FEHB 2003 GUIDE

Guide to Federal Employees Health Benefits Plans

Member Survey Results and Benefit Information

Retirement and Insurance Service

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

RI 70-13
Revised November 2002

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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present the Federal Employees Health Benefits (FEHB) Program Guide for the FEHB Open Season. I would like to take this opportunity to encourage you to become informed about your health plan choices this year. In keeping with the President's health care agenda, we are committed to providing FEHB Program members with affordable, quality health care choices. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep this program a model of consumer choice and on the cutting edge of employer-provided health benefits. I reminded them of President Bush's principles for health care: patient-centered health care, preservation of choice, and excellent quality. I encouraged each plan to explore all reasonable options to hold down premium increases while maintaining a benefits package that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with the plans to provide health plan choices this year that maintain competitive benefit packages and yet keep health care affordable. We will continue on this path.

Now, it is your turn. This is the time to reevaluate your personal needs and to change plans, if necessary, based on those needs; The Guide provides a comparison of the plans, benefits, premiums, results of a customer satisfaction survey and quality information. If you review the Guide and the health plan brochures you will have the information you need to make an informed choice. We suggest you also visit our web site at www.opm.gov/insure.

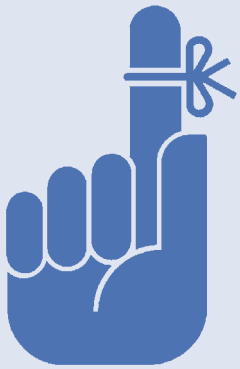
Sincerely,

Kay Coles James
Director

Table of Contents

Things to Remember

- ☑ The plan you choose can make a difference in your health.
- ☑ Be aware of benefit changes for 2003.
- ☑ Check the premium for 2003.



The information in this Guide gives you an overview of the FEHB Program and its participating plans. Read the plan brochures before you make any final decisions about health plans.

Patient Safety

A 1999 report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

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

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

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

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

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

FEHB and You

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

Getting information and selecting a health plan

Use this Guide and plan brochures to make your health plan decision. The Guide summarizes FEHB plans' benefits, costs, and quality performance; the plan brochures give complete benefit and cost information. You can get brochures from the health plans or your human resources office. Our web site www.opm.gov/insure provides the Guide, brochures, and other helpful information.

Before selecting a health plan:

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

Quality

Quality is how well health plans keep their members healthy or treat them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person -- and getting the best possible results. Health plan quality can be measured from the enrollees' viewpoint (member surveys) and by the independent evaluations (accreditation) in this Guide.

Member survey results in this Guide were collected, scored, and reported by an independent organization - not by the health plans. Here are the survey categories:

Getting Needed Care. Did you have problems getting a referral to a specialist or did you experience delays in obtaining care?

Getting Care Quickly. Did you get the advice or help you needed when you called your doctor during regular office hours? Could you get an appointment for regular or routine care when you wanted?

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

Customer Service. Was your plan helpful when you called its customer service department? Did you have paperwork problems? Were the plan's written materials understandable?

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

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

Accreditation is an approval by a private, independent organization. This approval is given after a nationally recognized organization carefully reviews a health plan and decides if it meets the organization's quality standards.

The National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and URAC (URAC) are independent, private, not-for-profit organizations dedicated to measuring the quality of health care organizations.

Compare the accreditation status of different health plans with the following key (a lower number means a better accredited plan).
NCQA (www.ncqa.org):
1 = Excellent (HMO) or Full (PPO)
2 =Commendable (HMO only)
3 = Accredited (HMO) or One-Year (PPO)
4 = Provisional (HMO and PPO)
6 = New Health Plan
JCAHO (www.jcaho.org):
1 = Accreditation with Full Compliance
2 = Accreditation with Requirements for Improvement
3 = Provisional
4 = Conditional
URAC (www.urac.org):
1 = Full Accreditation
2 = Conditional Accreditation
3 = Provisional Accreditation

Also, you should check your health plan's provider directory to see which provider networks are accredited or credentialed.

Benefits

What type of services do you think you and your family will need? Are there limits on the number of visits for the services you want or the types of services you want? All FEHB plans cover major medical benefits -- hospital costs, doctors' inpatient and outpatient visits -- but your share of the costs vary by plan. Don't assume benefits will be the same as they were last year.

- **Read plan brochures and the Change page carefully.**
- **Know what services are covered**
- **Know what services are not covered**

Cost

The premium you pay is an important consideration. What can you afford biweekly or monthly? Plans that offer two options distinguish the difference between the two by the benefits or services provided, and this in turn affects the premium and out-of-pocket costs you pay. What benefits and services do you need, and how much do you have to pay?

You also need to consider other costs: Check to see how you are protected by the plan's annual out-of-pocket maximum. If you need to go to the hospital, how much will you 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 your prescription?

Do you pay a deductible for the services you need? 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 pays for certain services, making you pay the rest?

- **Review the benefit summary in this Guide.**
- **Check plan brochures for specific information.**

How the Plan Works

Different types of plans help you get and pay for care differently. Fee-For-Service (FFS) plans generally use two approaches. In the first approach, you use a Fee-For-Service plan's Preferred Provider Organization (PPO), which offers you a choice of doctors and hospitals within a network. Most networks are quite wide, but they may not have the specific doctor or hospital you want. Using PPO providers usually will save you money and reduce your paperwork.

In the second approach, you choose any doctor and hospital. This may be more expensive for you and require extra paperwork.

Enrolling in a FFS plan does not guarantee that a PPO will be available in your area. PPOs have a stronger presence in some regions than others, and *in areas where there is no PPO, the non-PPO benefit is the only benefit*. In a PPO-only option, you must use the PPO's providers to receive benefits.

Health Maintenance Organizations (HMOs) generally limit their networks of physicians and facilities. You must use their network to get covered services and follow their guidance for referrals, prior authorizations, and other services. HMOs limit your out-of-pocket costs to the relatively low amounts shown in the benefit brochures.

Some plans are Point Of Service (POS) plans and have features similar to both FFS plans and HMOs. POS plans are identified in the charts by lines for "In-Network" and "Out-of-Network."

Be sure to look at the primary care physicians, specialists, and hospitals with whom your health plan contracts (the provider network). Does it have the specialists to treat your chronic condition? Does it contract with primary doctors and hospitals that are convenient to you?

You are in a FFS plan and...

You use the PPO

- You will generally pay less when you get care
- More preventive health care services may be covered
- You may have less paperwork

You do not use the PPO (or one is not available):

- You will generally pay more when you get care
- Fewer preventative health care services may be covered
- You will have to file your own claims for services you receive

NOTE: APWU's Consumer Driven Option differs from its FFS option in many important ways. Read the brochure for details.

You are in a FFS plan's "PPO-only" option

- **You must** use network providers to receive benefits.

You belong to an HMO:

- You will have limitations on the doctors, providers, and facilities you can use.
- You will usually pay less when you get care
- You will have little, if any, paperwork
- More preventive health care services may be covered

You belong to a POS plan and...

You use only the providers in that network:

- You will pay less when you get care
- You will get full network benefits and coverage
- You will have very little paperwork

You do not use the network providers or referral procedures:

- You will pay more when you get care
- You generally have to file claims for services yourself
- Some services may not be covered out of network at all

Things to do to make a plan work best for you

- When you need care, use your brochure to find out about the plan's **rules and coverage**. Know what services require precertification, prior approval, or referral before you use them. Verify physician participation.
- Request **generic drugs** instead of brand name drugs. A generic medication is a copy of a brand name drug. It has the same active ingredients and receives the same Food and Drug Administration approval but costs less. Most plans charge you a lower copay if you use generic drugs.
- If you're in a FFS 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.

FEHB Web Resources

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

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

- An interactive tool that will allow you to find the health plans that service your area and will allow you to make side-by-side comparisons of the costs, benefits, and quality indicators of the plans that interest you.
- Electronic versions of all plan brochures.
- Information on enrolling, with the ability to enroll online for annuitants and employees of selected agencies.
- Information on how plans in the FEHB Program coordinate benefit payments with Medicare.
- A comprehensive set of Frequently Asked Questions and answers on all aspects of the Program.
- An online version of the FEHB Handbook for detailed guidance on FEHB policies and procedures.

Program Features

- **No Waiting Periods.** You can use your benefits as soon as your coverage becomes effective. There are no pre-existing condition limitations even if you change plans.
- **A Choice of Coverage.** Choose between self only or self and family.
- **A Choice of Plans and Options.** Select from Fee-For-Service (with the option of a PPO), 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 the your premium, but not more than 75 percent of the total premium for any plan.
- **Premium Payment Deductions** from your check.
- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enrollment. This year the Open Season runs from November 11, 2002, through December 9, 2002. Other events allow for certain types of changes throughout the year; see your human resources office or retirement system for details.
- **Continued Group Coverage.** Eligible participants can continue coverage following retirement, divorce, death, or changes in employment status. See your human resources office or retirement system 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 resources office or retirement system for more information.

FEHB
Federal Employees
Health Benefits Program

Better Information
Better Choices
Better Health

Definitions

Accreditation - A rigorous and comprehensive evaluation performed by independent organizations that includes a review of records as well as on-site reviews of managed care organizations. Accreditation also includes an assessment of the care and service plans are delivering in important areas of public concern such as immunization rates, mammography rates, and member satisfaction. The following three organizations perform accreditation reviews we recognize:

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

- **Excellent -** NCQA's highest status. Levels of service and clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement AND achieve health plan performance results that are in the highest range of national or regional performance.
- **Commendable -** Meets or exceeds NCQA's requirements for consumer protection and quality improvement.
- **Accredited -** Meets most of NCQA's requirements for consumer protection and quality improvement.
- **Provisional -** Meets some but not all of NCQA's requirements for consumer protection and quality improvement.
- **New Health Plan -** Applies to health plans that are less than two years old.

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

- **Accreditation with Full Compliance -** Demonstrates satisfactory compliance with JCAHO standards in all performance areas.
- **Accreditation with Requirements for Improvement -** Demonstrates satisfactory compliance with JCAHO standards in most performance areas.
- **Provisional -** Demonstrates a previously unaccredited plan's satisfactory compliance with a subset of standards.
- **Conditional -** Demonstrates failure to meet standard(s) or specific policy requirement(s) but is believed capable to do so in a specified time period.

URAC - Formerly known as the American Accreditation Healthcare Commission. These are URAC's accreditation levels.

- **Full Accreditation -** Demonstrates full compliance with standards.
- **Conditional Accreditation -** Meets most of the standards but needs some improvement before achieving full compliance.
- **Provisional Accreditation -** A plan that has otherwise complied with all standards but has been in operation for less than 6 months.

Definitions

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

Consumer Driven Option - A fee-for-service option under the FEHB that offers you greater control over choices of your health care expenditures. You decide which health care services will be reimbursed under the health care plan funded Personal Care Account. Unused funds from the account will roll over at the end of the year. If you spend the entire account fund before the end of the year, then you must satisfy a member responsibility/deductible **before** benefits are payable under the traditional type of insurance covered by your plan. You decide whether to use PPO or Non-PPO providers to reach the maximum fund allowed under your account.

Copayment - The amount you pay as your share of the medical services you receive, like for a doctor's visit. Copayment is a fixed dollar amount (e.g., $15).

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

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

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

Managed care - A very broad term that generally refers to a system that manages the quality of health care, access to care, and the cost of that care. For example, a formulary controls the quality of medications dispensed to enrollees; a referral ensures that you see the right specialist for your condition; and going to a hospital that has an agreement with your plan can save both you and the plan money.

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

Point of Service (POS) - A product offered by an HMO or FFS plan that has both in-network and out-of-network features. In a POS you don't have to use the plan's network of providers, but there are advantages if you do.

Preferred Provider Organization (PPO) - The PPO is similar to FFS insurance except it uses a network of providers. PPO's give you the choice of using doctors and other providers within the plan's network (the PPO benefit), or using ones outside the plan's network. You don't have to use the PPO, but there are advantages if you do. (Be aware, however, that some of the services provided in a PPO hospital may not be covered by PPO arrangements. Room and board will be covered, but anesthesia and radiology, for instance, will probably be covered under non-PPO benefits.)

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

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums will be based on your age as of July 1, 2002. After Open Season, your premiums will be based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But...

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an applicatiuon automatically. You must request one through the toll-free number or website listed below.
- Open season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze."

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Stop Health Care Fraud!

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

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

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

CALL – THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

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

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

Quality and Safety Links

Want more information on health care quality and safety? The following web sites have information consumers can use when considering health plans, doctors and hospitals, medications, and more.

www.ihealthcoalition.org/content/tips.html
- This site offers tips on what to look for when searching for health information on the Internet.

www.ahrq.gov/consumer/pathqpack.htm
- The Agency for Healthcare Research and Quality has made available a wide-ranging list of topics to help consumers choose quality healthcare providers and improve the quality of care they receive.

www.npsf.org
- The National Patient Safety Foundation has information for patients on how to ensure safer healthcare for you and your family.

www.talkaboutrx.org/consumer.html
- The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

http://medlineplus.gov
- The world's largest medical library offering health information from the National Library of Medicine/National Institutes of Health.

www.leapfroggroup.com
- The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.org
- The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety and the quality of healthcare nationwide.

www.quic.gov/report
- Find out what Federal agencies are doing to identify threats to patient safety and help prevent mistakes in the Nation's healthcare delivery system.

www.nchc.org/releases/medical_error.pdf
- The National Coalition on Health Care and the Institute for Healthcare Improvement offer profiles on what institutions and organizations are doing to reduce medical errors and improve patient safety.

Notes

Nationwide Fee-for-Service Plans Open to All

How to read this chart:

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

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

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

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

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

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

Plan name	Plan code	Benefit type	Medical-Surgical — You pay						
			Deductible			Copay ($)/Coinsurance (%)			
			Per Person		Per stay Hospital inpatient	Doctors & Outpatient Tests	Hospital		
							Inpatient		Outpatient other
			Calendar Year	Prescription Drug			R&B	Other	
Alliance Health Plan (AHP)	1R	PPO Non-PPO	$200 $400	$200 $200	$150 $250	10% 30%	10% 30%	10% 30%	10% 30%
APWU Health Plan-High (APWU)	47	PPO Non-PPO	$275 $350	None None	None $200	10% 30%	10% 30%	10% 30%	10% 30%
APWU Health Plan-Consumer Driven (APWU)	47	See page 7 of this Guide for a benefit description, and carefully							
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	10	PPO Non-PPO	$250 $250	None None	$100 $300	10% 25%	Nothing 30%	Nothing 30%	10% 25%
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	11	PPO	None	None	$100/day x 5	$20/$30	Nothing	Nothing	$30
GEHA Benefit Plan-High (GEHA)	31	PPO Non-PPO	$350 $350	None None	$100 $300	10% 25%	Nothing Nothing	10% 25%	10% 25%
GEHA Benefit Plan-Std (GEHA)	31	PPO Non-PPO	$450 $450	None None	None None	15% 35%	15% 35%	15% 35%	15% 35%
Mail Handlers-High (MH)	45	PPO Non-PPO	$250 $250	$250 $250	None $250	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%
Mail Handlers-Std (MH)	45	PPO Non-PPO	$300 $300	$600 $600	$150 $300	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%
NALC	32	PPO Non-PPO	$250 $300	None $25 for Retail	None $100	15% 30%	10% 30%	10% 30%	15% 30%
PBP Health Plan-High (PBP)	36	PPO Non-PPO	$200 $450	$90 $90	None $150	10% 15%/25%	10% 25%	10% 25%	10% 25%
PBP Health Plan-Std (PBP)	36	PPO Non-PPO	$250 $500	$90 $90	None $250	9% 30%	9% 30%	9% 30%	9% 30%

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

A **Generic** drug is a copy of the manufacturer's **Brand Name** drug and is approved by the Food and Drug Administration. **Non-formulary** drugs are Brand Names that are not on your health plan's list of preferred drugs.

Prescription drug benefits have become more complex as you can see from the many variations. Multiple numbers for a plan mean there are different levels of cost sharing. For instance, you may pay one amount for your first prescription (e.g., 10% or $5) and then a different amount for some refills (e.g. 50%). You may have to pay the greater of a dollar amount or a percentage (e.g., $10 or 20%). In some cases, you'll pay less for a Brand Name drug that has no Generic equivalent than for a Brand Name that has a Generic (e.g., $15 versus $30). A few plans have lower copays for Medicare members. Plans vary in the number of days supply of drugs you get for the copays shown, and you'll almost always pay more if you use a non-PPO pharmacy (e.g., the + sign means you pay the amount shown plus a differential). **Read the brochures for details.**

Member Survey Results — See page 1 for a description.

Medical-Surgical — You pay Copay ($)/Coinsurance (%) Prescription drugs					Member Survey Results ● above average, ◒ average, ○ below average					
Generic	Brand Name	Non-formulary	Home Delivery		Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
			Generic	Brand Name						
10%/50% 10%/50% +	15%/50% 15%/50%+	15%/50% 15%/50%+	20% 20%	25% 25%	◒	◒	●	●	◒	◒
$7 45%	25% 45%	25% 45%	$10 $10	20% 20%	●	◒	◒	◒	●	●
read the APWU brochure for details.										
25% 45%+	25% 45%+	25% 45%+	$10/25% 45%+	$35/25% 45%+	○	◒	○	◒	◒	○
$10	$25	$35 or 50%	$10 *	$25 *						
$5/50% $5/50% +	$20/50% $20/50% +	$20/$35/50% $20/$35/50% +	$10 $10	$40/$55 $40/$55	●	◒	○	○	●	●
$5 $5 +	50% 50% +	50% 50% +	$15 $15	50% 50%	●	◒	○	○	●	●
$7 50%	$23 50%	$35 50%	$10 $10	$30/$45 $30/$45	○	○	○	◒	◒	○
$8 50%	$28 50%	$40 50%	$10 $10	$40/$55 $40/$55	○	○	○	◒	◒	○
25% 40%+	25% 40%+	25% 40%+	$10 $10	$30 $30	●	●	●	●	●	●
$3 20%+	$25 or 20% 20%+	$40 or 20% 20%+	$6 $6	$25/ $40 or 20%	○	◒	●	●	○	○
$4 30%+	$30 or 20% 30%+	$40 or 20% 30%+	$8 $8	$30/ $40 or 20%	○	◒	●	●	○	○

* The Mail Service Program is not available under Basic Option.

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

How to read this chart:

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

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

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

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

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

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

Plan name	Plan code	Benefit type	Medical-Surgical — You pay						
			Deductible			Copay ($)/Coinsurance (%)			
			Per Person		Per stay Hospital inpatient	Doctors & Outpatient Tests	Hospital		
							Inpatient		Outpatient other
			Calendar Year	Prescription Drug			R&B	Other	
Association Benefit Plan	42	PPO Non-PPO	$300 $300	None None	$100 $200	10% 30%	Nothing 30%	Nothing 30%	10% 30%
Foreign Service Benefit Plan	40	PPO Non-PPO	$300 $300	None None	Nothing $200	10% 30%	Nothing 20%	Nothing 20%	10% 30%
Panama Canal Area Benefit Plan	43	POS FFS	None None	$400 $400	$50 $125	Nothing 50%	Nothing 50%	Nothing 50%	Nothing 50%
Rural Carrier Benefit Plan	38	PPO Non-PPO	$350 $350	CY Applies CY Applies	Nothing $200	10% 15%	Nothing 15%	Nothing 15%	15% 25%
SAMBA	44	PPO Non-PPO	$350 $350	None None	$200 $300	10% 30%	Nothing 30%	10% 30%	$100/10% $150/30%
Secret Service	Y7	No PPO	$200	None	$100	20%	Nothing	Nothing	Nothing

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

A **Generic** drug is a copy of the manufacturer's **Brand Name** drug and is approved by the Food and Drug Administration. **Non-formulary** drugs are Brand Names that are not on your health plan's list of preferred drugs.

Prescription drug benefits have become more complex as you can see from the many variations. Multiple numbers for a plan mean there are different levels of cost sharing. For instance, you may pay one amount for your first prescription (e.g., 10% or $5) and then a different amount for some refills (e.g. 50%). You may have to pay the greater of a dollar amount or a percentage (e.g., $10 or 20%). In some cases, you'll pay less for a Brand Name drug that has no Generic equivalent than for a Brand Name that has a Generic (e.g., $15 versus $30). A few plans have lower copays for Medicare members. Plans vary in the number of days supply of drugs you get for the copays shown, and you'll almost always pay more if you use a non-PPO pharmacy (e.g., the + sign means you pay the amount shown plus a differential). **Read the brochures for details.**

Member Survey Results — See page 1 for a description.

Medical-Surgical — You pay Copay ($)/Coinsurance (%)					Member Survey Results ● above average, ◒ average, ○ below average					
Prescription drugs										
Generic	Brand Name	Non-formulary	Home Delivery		Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
			Generic	Brand Name						
$10 $10	$20 $20	$30/30% $30/30%	$20 $20	$40/ $45 or 30%	●	◒	◒	○	●	◒
$10/25% $10/25%	$20/25% $20/25%	$20/25% $20/25%	$20 $20	$40 $40	◒	○	◒	○	○	◒
50% 50%	50% 50%	50% 50%	N/A N/A	N/A N/A						
25% 25%	25% 25%	25% 25%	$15 $15	$25 $25	●	●	●	◒	●	●
$10 $10	$25 $25	$40 $40	$10 $10	$35/$50 $35/$50	◒	○	◒	◒	○	○
$10	$20	$20	$20	$40	○	●	○	◒	○	○

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

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

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

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

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Alabama													
PrimeHealth of Alabama, Inc.	AA	$15	$150/day x 4	$10	$20	$40	◒	◒	●	●	◒	◒	
The Oath - A Health Plan for Alabama, Inc.	DF	$20	$100	$10	$20	$30	●	◒	●	●	◒	◒	
Arizona													
Aetna Health Inc.	WQ	$20	$250/day x 3	$10	$25	$40	◒	○	○	○	○	◒	NCQA 1
Health Net of Arizona, Inc.	A7	$10	$100/day x 5	$10	$30	$45	○	○	○	○	○	○	NCQA 2
PacifiCare Health Plans	A3	$10	None	$10	$20	$20	○	○	○	◒	◒	◒	NCQA 1
California													
Aetna Health Inc.	2X	$20	$250/day x 3	$10	$25	$40	○	○	○	○	○	○	NCQA 2
Blue Cross- HMO	M5	$10	None	$5	$10	50%	○	○	○	◒	◒	◒	NCQA 2
Blue Shield of CA Access+	SJ	$10	None	$5	$10	$25	◒	○	○	◒	◒	◒	NCQA 2
CIGNA HealthCare of California	9T	$15	$250	$7	$15	$35	○	○	○	○	○	○	NCQA 2
Health Net	LB	$10	$100	$10	$20	$35	○	○	○	○	○	○	NCQA 2
Kaiser Permanente	59	$15	None	$10	$25	$25	◒	◒	○	○	◒	◒	NCQA 1
Kaiser Permanente	62	$10	None	$10	$25	$25	◒	◒	○	○	●	◒	NCQA 1
PacifiCare Health Plans	CY	$10	None	$10	$20	$20	◒	○	○	○	○	◒	NCQA 1
UHP Healthcare	C4	$10	None	$10	$20	$20							JCAHO 1
Universal Care	6Q	$10	$100/day x 3	$10	$20	$30	◒	○	○	◒	◒	◒	NCQA 2

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

Member Survey Results — See page 1 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Colorado													
Kaiser Permanente	65	$10	$100	$10	$20	$20	◒	◒	○	○	◒	◒	NCQA 1
PacifiCare of Colorado-High	D6	$10	$100	$10	$20	$30	○	○	◒	◒	◒	◒	NCQA 1
PacifiCare of Colorado-Std	D6	$15	$300	$10	$30	$40	○	○	◒	◒	◒	◒	NCQA 1
Connecticut													
ConnectiCare	TE	$10	None	$10	$20	$35	●	●	●	◒	●	●	NCQA 1
District of Columbia													
Aetna Health Inc.-High	JN	$15	$150/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
Aetna Health Inc.-Std	JN	$20	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
CareFirst BlueChoice	2G	$20	None	$10	$20	$35	◒	◒	○	○	○	○	NCQA 1
Kaiser Permanente	E3	$10	$100	$10$20Net	$20$40Net	$20$40Net	◒	◒	◒	○	●	◒	NCQA 2
M.D. IPA	JP	$10	None	$8	$17	$33	●	●	◒	◒	●	◒	NCQA 1

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

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

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

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

Plan name		Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
					Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Florida														
Av-Med Health Plan (North Florida)	EM	$20	$100/day x 5	$15	$30	$50	◒	○	○	◒	◒	◒	NCQA 2	
Av-Med Health Plan (South Florida)	ML	$15	$100	$10	$20	$30	◒	○	○	◒	◒	◒	NCQA 2	
Capital Health Plan	EA	$10	$100	$7	$20	$35	●	●	◒	◒	●	●	NCQA 1	
Foundation Health	5E	$10	$200	$7	$14	$34	○	○	○	○	○	◒	NCQA 2	
Healthplan Southeast	RK	$10	None	$7	$20	$35								
Humana Medical Plan	EE	$10	$100/day x 3	$5/$20	$20/$40	$100	◒	○	○	○	◒	◒	URAC 1	
JMH Health Plan	J8	$10	None	$5	50%	50%								
Total Health Choice	4A	$10	$100	$5	$15	$15								
Vista Healthplan	3N	$10	$250	$10	$20	$40	○	◒	○	◒	◒	◒	NCQA 2	
Georgia														
Aetna Health Inc.	2U	$20	$250/day x 3	$10	$25	$40	◒	○	○	◒	◒	◒	NCQA 1	
Kaiser Permanente	F8	$10	None	$10$16Com	$10$16Com	$10$16Com	●	●	◒	◒	●	◒	NCQA 1	

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

Member Survey Results — See page 1 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Guam													
PacifiCare Asia Pacific-High	JK	$10	None	$5	$20	$20	◒	◒	○	●	◒	◒	
PacifiCare Asia Pacific-Std	JK	$15	$150	$5	$20	$20	◒	◒	○	●	◒	◒	
Hawaii													
HMSA - In-Network - Out-of-Network	87	20% 30%	None 30%	$5 $5+20%+	$15 $15+20%+	$15 or 50% $15 or 50%+	●	●	●	●	●	●	NCQA 1
Kaiser Permanente-High	63	$10	None	$10	$10	$10	●	◒	◒	◒	●	◒	NCQA 1
Kaiser Permanente-Std	63	$15	None	$10	$10	$10	●	◒	◒	◒	●	◒	NCQA 1
Idaho													
Group Health Cooperative	VR	$15	$200/day x 3	$15	$25	$50	◒	◒	●	◒	●	●	NCQA 1

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

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

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

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

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Illinois													
BlueCHOICE	9G	$10	None	$7	$12	$25							NCQA 1
Group Health Plan	MM	$10	$100	$8	$20	$35	◒	◒	●	◒	◒	◒	URAC 1
Health Alliance HMO	FX	$15	$100	$10	$20	$40	●	◒	●	●	●	●	NCQA 1
Humana Health Plan Inc.-High	75	$10	$100/day x 3	$5/$15	$15/$35	25%	○	◒	○	◒	○	○	
Humana Health Plan Inc.-Std	75	$15	$250/day x 3	$10/$25	$25/$45	25%	○	◒	○	◒	○	○	
John Deere Health Plan	YH	$15	$100	$10	$20	$35	●	●	●	●	●	●	NCQA 1
Mercy Health Plans/Premier - In-Network - Out-of-Network	7M	$10 30%	None 30%	$10 N/A	$20 N/A	$35 N/A	●	◒	●	●	●	●	
OSF HealthPlans	9F	$20	$500	$10	$20	$40	●	●	●	●	◒	●	NCQA 1
PersonalCare's HMO	GE	$20	$100/day x 5	$10	$20	$50	●	●	●	◒	●	◒	NCQA 1
Unicare HMO	17	$15	None	$5	$15	$25	○	○	◒	◒	○	○	NCQA 1
Union Health Service	76	$10	None	$15	$15	N/A							
Indiana													
Advantage Health Plan, Inc.	6Y	$15	$400	$10	$30	$50	○	◒	◒	◒	○	○	NCQA 6
Aetna Health Inc.	RD	$20	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
Arnett HMO	G2	$10	None	$5	$15	$30	●	●	●	◒	●	●	NCQA 1
Health Alliance HMO	FX	$15	$100	$10	$20	$40	●	◒	●	●	●	●	NCQA 1
Humana Health Plan	D2	$15	$250/day x 3	$10/$25	$25/$45	25%	◒	○	○	○	◒	○	URAC 1
Humana Health Plan Inc.-High	75	$10	$100/day x 3	$5/$15	$15/$35	25%	○	◒	○	◒	○	○	
Humana Health Plan Inc.-Std	75	$15	$250/day x 3	$10/$25	$25/$45	25%	○	◒	○	◒	○	○	
M*Plan	IN	$10	$250	$5/$10	$15	$50	◒	◒	●	●	◒	◒	NCQA 1
Physicians Health Plan of Northern Indiana	DQ	$10	20%of$2500	$5	$15	$40	●	●	●	●	●	●	
Unicare HMO	17	$15	None	$5	$15	$25	○	○	◒	◒	○	○	NCQA 1

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

Member Survey Results — See page 1 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Iowa													
Avera Health Plans	AV	$10	$100/dayx3	$10	$20	$35 or 50%							
Coventry Health Care of Iowa	SV	$10	None	$5	$15	$30	○	●	●	◒	○	◒	
Health Alliance HMO	FX	$15	$100	$10	$20	$40	●	◒	●	●	●	●	NCQA 1
John Deere Health Plan	YH	$15	$100	$10	$20	$35	●	●	●	●	●	●	NCQA 1
Kansas													
Coventry Health Care of Kansas	7W	$15	$100/day x 3	$5	$15	$45							
Coventry Health Care of Kansas - Kansas City	HA	$15	$100/day x 3	$10	$20	$50	○	◒	◒	◒	○	○	
Humana Health Plan, Inc.-High	MS	$10	$100/day x 3	$5/$20	$20/$40	25%	○	◒	◒	○	○	○	URAC 1
Humana Health Plan, Inc.-Std	MS	$15	$250/day x 3	$10/$25	$25/$45	25%	○	◒	◒	○	○	○	URAC 1
Preferred Plus of Kansas	VA	$10	$50/day x 10	$5	$15	$15							JCAHO 2
Kentucky													
Humana Health Plan	D2	$15	$250/day x 3	$10/$25	$25/$45	25%	◒	○	○	○	◒	○	URAC 1
United Healthcare of Ohio, Inc.	3U	$15	$250	$10	$15	$30	◒	●	●	◒	◒	◒	NCQA 1

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

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

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

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

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Louisiana													
Coventry Healthcare Louisiana	BJ	$15	$100/day x 3	$10	$20	$45	○	○	○	◒	○	○	
Coventry Healthcare Louisiana	A	$15	$100/day x 3	$10	$20	$45	○	○	○	◒	○	○	
Vantage Health Plan	AQ	$15	$250	$10	$20	$35							
Vantage Health Plan	MV	$15	$250	$10	$20	$35							
Maryland													
Aetna Health Inc.-High	JN	$15	$150/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
Aetna Health Inc.-Std	JN	$20	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
CareFirst BlueChoice	2G	$20	None	$10	$20	$35	◒	◒	○	○	○	○	NCQA 1
Kaiser Permanente	E3	$10	$100	$10$20Net	$20$40Net	$20$40Net	◒	◒	◒	○	●	◒	NCQA 2
M.D. IPA	JP	$10	None	$8	$17	$33	●	●	◒	◒	●	◒	NCQA 1
Massachusetts													
Blue Chip, Coord Hlth Partners - In-Network - Out-of-Network	DA	$15 30%	$500 None	$7 $40+20%	$25 $40+20%	$40 $40+20%	◒	●	●	◒	◒	◒	NCQA 1
ConnectiCare	TE	$10	None	$10	$20	$35							NCQA 1
Fallon Community Health Plan	JV	$10	None	$5	$15	$35	●	●	●	●	●	◒	NCQA 1

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

Member Survey Results — See page 1 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Michigan													
Bluecare Network of MI	G7	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒	NCQA 1
Bluecare Network of MI	K5	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒	NCQA 1
Bluecare Network of MI	KF	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒	NCQA 1
Bluecare Network of MI	KN	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒	NCQA 1
Bluecare Network of MI	KR	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒	NCQA 1
Bluecare Network of MI	LN	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒	NCQA 1
Bluecare Network of MI	LX	$15	$250	$10	$20	$20	◒	◒	●	◒	◒	◒	NCQA 1
Grand Valley Health Plan	RL	$10	None	$5	$5	$5	●	◒	●	◒	●	◒	NCQA 1
Health Alliance Plan	52	$10	None	$10	$20	$30	◒	◒	◒	●	◒	◒	NCQA 1
HealthPlus MI	X5	$10	None	$5	$10	$10	●	●	●	●	●	●	NCQA 1
M-Care	EG	$10	None	$10	$20	$30	●	◒	◒	◒	●	●	NCQA 1
OmniCare	KA	$10	None	$2	$2	$2	○	○	○	◒	◒	○	NCQA 4
The Wellness Plan	K3	$10	None	$5	$5	$5	○	○	○	○	○	○	
Total Health Care	N2	$10	None	Nothing	Nothing	Nothing	○	○	○	○	○	◒	
Minnesota													
Avera Health Plans	AV	$10	$100/dayx3	$10	$20	$35 or 50%							
HealthPartners Classic	53	$15	$100	$12	$12	$24	◒	◒	◒	◒	◒	◒	NCQA 1
HealthPartners Primary Clinic Plan	HQ	$20	$200	$12	$12	$24	◒	◒	◒	◒	◒	◒	

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

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

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

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

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Missouri													
Mercy Health Plans/Premier - In-Network - Out-of-Network	7M	$10 30%	None 30%	$10 N/A	$20 N/A	$35 N/A	●	◒	◒	◒	●	●	
BlueCHOICE	9G	$10	None	$7	$12	$25	◒	◒	●	●	◒	◒	NCQA 1
Coventry Health Care of Kansas - Kansas City	HA	$15	$100/day x 3	$10	$20	$50	○	◒	◒	◒	○	○	
Group Health Plan	MM	$10	$100	$8	$20	$35	◒	◒	●	◒	◒	◒	URAC 1
Humana Health Plan, Inc.-High	MS	$10	$100/day x 3	$5/$20	$20/$40	25%	○	◒	◒	○	○	○	URAC 1
Humana Health Plan, Inc.-Std	MS	$15	$250/day x 3	$10/$25	$25/$45	25%	○	◒	◒	○	○	○	URAC 1
Montana													
New West Health Plan	NV	$15	$100	$10	$20								
Nevada													
Health Plan of Nevada	NM	$10	$100	$5	$20	$35	○	○	○	○	○	◒	NCQA 3
PacifiCare Health Plans	K9	$10	None	$10	$20	$20	○	○	○	○	○	◒	NCQA 2

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

Member Survey Results — See page 1 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
New Jersey													
Aetna Health Inc.	P3	$20	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
AmeriHealth HMO	FK	$30	$200/day x 3	$20	$40	50%	○	●	◒	◒	◒	○	NCQA 1
GHI Health Plan - In-Network - Out-of-Network	80	$15 50% of sch.	None None	$10 N/A	$20 N/A	$50 N/A	◒	●	◒	◒	◒	◒	URAC 1
New Mexico													
Cimarron Health Plan	PX	$10	None	$5	$10	$25	◒	○	○	◒	◒	◒	NCQA 2
Lovelace Health Plan	Q1	$15	$250	$7	$15	$35	◒	◒	◒	◒	◒	◒	NCQA 2 JCAHO 1
Presbyterian Health Plan	P2	$10	None	$5	$15	$35	◒	◒	○	○	◒	●	NCQA 2

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

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

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

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

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
New York													
GHI Health Plan - In-Network - Out-of-Network	80	$15 50% of sch.	None None	$10 N/A	$20 N/A	$50 N/A	◒	●	◒	◒	◒	◒	URAC 1
Aetna Health Inc.	JC	$20	$250/day x 3	$10	$25	$40	◒	◒	◒	○	◒	◒	NCQA 1
Blue Choice	MK	$10	None	$5	$15	$30	●	●	●	●	◒	●	NCQA 2
Capital District Physicians Health Plan	PW	$10	$100	$5	$20	$20	●	●	●	●	●	●	NCQA 1
Capital District Physicians Health Plan	QB	$10	$100	$5	$20	$20	●	●	●	●	●	●	NCQA 1
Capital District Physicians Health Plan	SG	$10	$100	$5	$20	$20	●	●	●	●	●	●	NCQA 1
GHI HMO Select	6V	$10	None	$10	$20	$30	○	○	○	○	○	○	NCQA 6
GHI HMO Select	X4	$10	None	$10	$20	$30	○	○	○	○	○	○	NCQA 6
HIP of Greater New York-High	51	$10	None	$10	$15	$40	◒	◒	○	◒	◒	○	NCQA 2
HIP of Greater New York-Std	51	$10	$500	$10	$20	$40	◒	◒	○	◒	◒	○	NCQA 2
HMO Blue	AH	$15	$240	$10	$25	$40	◒	●	●	●	◒	◒	NCQA 1
HMOBlue-CNY	EB	$10	None	$5	$20	$35	○	●	●	◒	○	◒	NCQA 1
Independent Health Assoc	QA	$15	None	$10	$20	$35	●	●	●	●	●	●	NCQA 1
MVP Health Care	GA	$15	$240	$5	$20	$40	●	●	●	●	●	●	NCQA 2
MVP Health Care	M9	$15	$240	$5	$20	$40	●	●	●	●	●	●	NCQA 2
MVP Health Care	MX	$15	$240	$5	$20	$40	●	●	●	●	●	●	NCQA 2
Preferred Care	GV	$15	None	$10	$20	$35	●	●	●	●	●	●	NCQA 1
Univera Healthcare	KQ	$15	$250	$5	$15	$35							
Univera Healthcare	Q8	$15	$250	$5	$15	$35	◒	●	●	●	◒	●	NCQA 1
Vytra Health Plans	J6	$10	None	$5	$10	$10	●	●	◒	◒	●	◒	

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

Member Survey Results — See page 1 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
North Dakota													
Heart of America HMO	RU	$10	None	50%	50%	50%							
Ohio													
Aetna Health Inc.	7D	$20	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
Aetna Health Inc.	RD	$20	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
AultCare HMO	3A	$10	None	$5	$10	$10	●	●	●	●	●	●	
Blue HMO	R5	$10	None	$10	$20	$30	◒	◒	●	◒	◒	◒	NCQA 1
Health Plan of the Upper Ohio Valley-High	U4	$10	None	$10	$20	$35	●	●	●	●	●	●	NCQA 1
Health Plan of the Upper Ohio Valley-Std	U4	$10	None	$15	$30	$50	●	●	●	●	●	●	NCQA 1
HMO Health Ohio	L4	$10	None	$10	$20	$20	◒	◒	◒	◒	○	○	NCQA 1
Kaiser Permanente	64	$10	None	$5	$15	$15	●	●	◒	◒	●	◒	NCQA 1
Paramount Health Care	U2	$10	$300	$5	$15	$25	●	●	◒	◒	●	●	NCQA 2
SummaCare Health Plan	5W	$10	None	$8	$15	$30	●	●	●	●	●	○	NCQA 1
SuperMed HMO	5M	$10	None	$10	$20	$20	◒	◒	◒	◒	○	○	NCQA 1
United Healthcare of Ohio, Inc.	3U	$15	$250	$10	$15	$30	◒	●	●	◒	◒	◒	NCQA 1

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

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

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

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

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Oklahoma													
PacifiCare Health Plans	2N	$10	None	$10	$20	$20	◒	○	○	◒	○	●	NCQA 1
Oregon													
Kaiser Permanente-High	57	$10	None	$10	$20	$20	◒	◒	○	○	●	◒	NCQA 1
Kaiser Permanente-Std	57	$15	None	$15	$30	$30	◒	◒	○	○	●	◒	NCQA 1
PacifiCare Health Plans	7Z	$10	None	$10	$20	$20	○	○	◒	◒	○	◒	NCQA 1
Pennsylvania													
Aetna Health Inc.	P3	$20	$250/day x 3	$10	$25	$40	◒	●	●	◒	◒	◒	NCQA 1
Health Net of Pennsylvania	2K	$10	None	$10	$20	$35	○	◒	●	●	○	○	
HealthAmerica Pennsylvania	26	$10	None	$8	$14	$35	●	●	●	●	◒	●	NCQA 1
HealthAmerica Pennsylvania	SW	$10	None	$8	$14	$35	●	●	●	●	◒	●	NCQA 1
HealthGuard	NQ	$10	None	$10	$25	$40	●	●	●	◒	◒	●	NCQA 1
Keystone Health Plan Central	S4	$10	None	$10	$25	$40	●	●	●	●	●	●	NCQA 1
Keystone Health Plan East	ED	$10	None	$5	$15	$25	○	●	◒	◒	◒	◒	NCQA 1
UPMC Health Plan	8W	$10	None	$5	$15	$35	◒	●	◒	◒	◒	◒	

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

Member Survey Results — See page 1 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Puerto Rico													
Humana Health Plans of Puerto Rico													
- In-Network	ZJ	$5	None	$2.50	$5	$5							
- Out-of-Network		$8	$50	N/A	N/A	N/A							
Triple-S - In-Network	89	$7.50	None	$2	$5/$10	$10 or 20%	●	●	○	●	◒	◒	
- Out-of-Network		$7.50 + 10%	None	25%	25%	25%							
Rhode Island													
Blue Chip, Coord Hlth Partners													
- In-Network	DA	$15	$500	$7	$25	$40	◒	●	●	◒	◒	◒	NCQA 1
- Out-of-Network		30%	None	$40+20%	$40+20%	$40+20%							
South Dakota													
Sioux Valley Health Plan - In-Network	AU	$20	$100	$10	$20	$35	○	●	●	●	◒	◒	JCAHO 1
- Out-of-Network		40%	40%	N/A	N/A	N/A							NCQA 6
Avera Health Plans	AV	$10	$100/dayx3	$10	$20	$35 or 50%							

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

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

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

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

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Tennessee													
Aetna Health Inc.	6J	$20	$250/day x 3	$10	$25	$40	○	○	◒	◒	◒	○	NCQA 1
Aetna Health Inc.	UB	$20	$250/day x 3	$10	$25	$40	○	○	◒	◒	◒	○	NCQA 1
HealthSpring-High	6K	$15	$250	$10	$20	$35							
HealthSpring-Std	6K	$20	$250	$10	$20	50%							
Texas													
Amcare Health Plans	2V	$10	None	$5	$15	50%	○	○	○	◒	○	○	NCQA 6
Amcare Health Plans	ZG	$10	None	$5	$15	50%	○	○	○	◒	○	○	NCQA 6
FIRSTCARE	6U	$15	$100	$10	$20	$40	◒	◒	◒	●	●	◒	
FIRSTCARE	CK	$15	$100	$10	$20	$40	◒	●	◒	●	●	●	
HMO Blue Texas	YM	$20	$100/dayx4	$10	$25	$40	○	○	○	○	○	○	NCQA 2
Humana Health Plan of Texas-High	UR	$10	$100/day x3	$5/$20	$20/$40	25%	◒	○	○	○	◒	◒	
Humana Health Plan of Texas-Std	UR	$15	$250/day x3	$10/$25	$25/$45	25%	◒	○	○	○	◒	◒	
Mercy Health Plans/Premier - In-Network - Out-of-Network	HM	$10 40%	None 40%	$7 N/A	$12 N/A	$25 N/A	●	◒	○	●	◒	◒	
PacifiCare Health Plans	GF	$10	None	$10	$20	$20	○	○	○	◒	○	○	NCQA 2

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

Member Survey Results — See page 1 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Utah													
Altius Health Plans	9K	$10	None	$10	$20	$40	◒	◒	◒	◒	○	○	
Vermont													
MVP Health Care	VW	$15	$240	$5	$20	$40	●	●	●	●	●	●	NCQA 2
Virginia													
Aetna Health Inc.-High	JN	$15	$150/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
Aetna Health Inc.-Std	JN	$20	$250/day x 3	$10	$25	$40	◒	◒	◒	◒	◒	◒	NCQA 1
CareFirst BlueChoice	2G	$20	None	$10	$20	$35	◒	◒	○	○	○	○	NCQA 1
Kaiser Permanente	E3	$10	$100	$10$20Net	$20$40Net	$20$40Net	◒	◒	◒	○	●	◒	NCQA 2
M.D. IPA	JP	$10	None	$8	$17	$33	●	●	◒	◒	●	◒	NCQA 1
Optima Health Plan	9R	$10	$250	$10	$20	$40	◒	●	◒	◒	●	●	NCQA 1
Piedmont Community Healthcare - In-Network - Out-of-Network	2C	 $20 40%	 None None	 $10 $10	 $20 $20	 $20 $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. This chart does not show all of your possible out-of-pocket costs.

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

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

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Washington													
Aetna Health Inc.	8J	$20	$250/day x 3	$10	$25	$40	○	○	◒	◒	○	◒	
Group Health Cooperative	54	$15	$200/day x 3	$15	$25	$50	◒	◒	●	◒	●	●	NCQA 1
Group Health Cooperative	VR	$15	$200/day x 3	$15	$25	$50	◒	◒	●	◒	●	●	NCQA 1
Kaiser Permanente-High	57	$10	None	$10	$20	$20	◒	◒	○	○	●	◒	NCQA 1
Kaiser Permanente-Std	57	$15	None	$15	$30	$30	◒	◒	○	○	●	◒	NCQA 1
KPS Health Plans-High	VT	$10	$100/day x 10	$5	50%	50%	●	●	●	●	●	●	
KPS Health Plans-Std	VT	$20	None	$5	$20	$100or50%	●	●	●	●	●	●	
PacifiCare Health Plans	7Z	$10	None	$10	$20	$20	◒	○	◒	◒	◒	◒	NCQA 1
PacifiCare Health Plans	WB	$10	None	$10	$20	$20	◒	○	◒	◒	◒	◒	NCQA 1
West Virginia													
Health Plan of the Upper Ohio Valley-High	U4	$10	None	$10	$20	$35	●	●	●	●	●	●	NCQA 1
Health Plan of the Upper Ohio Valley-Std	U4	$10	None	$15	$30	$50	●	●	●	●	●	●	NCQA 1

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

Member Survey Results — See page 1 for a description.
Accredited — The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or the American Accreditation Healthcare Commission/URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Plan code	Primary care doctor office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results ● above average, ◒ average, ○ below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Accredited
Wisconsin													
Dean Health Plan	WD	$10	None	$10	30% to 1500	N/A	●	●	●	◒	●	●	NCQA 1
Group Health Cooperative	WJ	$20	None	$6	$12	$12	●	●	●	◒	●	●	NCQA 1
Group Health Cooperative/Eau Claire	WT	$10	None	$10	$20	$20	●	●	●	●	●	●	
HealthPartners Classic	53	$15	$100	$12	$12	$24	◒	◒	◒	◒	◒	◒	NCQA 1
HealthPartners Primary Clinic Plan	HQ	$20	$200	$12	$12	$24	◒	◒	◒	◒	◒	◒	
Wyoming													
WINhealth Partners	PV	$10	None	$10	$15	$40							

Notes

Notes


FEHB
2003
GUIDE