



# Guide to Federal Employees Health Benefits Plans

For Federal Deposit Insurance  
Corporation Employees

Note: The rates in this Guide do not apply to FDIC  
Presidential Appointees or Retirees





OFFICE OF THE DIRECTOR

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

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](http://www.opm.gov/insure).

Sincerely,

A handwritten signature in blue ink that reads "Kay C. James".

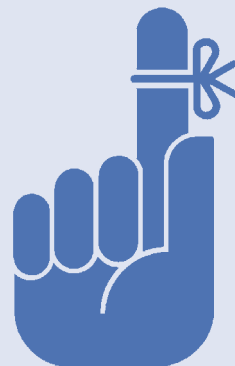
Kay Coles James  
Director

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## 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 8.5 million people are in the Program, including 2.2 million Federal employees, 1.85 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](http://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.** Were you satisfied with the choices your health plan gave you to select a personal doctor? Were you satisfied with the time it takes to get a referral to a specialist?

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

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

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

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

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

# FEHB and You

**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](http://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](http://www.jcaho.org)):

- 1 = Accreditation with Full Compliance
- 2 = Accreditation with Requirements for Improvement
- 3 = Provisional
- 4 = Conditional

URAC ([www.urac.org](http://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 a PPO-only option, you must use the PPO's providers to receive benefits.

# F E H B a n d Y o u

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.

## **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](http://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.

You can also look at and download:

- All of the FEHB Guides including the Guide for Federal Deposit Insurance Corporation Employees.
- Plan Brochures that include the benefits, cost, and other major features and provisions of each health plan.

# 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.
- **An Employer Contribution.** For 2003, the FDIC will pay 85 percent of the average premium toward the total cost of your premium, but not more than 88.75 percent of the total premium for any individual plan. If you continue FEHB coverage as a retiree, the contribution made on your behalf will be different than an active FDIC employee. The government contribution will be 72 percent of the average premium, but not more than 75 percent of the total premium for any individual plan.
- **Salary Deduction.** For 2003, all eligible FDIC employees who elect FEHB health plan coverage, including permanent, temporary, full-time, or part-time employees, will pay the biweekly premium amount shown under the "Your Share" column of the plan comparison chart in this Guide. If you continue FEHB coverage as a retiree, you will pay the same premium cost as other non-FDIC Federal government retirees, which is different than the FDIC share that is paid for active employees.
- **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 for more information.
- **Coverage after FEHB Ends.** You or your family members may be eligible for temporary continuation of FEHB coverage or for conversion to non-group (private) coverage when FEHB coverage ends. See your human resource office for more information.
- **Choice of Tax Treatment.** Your share of the premium may be withheld from your biweekly salary payment on a pre-tax or post tax basis. Premiums are automatically withheld on a pre-tax basis unless you submit a waiver of your participation in the FDIC Premium Conversion Plan. Your waiver will remain in effect until you submit a request to restore pre-tax payment of your health insurance premiums.



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 Accredited** - 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 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. PPOs 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.) Note that some FFS plans may offer an enrollment option that is "PPO-only." Under this option you **must** use network providers to receive 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 application 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](http://www.ltcfeds.com) to get more information and to request an application.

# Stop Health Care Fraud!

**F**raud 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](http://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](http://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](http://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](http://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](http://www.leapfroggroup.com)

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

[www.ahqa.org](http://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](http://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](http://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.

# FDIC Premium Conversion

**S**ection 125 of the Internal Revenue Code allows an employer to provide a portion of an employee's salary in benefits rather than cash. Instead of paying a certain amount to an employee as taxable income, the employer uses it to purchase benefits for the employee. Several years ago, the Federal Deposit Insurance Corporation (FDIC) established the Premium Conversion Plan as a tax-savings benefit for its employees. The FDIC Premium Conversion Plan enables employees to pay their share of Federal Employees Health Benefits (FEHB) Program premiums on a pre-tax basis, which reduces an employee's taxable income by the amount of health insurance premiums. As a result, taxes are calculated on a lower income base.

This feature is offered and administered by the FDIC and is not a provision of the FEHB Program's Premium Conversion Plan. FDIC employees will continue to be covered by the FDIC-sponsored premium conversion plan. Both plans comply with plan requirements under Section 125 of the Internal Revenue Code and provide the same benefit of lower tax liability. For specific details about the FDIC Premium Conversion Plan, contact your FDIC servicing benefits representative.

**Open Season Dates**                      **November 11, 2002 - December 9, 2002**

**Effective Date**                              Your change in tax treatment of your health insurance premiums will become effective **December 15, 2002. (Pay date of January 09, 2003)**

**Eligibility**                                      All employees who are eligible for and elect FEHB coverage. (By law, the Premium Conversion Plan is not available to retirees.) **FEHB premiums are withheld on a pre-tax basis automatically, unless you waive this provision.**

**Elections**                                      If you would like to have your 2003 FEHB premiums paid with after-tax money, you must submit a Premium Conversion Waiver/Election form to your servicing benefits representative during this open season. If you submit a waiver your premiums will continue to be paid with after tax money until you submit a request to restore pre-tax payment of health insurance premiums. **The only time of year that you may change the method of payment from pre-tax to post-tax, or the reverse, is during the annual open season.** Premium Conversion Plan Waiver/Election forms may be obtained from your servicing benefits representative.

**How does PCP Work?**                      Under the health insurance premium conversion arrangement, your taxable income is reduced by the amount of health insurance premiums withheld for basic pay. The FEHB premium deduction will be withheld from pay as "pre-tax money," which means the premium amount is not subject to income, Social Security, or Medicare taxes. You save on Federal income taxes, and where applicable, also on state and local income taxes. This premium conversion feature applies only to health insurance premiums you pay under the FEHB Program. Dental and vision insurance premiums are withheld on a pre-tax basis under the Flexible Cafeteria Benefits Plan - "FDIC Choice."

# FDIC Premium Conversion

## Impact of Premium Conversion on Benefits

Paying for health insurance premiums on a pre-tax basis does not affect your other benefit programs; it only changes the way you pay for your share of the FEHB premium cost. Other benefits such as life insurance and retirement will continue to be based on adjusted basic salary before biweekly premiums are deducted.

Most employees prefer paying their premiums with pre-tax money because they save on taxes. However, there are two possible disadvantages to paying your premiums with pre-tax money that you should balance against the tax savings you receive. Those possible disadvantages are:

- Paying your premiums with pre-tax money reduces the earnings reported to the Social Security Administration. When you retire and begin to collect Social Security, you may receive a slightly lower Social Security benefit. Your Medicare, life insurance, retirement plan, and both the Thrift Savings Plan and the FDIC Savings Plan benefits will not be affected.
- There are some Internal Revenue Service (IRS) restrictions on the ability to reduce your health insurance coverage outside of an open season if you pay your premium contributions with pre-tax money. These are explained in detail in the "IRS Guidelines for Reducing Coverage" section below. If you pay premiums with after-tax money you will not be affected by the IRS guidelines that restrict reductions in coverage. You may cancel your level of health insurance coverage at any time of year without having a qualified life status change.

## IRS Guidelines For Reducing Coverage

When your premium deductions are withheld on a pre-tax basis, certain IRS rules affect your ability to change coverage. You may elect to reduce your coverage, that is, to cancel your health insurance enrollment, or change from family to self-only coverage, during the health insurance open season or following one of the life status changes listed below:

- Marriage or divorce
- Birth of a child or addition of a qualified dependent
- Death of your spouse or loss of a qualified dependent
- Start or end of your spouse's employment
- Change in your spouse's employment status from either full-time to part-time, (or the reverse)
- Start or end of your spouse's unpaid leave of absence
- Significant changes in your (or your spouse's) health coverage because of your spouse's employment
- Completion of a full pay period in non-pay status, e.g., leave without pay.

# FDIC Premium Conversion

If you want to reduce your health insurance coverage outside the FEHB open season, the change must be consistent with your qualified life status change. For example, if you have a new baby, you can not change from a self and family to a self-only enrollment.

To reduce your coverage outside of a FEHB open season, complete and submit a Health Benefits Registration Form (SF-2809) to your servicing benefits representative no later than 60 calendar days after a qualified life status change has occurred, and provide any necessary supporting documentation.

If you are the only person remaining in your self and family enrollment as a result of a change in marital or family status (death of a spouse, divorce, child marries or becomes age 22), you must elect to reduce the enrollment (self only or cancel) within 60 calendar days of such a life status change. Otherwise, the self and family enrollment will continue until another event (life status change or FEHB Open Season) occurs that will allow an election to reduce coverage. The effective date of change from family to self-only will be the first day of the pay period that follows the pay period in which your enrollment form is received.

*Information in this section serves as the FDIC Premium Conversion Plan Summary Plan Description.  
If you need additional information, contact your DOA/Personnel Services Branch  
or OIG/Human Resources Branch for assistance.*

# Plan Comparisons

## Nationwide Fee-For-Service Plans Open to All

(Pages 16 through 18)

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

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

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

**Consumer Driven Option** offers three major benefit elements.

- A) **In-Network Preventive Care** – you pay nothing for preventive services provided in PPO. Your in-network preventive care does not count against your Personal Care Account.
- B) **Personal Care Account** – you pay nothing for the first \$1,000 (\$2,000 for self and family enrollment) in covered services by your FFS plan. A PPO or Non-PPO provider may provide your service. These services may include limited dental and vision care that you select.
- C) **Traditional Health Care** – you pay stated coinsurance **after** spending the amount allowed in the Personal Care Account **and** satisfy the member responsibility/deductible. A PPO or Non-PPO provider may provide your service.

## 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 Home delivery and local pharmacies count toward the deductible. In other plans only purchases from local pharmacies count. Some plans require each family member to meet a per person deductible.

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

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

Plan name	Telephone number	Enrollment code		Your Share		FDIC Share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Alliance Health Plan (AHP)	202/939-6325	1R1	1R2	52.76	90.70	129.03	294.70
APWU Health Plan-High (APWU)	800/222-2798	471	472	32.35	59.45	129.03	294.70
APWU Health Plan-Consumer Driven (APWU)	800/222-2798	474	475	16.57	41.22	129.03	294.70
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	25.93	60.14	129.03	294.70
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	Local phone #	111	112	15.75	37.02	124.23	292.08
GEHA Benefit Plan-High (GEHA)	800/821-6136	311	312	47.44	89.36	129.03	294.70
GEHA Benefit Plan-Std (GEHA)	800/821-6136	314	315	12.37	28.12	97.63	221.88
Mail Handlers-High (MH)	800/410-7778	451	452	44.56	71.46	129.03	294.70
Mail Handlers-Std (MH)	800/410-7778	454	455	12.64	27.44	99.71	216.45
NALC	888/636-6252	321	322	28.71	42.37	129.03	294.70
PBP Health Plan-High (PBP)	800-544-7111	361	362	140.09	285.94	129.03	294.70
PBP Health Plan-Std (PBP)	800-544-7111	364	365	28.72	62.62	129.03	294.70

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

Plan	Benefit type	Medical-Surgical – You pay											
		Deductible			Copay (\$)/Coinsurance (%)								
		Per Person		Per stay Hospital inpatient	Doctors & Outpatient Tests	Hospital			Prescription drugs				
		Calendar Year	Prescription Drug			Inpatient		Outpatient other	Generic	Brand Name	Non-formulary	Home Delivery	
R&B	Other			Generic	Brand Name								
AHP	PPO Non-PPO	\$200 \$400	\$200 \$200	\$150 \$250	10% 30%	10% 30%	10% 30%	10% 30%	10%/50% 10%/50% +	15%/50% 15%/50%+	15%/50% 15%/50%+	20% 20%	25% 25%
APWU-High	PPO Non-PPO	\$275 \$350	None None	None \$200	10% 30%	10% 30%	10% 30%	10% 30%	\$7 45%	25% 45%	25% 45%	\$10 \$10	20% 20%
APWU	<b>See pages 7 and 15 of this Guide for a benefit description, and carefully read the APWU brochure for details.</b>												
BCBS-Std	PPO Non-PPO	\$250 \$250	None None	\$100 \$300	10% 25%	Nothing 30%	Nothing 30%	10% 25%	25% 45%+	25% 45%+	25% 45%+	\$10/25% 45%+	\$35/25% 45%+
BCBS-Basic	PPO	None	None	\$100/day x 5	\$20/\$30	Nothing	Nothing	\$30	\$10	\$25	\$35 or 50%	\$10 *	\$25 *
GEHA-High	PPO Non-PPO	\$350 \$350	None None	\$100 \$300	10% 25%	Nothing Nothing	10% 25%	10% 25%	\$5/50% \$5/50% +	\$20/50% \$20/50% +	\$20/\$35/50% \$20/\$35/50% +	\$10 \$10	\$40/\$55 \$40/\$55
GEHA-Std	PPO Non-PPO	\$450 \$450	None None	None None	15% 35%	15% 35%	15% 35%	15% 35%	\$5 \$5 +	50% 50% +	50% 50% +	\$15 \$15	50% 50%
MH-High	PPO Non-PPO	\$250 \$250	\$250 \$250	None \$250	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%	\$7 50%	\$23 50%	\$35 50%	\$10 \$10	\$30/\$45 \$30/\$45
MH-Std	PPO Non-PPO	\$300 \$300	\$600 \$600	\$150 \$300	10% 30%	Nothing Nothing	Nothing Nothing	10% 30%	\$8 50%	\$28 50%	\$40 50%	\$10 \$10	\$40/\$55 \$40/\$55
NALC	PPO Non-PPO	\$250 \$300	None \$25 for Retail	None \$100	15% 30%	10% 30%	10% 30%	15% 30%	25% 40%+	25% 40%+	25% 40%+	\$10 \$10	\$30 \$30
PBP-High	PPO Non-PPO	\$200 \$450	\$90 \$90	None \$150	10% 15%-25%	10% 25%	10% 25%	10% 25%	\$3 20%+	\$25 or 20% 20%+	\$40 or 20% 20%+	\$6 \$6	\$25/ \$40 or 20%
PBP-Std	PPO Non-PPO	\$250 \$500	\$90 \$90	None \$250	9% 30%	9% 30%	9% 30%	9% 30%	\$4 30%+	\$30 or 20% 30%+	\$40 or 20% 30%+	\$8 \$8	\$30/ \$40 or 20%

\* Home delivery is available from Internet pharmacies and may be available from certain retail pharmacies. The Mail Service Program is not available under Basic Option.

## Nationwide Fee-for-Service Plans Open to All

**Member Survey Results** — See page 1 for a description.

Plan name	Member Survey Results						
	Plan code	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Alliance Health Plan	1R	⊖	⊖	●	●	⊖	⊖
APWU Health Plan-High	47	●	⊖	⊖	⊖	●	●
APWU Health Plan-Consumer Driven	47						
Blue Cross and Blue Shield Service Benefit Plan-Std	10	○	⊖	○	⊖	⊖	○
Blue Cross and Blue Shield Service Benefit Plan-Basic	11						
GEHA Benefit Plan-High	31	●	⊖	○	○	●	●
GEHA Benefit Plan-Std	31	●	⊖	○	○	●	●
Mail Handlers-High	45	○	○	○	⊖	⊖	○
Mail Handlers-Std	45	○	○	○	⊖	⊖	○
NALC	32	●	●	●	●	●	●
PBP Health Plan-High	36	○	⊖	●	●	○	○
PBP Health Plan-Std	36	○	⊖	●	●	○	○

# Plan Comparisons

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

**(Pages 20 through 22)**

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

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

## 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	Telephone number	Enrollment code		Your Share		FDIC Share	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Association Benefit Plan (ABP)	800/634-0069	421	422	34.82	82.76	129.03	294.70
Foreign Service Benefit Plan (FS)	202/833-4910	401	402	19.53	66.11	129.03	294.70
Panama Canal Area Benefit Plan (PCA)	800/548-8969	431	432	16.31	34.04	128.65	268.55
Rural Carrier Benefit Plan (Rural)	800/638-8432	381	382	50.95	71.90	129.03	294.70
SAMBA	800/638-6589	441	442	53.93	136.18	129.03	294.70
Secret Service (SS)	800/424-7474	Y71	Y72	17.42	52.38	129.03	294.70

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

Plan	Benefit type	Medical-Surgical – You pay											
		Deductible			Copay (\$)/Coinsurance (%)								
		Per Person		Per stay Hospital inpatient	Doctors & Outpatient Tests	Hospital			Prescription drugs				
		Calendar Year	Prescription Drug			Inpatient		Outpatient other	Generic	Brand Name	Non-formulary	Home Delivery	
R&B	Other			Generic	Brand Name								
ABP	PPO	\$300	None	\$100	10%	Nothing	Nothing	10%	\$10	\$20	\$30/30%	\$20	\$40/
	Non-PPO	\$300	None	\$200	30%	30%	30%	\$10	\$20	\$30/30%	\$20	\$45 or 30%	
FS	PPO	\$300	None	Nothing	10%	Nothing	Nothing	10%	\$10/25%	\$20/25%	\$20/25%	\$20	\$40
	Non-PPO	\$300	None	\$200	30%	20%	20%	30%	\$10/25%	\$20/25%	\$20/25%	\$20	\$40
PCA	POS	None	\$400	\$50	Nothing	Nothing	Nothing	Nothing	50%	50%	50%	N/A	N/A
	FFS	None	\$400	\$125	50%	50%	50%	50%	50%	50%	50%	N/A	N/A
Rural	PPO	\$350	CY Applies	Nothing	10%/15%	Nothing	Nothing	15%	25%	25%	25%	\$15	\$25
	Non-PPO	\$350	CY Applies	\$200	15%/25%	15%	15%	25%	25%	25%	25%	\$15	\$25
SAMBA	PPO	\$350	None	\$200	10%	Nothing	10%	\$100/10%	\$10	\$25	\$40	\$10	\$35/\$50
	Non-PPO	\$350	None	\$300	30%	30%	30%	\$150/30%	\$10	\$25	\$40	\$10	\$35/\$50
SS	No PPO	\$200	None	\$100	20%	Nothing	Nothing	Nothing	\$10	\$20	\$20	\$20	\$40

\*The Panama Canal Area Plan provides a point-of-service product within the Republic of Panama.

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

**Member Survey Results** — See page 1 for a description.

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





Alabama												
The Oath - A Health Plan for Alabama, Inc.	\$20	\$20	\$100	\$10	\$20	* \$30	h	h	*	*		
Arizona												
Health Net of Arizona, Inc.	\$10	\$10	\$100/day x 5	\$10	\$30f	\$45	f	f	f	f		
California												
Blue Cross- HMO	\$10	\$10	None	\$5	\$10	f 50%f	f	*	*	*		
CIGNA HealthCare of California	\$15	\$25	\$250	\$7	\$15 f	\$35	f	f	f	f		
Kaiser Permanente	\$15	\$15	None	\$10	\$25	* \$25*	f	f	*	*		
PacifiCare Health Plans	\$10	\$20	None	\$10	\$20	* \$20	f	f	f	*		
Universal Care	\$10	\$10	\$100/day x 3	\$10	\$20	* \$30f	f	**	*	*		
Colorado												
PacifiCare of Colorado-High	\$10	\$20	\$100	\$10	\$20 f	\$30	*	**	*	*		
Connecticut												

District of Columbia								
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Aetna Health Inc.-Std - Washington, DC Area	800/537-9384	JN4	JN5	11.90	27.84			
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Kaiser Permanente - Washington, DC Area	301/468-6000	E31	E32	13.86	33.00			
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Florida								
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Av-Med Health Plan (South Florida) - Broward, Dade and Palm Beach	800/882-8633	ML1	ML2	14.12	50.4			
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Foundation Health - Southern Florida	800/441-5501	5E1	5E2	10.24	28.17	80.		
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Humana Medical Plan - South Florida	888/393-6765	EE1	EE2	13.37	33.43	105		
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Total Health Choice - Broward/Dade/Palm Beach Counties	305/408-5823	4A1	4A2	13.14	32.74			
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Georgia								
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Kaiser Permanente - Atlanta Area	800/611-1811	F81	F82	12.96	32.89	102		
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District of Columbia													
Aetna Health Inc.-Std	\$20	\$25	\$250/day x 3	\$10	\$25 *	\$40	*	*	*	*			
Kaiser Permanente	\$10	\$20	\$100	\$10	\$20Net	\$20	\$40Net	\$20	\$40Net	f	h	*	
Florida													
A-Med Health Plan (South Florida)	\$15	\$15	\$100	\$10	\$20*	\$30	f	*	*	*	*		
Foundation Health	\$10	\$15	\$200	\$7	\$14	f	\$34	f	f	f	f	*	
Humana Medical Plan	\$10	\$20	\$100/day x 3	\$5/\$20	\$20/\$40	\$100	f	f	*	*			
Total Health Choice	\$10	\$10	\$100	\$5	\$15	\$15							
Georgia													
Kaiser Permanente	\$10	\$10	\$10	\$46 Com	\$10	\$16	\$16	Comh	h	*	*	h	*

Guam								
PacificCare Asia Pacific-Std - Guam/N. Mariana Islands/Palau		671/647-3526	JK4	JK5	11.37	30.03		
Hawaii								
Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu/Kauai		808/432-5955	631	632	16.11	34.63		
Idaho								
Illinois								
Group Health Plan - Southern/Metro East/Central		800/755-3901	MM1	MM2	37.11	64.16		
Humana Health Plan Inc.-High -Chicago Area		888/393-6765	751	752	15.13	36.30	1	
John Deere Health Plan - Bloomington/Joliet/Moline/Peoria/Rock Island		800/247-9110	YH1	YH2	13.97	34.22		
OSF HealthPlans - Central/Central-Northwestern Illinois		800/673-5222	9F1	9F2	12.78	33.60		
Unicare HMO - Chicagoland Area		888/234-8855	171	172	13.75	55.49	108	

Guam													
PacifiCare Asia Pacific-Std		\$15	\$15	\$150	\$5	\$20	*	\$20	f	h	*	*	
Hawaii													
Kaiser Permanente-High		\$10	\$10	None	\$10	\$10	h	\$10	*	*	h	*	
Idaho													
Illinois													
Group Health Plan		\$10	\$20	\$100	\$8	\$20	*	\$35	*	h	*	*	*
Humana Health Plan Inc.-High		\$10	\$20	\$100/day x 3	\$5/\$15	\$15/\$35	*	25%	f	*	f	f	
John Deere Health Plan		\$15	\$15	\$100	\$10	\$20	h	\$35	h	h	h	h	
OSF HealthPlans		\$20	\$20	\$500	\$10	\$20	h	\$40	h	h	h	*	h
Unicare HMO		\$15	\$15	None	\$5	\$15	f	\$25	f	*	*	f	f

Indiana								
Aetna Health Inc. - Southeastern Indiana	800/537-9384	RD1	RD2	15.75	49.29	12		
Health Alliance HMO - Fountain/Vermillion/Warren Counties	800/851-3379	FX1	FX2	22.22	58.31			
Humana Health Plan Inc.-High -Lake/Porter/LaPorte Counties	888/393-6765	751	752	15.13	36.30			
M*Plan - Indiana Metropolitan Areas	317/571-5320	IN1	IN2	40.51	94.41	129.0		
Unicare HMO - Lake/Porter Counties	888/234-8855	171	172	13.75	55.49	108		
Iowa								
Coventry Health Care of Iowa - Central Iowa/Cedar Rapids/Sioux City	800/257-4692	SV1	SV2	13.12	35			
John Deere Health Plan - Central/Eastern Iowa	800/247-9110	YH1	YH2	13.97	34.22			
Kansas								
Coventry Health Care of Kansas - Kansas City - Kansas City Area	800/969-3343	HA1	HA2	12.82	33			
Humana Health Plan, Inc.-Std - Kansas City Area	888/393-6765	MS4	MS5	9.21	22.10			
Kentucky								
United Healthcare of Ohio, Inc. - Northern Kentucky	800/231-2918	3U1	3U2	48.79	114.30			

Indiana													
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	*	\$40	*	*	*	*	*
Health Alliance HMO		\$15	\$15	\$100	\$10	\$20	h	\$40	*	h	h	h	h
Humana Health Plan Inc.-High		\$10	\$20	\$100/day x 3	\$5/\$15	\$15/\$35	*	25%	f	*	f	f	
M*Plan		\$10	\$15	\$250	\$5/\$10	\$15	\$50	*	h	h	*	*	
Unicare HMO		\$15	\$15	None	\$5	\$15	\$25						
Iowa													
Coventry Health Care of Iowa		\$10	\$10	None	\$5	\$15	f	\$80	h	*		3	*
John Deere Health Plan		\$15	\$15	\$100	\$10	\$20	h	\$35	h	h	h	h	
Kansas													
Coventry Health Care of Kansas - Kansas City		\$15	\$15	\$100/day x 3	\$10	f	\$20*	\$50	*	f	f		
Humana Health Plan, Inc.-Std		\$15	\$25	\$250/day x 3	\$10/\$25	\$25/\$45	*	25%*	f	f	f		
Kentucky													
United Healthcare of Ohio, Inc.		\$15	\$15	\$250	\$10	\$15	*	\$80	h	*	*	*	

Louisiana								
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Coventry Healthcare Louisiana - Baton Rouge Area		800/341-6613	JA1	JA2	15.40	35.77
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Vantage Health Plan - Shreveport/Alexandria Areas		888/823-1910	MV1	MV2	33.32	140.89
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Maryland							
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Aetna Health Inc.-Std - North/Central/Southern Maryland		800/537-9384	JN4	JN5	11.90	27.84
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Kaiser Permanente - Baltimore/Washington, DC Areas		301/468-6000	E31	E32	13.86	33.00
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Massachusetts							
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ConnectiCare - Counties Hampden, Hampshire, Franklin		800/251-7722	TE1	TE2	15.15	57.97
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Louisiana												
Coventry Healthcare Louisiana		\$15	\$15	\$100/day x 3	\$10	\$20	f \$45	f	*	f	f	
Vantage Health Plan		\$15	\$15	\$250	\$10	\$20	\$35					
Maryland												
Aetna Health Inc.-Std		\$20	\$25	\$250/day x 3	\$10	\$25 *	\$40	*	*	*	*	
Kaiser Permanente		\$10	\$20	\$100	\$10	\$20Net	\$20 \$40Net	\$20 \$40Net		f	h	*
Massachusetts												
ConnectiCare		\$10	\$10	None	\$10	\$20	\$35					

Michigan								
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Bluecare Network of MI - Midland County Area		800/662-6667	K51	K52	14.88	75.13		
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Bluecare Network of MI - Genesee County Area		800/662-6667	KN1	KN2	15.92	100.77		
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Bluecare Network of MI - Mid Michigan		800/662-6667	LN1	LN2	48.66	133.16	129	
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Grand Valley Health Plan - Grand Rapids Area		616/949-2410	RL1	RL2	15.14	83.28		
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HealthPlus MI - Flint/Saginaw Areas		800/332-9161	X51	X52	21.04	73.21	129	
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OmniCare - Southeastern Michigan		800/477-6664	KA1	KA2	13.52	33.25	106	
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Total Health Care - Greater Detroit/Flint Areas		800/826-2862	N21	N22	13.33	33.91	1	
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Minnesota								
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HealthPartners Classic - Minneapolis/St. Paul/St. Cloud Areas		952/883-5000	531	532	34.10	96.81		
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<b>Michigan</b>													
Bluecare Network of MI		\$15	\$15	\$250	\$10	\$20	*	\$20	h	*	*	*	
Bluecare Network of MI		\$15	\$15	\$250	\$10	\$20	*	\$20	h	*	*	*	
Bluecare Network of MI		\$15	\$15	\$250	\$10	\$20	*	\$20	h		*	*	*
Grand Valley Health Plan		\$10	\$10	None	\$5	\$5	h	\$5	*	h	*	h	*
HealthPlus MI		\$10	\$10	None	\$5	\$10	f	\$10	h	h	h	h	h
OmniCare		\$10	\$10	None	\$2	\$2	\$2	f	f		*	*	f
Total Health Care		\$10	Nothing	None	Nothing	Nothing	f	Nothing	f	f	f		*
<b>Minnesota</b>													
HealthPartners Classic		\$15	\$15	\$100	\$12	\$12	*	\$24	*	*	*	*	

Missouri

Coventry Health Care of Kansas - Kansas City - Kansas City Area	800-969-3343	HA1	HA2	12.82	33.00
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Humana Health Plan, Inc.-High -Kansas City Area	888/393-6765	MS1	MS2	15.84	43.12
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Mercy Health Plans/Premier Health Plans - East/Central;Southwest Missouri	800/327-0763; 800/836-0402	7M1	7M2	140.70	337.29	64.94	155.67
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Montana

Nevada

PacifiCare Health Plans - Clark County	800/531-3341	K91	K92	14.01	39.54	110.00
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New Jersey

AmeriHealth HMO - All of New Jersey	800/454-7651	FK1	FK2	18.24	56.30	120.00
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New Mexico

Lovelace Health Plan - All of New Mexico	800/244-6224	Q11	Q12	15.06	53.23	110.00	NCQA 2 JCAHO 11
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Missouri													
Coventry Health Care of Kansas - Kansas City		\$15	\$15	\$100/day x 3	\$10	f	\$20*	\$50	*	f	f		
Humana Health Plan, Inc.-High		\$10	\$20	\$100/day x 3	\$5/\$20	\$20/\$40	* 25% *			f	f	f	
Mercy Health Plans/Premier - In-Network - Out-of-Network	\$10 30%	\$20 30%	None 30%	\$10 N/A	\$20 N/A	\$35 N/A	* N/A	*	*	*	h	h	
Montana													
Nevada													
PacifiCare Health Plans		\$10	\$20	None	\$10	\$20	f	\$20	f	f	f	*	
New Jersey													
AmeriHealth HMO		\$30	\$35	\$200/day x 3	\$20	\$40	f	50%	*	*	*	f	
New Mexico													
Lovelace Health Plan		\$15	\$25	\$250	\$7	\$15	*	\$35*	*	*	*	*	

New York								
Blue Choice - Rochester Area	800/462-0108	MK1	MK2	15.21	44.02	120		
Capital District Physicians Health Plan - Hudson Valley Area	518/641-3700	QB1	QB2	14.88	45.23			
GHI Health Plan - All of New York	212/501-4444	801	802	39.62	126.90	129		
GHI HMO Select - Capital/Hudson Valley Regions	877/244-4466	X41	X42	15.76	38.97			
HIP of Greater New York-Std - New York City Area	800/HIP-TALK	514	515	12.09	33.86			
HMO-CNY - Syracuse/Binghamton/Elmira Areas	800/828-2887	EB1	EB2	29.64	125.75			
MVP Health Care - Eastern Region	888/687-6277	GA1	GA2	13.36	34.52	10		
MVP Health Care - Mid-Hudson Region	888/687-6277	MX1	MX2	15.38	58.29	12		
Univera Healthcare - Western New York (Southern Counties)	716/847-0881	KQ1	KQ2	14.84	55.10			
Vytra Health Plans - Queens/Nassau/Suffolk Counties	800/406-0806	J61	J62	15.70	71.16			

New York													
Blue Choice		\$10	\$10	None	\$5	\$15	\$30	h	h	h	*	h	
Capital District Physicians Health Plan		\$10	\$10	\$100	\$5	\$20	\$20	h	h	h	h		
GHI Health Plan	- In-Network	\$15	\$15	None	\$10	\$20	\$50	h	*	*	*	*	
	- Out-of-Network	50% of sch.	50% of sch.	None	N/A	N/A	N/A	N/A					
GHI HMO Select		\$10	\$10	None	\$10	\$20	f \$30	f	f	f	f	f	
HIP of Greater New York-Std		\$10	\$20	\$500	\$10	\$20	\$40	f	*	*	f		
HMO-CNY		\$10	\$10	None	\$5	\$20	\$35	h	h	*	f	*	
MVP Health Care		\$15	\$15	\$240	\$5	\$20	h \$40	h	h	h	h	h	
MVP Health Care		\$15	\$15	\$240	\$5	\$20	h \$40	h	h	h	h	h	
Univera Healthcare		\$15	\$15	\$250	\$5	\$15	\$35						
Vetra Health Plans		\$10	\$10	None	\$5	\$10	h \$10	h	*	*	h	*	

North Dakota								
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Ohio								
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Aetna Health Inc. - Greater Cincinnati Area	800/537-9384	RD1	RD2	15.75	49.29	1
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Blue HMO - Most of Ohio	800/228-4375	R51	R52	20.07	75.63	129.03
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Health Plan of the Upper Ohio Valley-Std - Eastern Ohio	800/624-6961	U44	U45	15.62	87.06
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Kaiser Permanente - Cleveland/Akron Areas	800/686-7100	641	642	15.41	41.48	1
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SummaCare Health Plan - Cleveland, Akron Areas	330/996-8700	5W1	5W2	14.92	69.96
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United Healthcare of Ohio, Inc. - Cincinnati/Dayton/Springfield Areas	800/231-2918	3U1	3U2	48.79	114.3
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Oklahoma								
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Oregon								
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Kaiser Permanente-Std - Portland/Salem Areas	800/813-2000	574	575	15.42	35.39
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North Dakota													
Ohio													
Aetna Health Inc.	\$20	\$25	\$250/day x 3	\$10	\$25	*	\$40	*	*	*	*	*	*
Blue HMO	\$10	\$10	None	\$10	\$20	\$30	*	h	*	*	*	*	*
Health Plan of the Upper Ohio Valley-Std	\$10	\$20	None	\$15	\$80	h	\$50	h	h	h	h	h	h
Kaiser Permanente	\$10	\$10	None	\$5	\$15	h	\$15	h	*	*	h	*	*
SummaCare Health Plan	\$10	\$10	None	\$8	\$15	h	\$30	h	h	h	h	h	f
United Healthcare of Ohio, Inc.	\$15	\$15	\$250	\$10	\$15	*	\$80	h	*	*	*	*	*
Oklahoma													
Oregon													
Kaiser Permanente-Std	\$15	\$15	None	\$15	\$30	*	\$30	f	f	h	*	*	*

Pennsylvania								
Health Net of Pennsylvania - Scranton/Wilkes Barre Areas		877/747-9585	2K1	2K2	17.46	64.80		
HealthAmerica Pennsylvania - Central Pennsylvania		800/788-8445	SW1	SW2	15.95	74.05		
Keystone Health Plan Central - Harrisburg/Northern Region/Lehigh Valley		800/622-2843	S41	S42	27.18	83.00		
UPMC Health Plan - Western Pennsylvania Area		888/876-2756	8W1	8W2	15.63	59.59		
Puerto Rico								
Triple-S - All of Puerto Rico		787/749-4777	891	892	10.77	23.12	84.93	
Rhode Island								
South Dakota								
Sioux Valley Health Plan - Eastern/Central/Rapid City Areas		800/752-5863	AU1	AU2	38.06		NCOA 87.94 JCAHC	

Pennsylvania												
Health Net of Pennsylvania		\$10	\$10	None	\$10	\$20	f	\$35	h	h	f	f
HealthAmerica Pennsylvania		\$10	\$15	None	\$8	\$14	h	\$35	h	h	*	h
Keystone Health Plan Central		\$10	\$10	None	\$10	\$25	h	\$40	h	h	h	h
UPMC Health Plan		\$10	\$10	None	\$5	\$15	*	\$35	h	*	*	*
Puerto Rico												
Tripe-S	- In-Network	\$7.50	\$10	None	\$2	\$5/\$10	\$10 or 20%		f	h	*	*
	- Out-of-Network	\$7.50 + 10%	\$10 + 10%	None		25%	25%	25%				
Rhode Island												
South Dakota												
Sioux Valley Health Plan	- In-Network	\$20	\$20	\$100	\$10	\$20		\$35	h	h	h	*
	- Out-of-Network	40%	40%	40%	N/A	N/A		N/A				*

Tennessee								
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Aetna Health Inc. - Memphis Area	800/537-9384	UB1	UB2	14.49	49.86	114		
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HealthSpring-Std - Nashville/Middle Tennessee Area	615/291-5030	6K4	6K5	13.93	50.26			
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Texas								
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Amcare Health Plans - Austin/San Antonio/Dallas/Ft Worth Areas	800/782-8373	ZG1	ZG2	13.34	34.6			
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FIRSTCARE - West Texas	800/884-4901	CK1	CK2	47.48	84.43	129		
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Humana Health Plan of Texas-High -San Antonio Area	888/393-6765	UR1	UR2	15.05	49.16			
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Mercy Health Plans/Premier Health Plans - Webb/Zapata/Duval/Jim Hogg Counties	800/617-3433	HM1	HM2	45.08				
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Utah								
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Tennessee													
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	f	\$40	*	*	*		f
HealthSpring-Std		\$20	\$20	\$250	\$10	\$20		50%					
Texas													
Amcare Health Plans		\$10	\$10	None	\$5	\$15	f	50%	f	*	f		f
FIRSTCARE		\$15	\$25	\$100	\$10	\$20	*	\$40 h	*		h	h	h
Humana Health Plan of Texas-High		\$10	\$20	\$100/day x 3	\$5/\$20	\$20/\$40	f	25%	f	*			*
Mercy Health Plans/Premier	- In-Network	\$10	\$10	None	\$7	\$12	\$25	*		f	h	*	*
	- Out-of-Network	40%	40%	40%	N/A	N/A	N/A						
Utah													

Vermont								
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Virginia								
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Aetna Health Inc.-Std - N.VA/Fredericksburg Areas		800/537-9384	JN4	JN5	11.90	27.84		
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Kaiser Permanente - Washington, DC Area		301/468-6000	E31	E32	13.86	33.00		
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Optima Health Plan - Peninsula/Southside Hampton Roads		800/206-1060	9R1	9R2	32.87	88.38		
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Washington								
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Group Health Cooperative - Most of Western Washington		888/901-4636	541	542	24.46	51.82		
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Kaiser Permanente-High -Vancouver/Longview		800/813-2000	571	572	24.27	57.11		
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KPS Health Plans-High -Most of Western Washington		800/552-7114	VT1	VT2	93.61	181.53		
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PacifiCare Health Plans - Clark County		800/531-3341	7Z1	7Z2	33.05	64.40	12	
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Health Plan of the Upper Ohio Valley-High -Northern/Central West Virginia		800/624-6961	U41	U42	20.36	116		
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Vermont													
Virginia													
Aetna Health Inc.-Std	\$20	\$25	\$250/day x 3	\$10	\$25 *	\$40	*	*	*	*			
Kaiser Permanente	\$10	\$20	\$100	\$10	\$20Net	\$20 \$40Net	\$20 \$40Net	f	h	*			
Optima Health Plan	\$10	\$20	\$250	\$10	\$20	* \$40	h	*	*	h	h		
Washington													
Group Health Cooperative	\$15	\$15	\$200/day x 3	\$15	\$25*	\$50	h	*	h	h			
Kaiser Permanente-High	\$10	\$10	None	\$10	\$20 *	\$20	f	f	h	*			
KPS Health Plans-High	\$10	\$10	\$100/day x 10	\$5	50%h	50%	h	h	h	h			
PacifiCare Health Plans	\$10	\$20	None	\$10	\$20 *	\$20	*	*	*	*			
Health Plan of the Upper Ohio Valley-High	\$10	\$10	None	\$10	\$20	h\$35	h	h	h	h			



**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 URAC (U). See pages 2 and 6 for details. A lower number means a better accreditation.

Plan name	Primary care doctor office copay	Specialist 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
<b>West Virginia</b>												
Health Plan of the Upper Ohio Valley-Std	\$10	\$20	None	\$15	\$30	\$50	●	●	●	●	●	●
<b>Wisconsin</b>												
Dean Health Plan	\$10	\$10	None	\$10	30% to 1500	N/A	●	●	●	◐	●	●
Group Health Cooperative	\$20	\$20	None	\$6	\$12	\$12	●	●	●	◐	●	●
Group Health Cooperative/Eau Claire	\$10	\$10	None	\$10	\$20	\$20	●	●	●	●	●	●
HealthPartners Classic	\$15	\$15	\$100	\$12	\$12	\$24	◐	◐	◐	◐	◐	◐
HealthPartners Primary	\$20	\$20	\$200	\$12	\$12	\$24	◐	◐	◐	◐	◐	◐
<b>Wyoming</b>												
WINhealth Partners	\$10	\$10	None	\$10	\$15	\$40						

