IN THE DoD/FEHB
DEMONSTRATION PROJECT**

*Be sure to visit our web site at www.opm.gov/insure
and the DoD web site at www.tricare.osd.mil/fehbp*



**UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT**

**RETIREMENT AND INSURANCE
SERVICE**

RI 70-15
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 Government Contribution.** The Government pays 72 percent of the average premium toward the total cost of your premium, but not more than 75 percent of the total premium for any plan.
- **Premium Payment Deductions** from your check. For details see page 3.
- **Annual Enrollment Opportunity.** Each year during the 3-year demonstration project you can enroll or change your health plan enrollment.
- **Continued Group Coverage.** Eligible participants can continue coverage following divorce or death. Contact the Information Processing Center for more information.
- **Coverage After FEHB Ends.** You or your family members may be eligible for temporary continuation of FEHB coverage when FEHB coverage ends. Contact the DoD Customer Care Center for more information.



**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.



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.

Eligibility and Enrollment Requirements

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

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

Who is Eligible

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

- You are an active or retired uniformed service member and are eligible for Medicare,
 - You are a dependent of an active or retired uniformed service member and are eligible for Medicare,
 - You are a qualified former spouse of an active or retired uniformed service member and you have not remarried, or
 - You are a survivor dependent of a deceased active or retired uniformed service member, and
 - You live in one of the ten geographic demonstration areas.
- Fort Knox, KY area, including parts of Indiana bordering Kentucky
 - Greensboro/Winston Salem/High Point, NC area
 - Dallas, TX area
 - Humboldt County, CA area
 - Naval Hospital, Camp Pendleton, CA area
 - New Orleans, LA area
 - Coffee County, GA area, including parts of Florida, Georgia and South Carolina
 - Adair County, IA area, including most of Iowa and parts of Minnesota, South Dakota, Nebraska, Kansas and Missouri

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

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

The Demonstration Areas

- Dover AFB, DE area, including most of Delaware and parts of Maryland
- Commonwealth of Puerto Rico

Using Military Treatment Facilities

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

Opportunities to Enroll

Your next opportunity to enroll is during the 2000 Open Season, November 13, 2000, through December 11, 2000. You may select coverage for yourself (self-only) or for you and your family (self and family). Your coverage will begin January 1, 2001. DoD has set-up a Customer Care Center (CCC) in Iowa to provide you with information about how to enroll. CCC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the CCC is 1-877-DOD-FEHB (1-877-363-3342).

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

Eligibility and Enrollment Requirements

Dependent Coverage

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

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

Selecting a Plan

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

Some FFS plans require that you join the organization that sponsors the plan. Membership requirements and/or limitations also apply to any POS product the FFS plan offers.

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

Deduction from your Monthly Annuity

After the Government pays its share toward the total premium, you pay the rest. Each plan's premium in this Guide is the amount that will be withheld in 2001. Premiums take effect January 1, 2001, and are reflected in monthly annuities beginning in February 2001.

If the premium is more than your monthly annuity, you may pay the amount directly to the DoD Customer Care

Center (CCC), either by Electronic Funds Transfer (EFT) from your bank account or by check or money order. The CCC will tell you about these options.

When Your Enrollment Ends

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

Eligibility for Temporary Continuation of Coverage (TCC) —

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

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

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

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

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

FEHB and You

The Federal Employees Health Benefits (FEHB) Program began operation in July 1960. It is the nation's largest employer-sponsored health insurance program. Almost 9 million people, including 2.3 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 our web site at www.opm.gov/insure and your plan's brochure for details.
- Patient Safety: See page 7 for five important steps you can take to prevent medical error and improve your healthcare safety.
- In support of the Presidential initiative on plain language, OPM and the FEHB plans are committed to providing written information that is easy to understand. We worked hard to develop benefit descriptions that are clear, customer-focused, and improve plan-to-plan comparisons. You will find benefit descriptions in the plan brochures.
- 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. Our 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.

Selecting a Health Plan

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

You should review the Fee-for-Service plans that are available nationwide as well as the plans available where you live or work.

Before selecting a plan:

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

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.**

F E H B a n d Y o u

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.**

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.

- Say you're considering a plan that offers a list of physicians from which you must select one. What does the survey information in this Guide say about the experiences of others in that plan in "getting needed care" or "getting care quickly"?
 - ✓ **Check the customer service column to see how your plan rates.**
- Since most people aren't familiar with the technical aspects of care, they often make judgments based on the art of care, e.g., how well the doctor communicates treatment choices to patients.
 - ✓ **See what the survey information says about how well your plan's doctors communicate.**
- A recent study concluded that health plans that provide better access to care do a better job of delivering preventive services (e.g., immunizations and check-ups). Higher scores on "getting needed care" and "customer service" also were associated with higher scores on things the plan does for you and how well it treats you when you are sick.
 - ✓ **Review your plan's rating in these areas.**

FEHB and You

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.

✓ **Is your health plan accredited?**



**Call the
FEHB Fraud Hot
Line**

(202) 418-3300

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

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 plans' members. A plan's ratings show how well the plan scored based on the responses of its surveyed members.

The complete questionnaire is on our web site at www.opm.gov/insure.

We have summarized the findings in these 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?
- **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**.

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.

WWW.OPM.GOV/INSURE

There is a new look to the FEHB web site and we've added more valuable information to help you choose a health plan and to learn more about the Program.

We now have 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. We also have 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

DoD Web Site

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

Learning about today's Medicare can be beneficial to your health.

Today's Medicare offers more.

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

Medicare Questions?

www.medicare.gov



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



An education program of the
Department of Health and Human
Services and the Health Care
Financing Administration

Medicare & You Handbook



Plan Comparisons

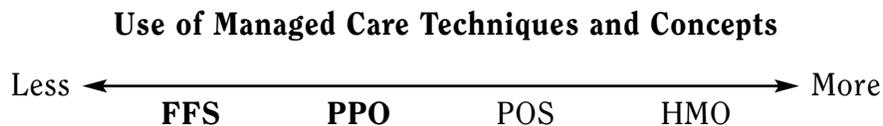
Nationwide Fee-for-Service Plans Open to All

(Pages 12 through 14)

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 16–21 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		Monthly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Alliance Health Plan	202/939-6325	1R1	1R2	209.89	418.51
APWU Health Plan [◇]	800/222-2798	471	472	308.15	663.65
Blue Cross and Blue Shield-High	local phone #	101	102	151.97	301.86
Blue Cross and Blue Shield-Std [◇]	local phone #	104	105	74.23	175.30
GEHA Benefit Plan-High	800/821-6136	311	312	109.25	221.78
GEHA Benefit Plan-Std	800/821-6136	314	315	59.58	135.42
Mail Handlers-High	800/410-7778	451	452	103.16	246.72
Mail Handlers-Std	800/410-7778	454	455	75.53	182.97
NALC	703/729-4677	321	322	135.57	266.28
Postmasters-High	703/683-5585	361	362	406.77	858.21
Postmasters-Std	703/683-5585	364	365	219.33	456.02

[◇] 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.

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%	20%	\$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%	25%	\$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%	\$10/20%	\$25/20%
	Non-PPO	\$400	\$150	\$150	\$3,500	20%	20%	25%	25%	20%	\$10/20%	\$25/20%
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 6 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

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

(Pages 16 through 21)

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.

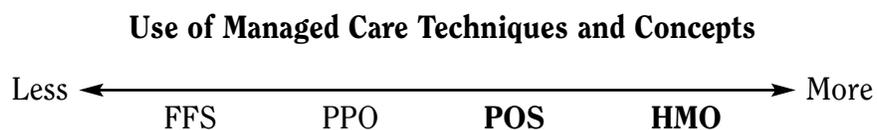
Plans Offering a Point of Service (POS) Product — A product offered by an HMO or FFS plan that has features of both.

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		Monthly premium your share	
		Self only	Self & family	Self only	Self & family
California					
Aetna U.S. Healthcare - Southern California area	800/537-9384	2X1	2X2	99.17	142.52
Blue Cross- HMO - Most of California	800/235-8631	M51	M52	58.14	168.78
Blue Shield of CA Access+ - Most of California	800/334-5847	SJ1	SJ2	109.68	211.77
CIGNA HealthCare of California - Northern/Southern California	800/832-3211	9T1	9T2	139.12	229.19
Health Net - Most of California	800/522-0088	LB1	LB2	141.27	200.80
Kaiser Permanente - Southern California	800/464-4000	621	622	86.11	136.33
Maxicare Southern California - Southern California	800/234-6294	CM1	CM2	49.58	104.11
PacifiCare Health Plans - Most of California	800/624-8822	CY1	CY2	94.06	234.19
Delaware					
Aetna U.S. Healthcare-High -All of Delaware	800-537-9384	SU1	SU2	361.71	674.35
Aetna U.S. Healthcare-Std - All of Delaware	800-537-9384	SU4	SU5	295.17	547.67
Florida					
Av-Med Health Plan - Gainesville area	800/882-8683	JF1	JF2	150.30	363.07
Indiana					
Aetna U.S. Healthcare - Southern Indiana	800-537-9384	7L1	7L2	171.45	293.88
Humana Health Plan - Southern Indiana	888/393-6765	D21	D22	84.29	229.66
M*Plan - Central/NE/SW Indiana	317/571-5320	IN1	IN2	183.37	331.89
Iowa					
Coventry Health Care of Iowa - Des Moines/Central Iowa/Waterloo	800/257-4692	SV1	SV2	135.90	222.75
John Deere Health Plan - Central/Eastern Iowa	800/247-9110	YH1	YH2	153.64	258.22

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 6 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		
California													
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	●	●	○	○	○	●	●	●	✓
Maxicare Southern California	\$10	None	\$5	\$10/\$25	●	○	○	●	○	○	○	○	✓
PacifiCare Health Plans	\$10	None	\$5	\$15	●	○	○	○	○	○	○	○	✓
Delaware													
Aetna U.S. Healthcare-High	\$10	None	\$5	\$10/\$25									
Aetna U.S. Healthcare-Std	\$15	\$240	\$10	\$15/\$30									
Florida													
Av-Med Health Plan	\$10	None	\$5	\$5	●	○	○	●	●	●	○	○	✓
Indiana													
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25									
Humana Health Plan	\$10	None	\$5	\$10/\$25	●	●	●	●	●	○	○	○	
M*Plan	\$10	None	\$5	\$10/\$30	●	●	●	●	●	○	○	○	✓
Iowa													
Coventry Health Care of Iowa	\$10	None	\$5 or 25%*	\$5 or 25%*	●	●	●	●	●	○	○	○	✓
John Deere Health Plan	\$10	\$100	\$5	\$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		Monthly premium your share	
		Self only	Self & family	Self only	Self & family
Kansas					
Blue Cross and Blue Shield-Std - Most of Kansas	800/432-0379	104	105	74.23	175.30
Humana Kansas City, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	61.44	165.34
Humana Kansas City, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	47.62	114.24
Kaiser Permanente - Kansas City area	913/642-2662	HA1	HA2	77.63	260.06
Kentucky					
Aetna U.S. Healthcare - Lexington/Louisville areas	800-537-9384	7L1	7L2	171.45	293.88
Humana Health Plan - Louisville area	888/393-6765	D21	D22	84.29	229.66
Louisiana					
Aetna U.S. Healthcare - New Orleans area	800/537-9384	NG1	NG2	66.06	126.79
Blue Cross and Blue Shield-Std - New Orleans area	800/272-3029	104	105	74.23	175.30
Maxicare Louisiana - Baton Rouge/New Orleans areas	800/933-6294	JA1	JA2	55.46	116.47
Maryland					
Free State Health Plan - All of Maryland	800/445-6036	LD1	LD2	182.52	315.98
MD-IPA - All of Maryland	800/251-0956	JP1	JP2	82.01	134.81
Minnesota					
Blue Cross and Blue Shield-Std - All of Minnesota	800/859-2128	104	105	74.23	175.30
HealthPartners Classic-High -Minneapolis/St. Paul areas	952/883-5000	531	532	92.52	140.07
HealthPartners Classic-Std - Minneapolis/St. Paul areas	952/883-5000	534	535	62.42	124.84
HealthPartners Health Plan - Minneapolis/St. Paul/St. Cloud areas	952/883-5000	HQ1	HQ2	114.25	179.44

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 6 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		
Kansas													
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%	●	●	●	●	●	●	●	●	
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	●	●	●	○	●	●	●	●	✓
Kentucky													
Aetna U.S. Healthcare	\$10	None	\$5	\$10/\$25									
Humana Health Plan	\$10	None	\$5	\$10/\$25	●	●	●	●	●	○	●	●	
Louisiana													
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%	●	●	○	●	○	●	●	●	
Maxicare Louisiana - In-Network	\$10	None	\$7	\$15/\$25	●	○	○	●	○	○	○	○	
Maxicare Louisiana - Out-of-Network	20%	20%	N/A	N/A	●	○	○	●	○	○	○	○	
Maryland													
Free State Health Plan - In-Network	\$10	None	\$10	\$20/\$35	●	●	●	●	●	●	●	●	✓
Free State Health Plan - Out-of-Network	20%	\$200#	\$10	\$20/\$35	●	●	●	●	●	●	●	●	✓
MD-IPA	\$10	None	\$5	\$10/\$25	●	●	●	●	●	●	●	●	✓
Minnesota													
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%	●	●	●	●	●	●	●	●	
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

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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		Monthly premium your share	
		Self only	Self & family	Self only	Self & family
Missouri					
BlueCHOICE - St. Louis/Central/SW/Poplar Bluff areas	800/634-4395	9G1	9G2	126.12	200.24
Health Partners of the Midwest - St. Louis and Columbia areas	800/338-4123	RN1	RN2	139.58	268.84
Humana Kansas City, Inc.-High -Kansas City area	888/393-6765	MS1	MS2	92.04	224.85
Humana Kansas City, Inc.-Std - Kansas City area	888/393-6765	MS4	MS5	54.69	125.74
Kaiser Permanente - Kansas City area	913/642-2662	HA1	HA2	45.95	118.55
Mercy Health Plans/Premier - East/Central Missouri	800/327-0763	7M1	7M2	105.32	161.59
Prudential HealthCare HMO - St. Louis area	800/856-0764	VZ1	VZ2	153.75	258.44
North Carolina					
PARTNERS NHP of NC - Most of North Carolina	800/942-5695	EQ1	EQ2	172.92	296.79
UHC of North Carolina - Central/Eastern/Western areas	800/999-1147	XM1	XM2	184.19	319.32
Puerto Rico					
Triple-S - All of Puerto Rico	787/749-4777	891	892	57.10	135.19
Texas					
APWU Health Plan - Eastern and Central Texas	800/222-2798	471	472	308.15	663.65
HMO Blue Texas - Dallas/Ft. Worth/Amarillo/East & West Texas	800/486-3040	YX1	YX2	122.55	196.04
PacifiCare Health Plans - S Ant/Hston/Glvston/Da/Ft Wor/Glf Coast	800/531-3341	GF1	GF2	94.06	230.57
Texas Health Choice, L. C. - Dallas/Ft. Worth areas	972/458-5000	UK1	UK2	94.17	140.88

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	
Missouri												
BlueCHOICE	\$10	None	\$5	\$10/\$15	○	●	◐	◐	◐	○	◐	✓
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	○	○	◐	◐	◐	○	○	✓
North Carolina												
PARTNERS NHP of NC	\$10	\$250	\$10	\$10	●	◐	◐	◐	◐	●	●	✓
UHC of North Carolina	\$10	None	\$10	\$15/\$25	●	●	●	●	●	●	●	✓
Puerto Rico												
Triple-S - In-Network	\$7.50	None	\$2	\$5/\$10**	●	●	○	●	◐	●	◐	
- Out-of-Network	\$7.50*	None#	\$2	\$5/\$10**								
Texas												
APWU Health Plan - In-Network	\$10	None	\$5 or 25%*	\$5 or 25%*								
- Out-of-Network	30%	\$200	\$5 or 45%*	\$5 or 45%*								
HMO Blue Texas	\$10	\$100	\$5	\$10/\$25	○	○	○	◐	◐	◐	○	✓
PacifiCare Health Plans	\$10	None	\$5	\$15	○	○	○	◐	◐	○	○	
Texas Health Choice, L. C.	\$10	None	\$6	\$12/50%	○	○	○	○	○	○	○	✓

* Plus 10%; see plan brochure for details

**See plan brochure for details

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

**See page 5
for a message
that can save
your life!**

