



Guide to Federal Employees Health Benefits Plans

For Federal Retirees and
Their Survivors





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,

A handwritten signature in blue ink that reads "Kay C. James". The signature is fluid and cursive, with a large "K" and "J".

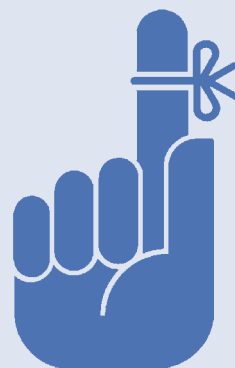
Kay Coles James
Director

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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.

Changing Enrollment During Open Season

Each year, in early November, your current health benefits plan sends you a brochure, and your retirement office sends you instructions for ordering brochures and making Open Season changes. It is very important that you keep your address up to date to ensure that you receive your Open Season materials each year. If you move, please be sure to let your retirement office know your new address by calling the number listed on the back cover of this Guide.

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

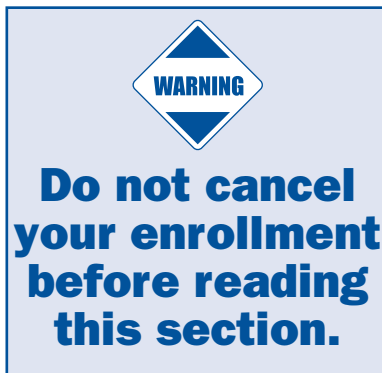
If you decide not to change your enrollment, no action is necessary.

You may voluntarily cancel your enrollment at any time. However, once your cancellation takes effect, you probably will not be able to enroll again as a retiree. You will not be entitled to a 31-day extension of coverage for conversion to a non-group (private) policy and neither you nor your family members will be entitled to temporarily continue coverage.

You will not be able to reenroll in FEHB except under the following circumstances:

- You have been continuously covered as a family member under another enrollment in FEHB since the date of your cancellation, and you lose the coverage because the enrollment ends or the enrollee changes from self and family to self only; or
- You suspended your FEHB coverage to enroll in a Medicare-sponsored health plan (these are Health Maintenance Organization or Fee-for-Service plans approved by the Center for Medicare and Medicaid Services), or because you are eligible under Medicaid or a similar state-sponsored program of medical assistance for the needy, or because you are enrolled with TRICARE, TRICARE For Life or CHAMPVA military program.

For more information on how to suspend your FEHB enrollment, contact your retirement office at the number listed on the back cover of this Guide.



Time limitations and other restrictions apply. For instance, you must submit eligibility documentation that you are suspending FEHB to enroll in one of the other programs listed in case you wish to reenroll in the FEHB Program at a later time.

If you have suspended FEHB coverage for one of the eligible programs (and submitted the required documentation) but now want to enroll in the FEHB Program again, you may enroll during Open Season. You may reenroll outside Open Season only if you move out of the Medicare-sponsored health plan's service area, or you involuntarily lose coverage under one of the eligible programs. If you cancel your coverage for any reason, you cannot reenroll.

If the Original Medicare Plan is your primary payer, which is generally the case if you have Medicare and are not working, check the plan brochure to see if the plan waives some of its FEHB cost-sharing for you. This information is located in each plan brochure in Section 9, "Coordinating benefits with other coverage".

If you are interested in an HMO plan, some FEHB HMO's also offer Medicare managed care plans. If you enroll in both the FEHB HMO and its Medicare managed care plan, your FEHB cost-sharing may be reduced. This information is also located in Section 9 of the brochure for plans with Medicare managed care options.

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?

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):

- 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.

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: APWUs 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 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 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 retirement system for more information.

If the Original Medicare Plan is your primary payer, which is generally the case if you have Medicare and are not working, check the plan brochure to see if the plan waives some of its FEHB cost-sharing for you. This information is located in each plan brochure in Section 9, "Coordinating benefits with other coverage".

If you are interested in an HMO plan, some FEHB HMO's also offer Medicare managed care plans. If you enroll in both the FEHB HMO and its Medicare managed care plan, your FEHB cost-sharing may be reduced. This information is also located in Section 9 of the brochure for plans with Medicare managed care options.



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 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 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.

Plan Comparisons

Nationwide Fee-for-Service Plans Open to All

(Pages 14 through 16)

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

Fee-for-Service (FFS) Plans (non-PPO) — A traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse you after you have 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 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	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Alliance Health Plan (AHP)	202/939-6325	1R1	1R2	130.48	242.06	157.06	294.19
APWU Health Plan-High (APWU)	800/222-2798	471	472	105.82	213.50	112.84	226.49
APWU Health Plan-Consumer Driven (APWU)	800/222-2798	474	475	0.00	0.00	78.87	186.99
Blue Cross and Blue Shield Service Benefit Plan-Std (BCBS)	Local phone #	104	105	89.09	205.46	98.93	227.98
Blue Cross and Blue Shield Service Benefit Plan-Basic (BCBS)	Local phone #	112	111	68.50	164.10	75.82	178.26
GEHA Benefit Plan-High (GEHA)	800/821-6136	311	312	129.35	258.91	145.53	291.29
GEHA Benefit Plan-Std (GEHA)	800/821-6136	314	315	59.58	135.42	59.58	135.42
Mail Handlers-High (MH)	800/410-7778	451	452	119.34	214.93	139.29	252.51
Mail Handlers-Std (MH)	800/410-7778	454	455	55.58	120.64	60.86	132.11
NALC	888/636-6252	321	322	99.39	181.39	104.95	189.48
PBP Health Plan-High (PBP)	800-544-7111	361	362	354.08	737.36	346.27	717.21
PBP Health Plan-Std (PBP)	800-544-7111	364	365	110.39	213.41	104.97	233.35

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.**

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	See pages 8 and 13 of this Guide for a benefit description, and carefully read the APWU brochure for details.												
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%

Nationwide Fee-for-Service Plans Open to All

Member Survey Results — See page 2 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 18 through 20)

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

Fee-for-Service (FFS) Plans (non-PPO) — A traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse you after you have 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		Premium You Paid in 2002		Premium You Will Pay in 2003	
		Self only	Self & family	Self only	Self & family	Self only	Self & family
Association Benefit Plan (ABP)	800/634-0069	421	422	102.42	240.32	118.19	276.99
Foreign Service Benefit Plan (FS)	202/833-4910	401	402	81.12	227.91	85.06	240.92
Panama Canal Area Benefit Plan (PCA)	800/548-8969	431	432	81.49	159.13	78.52	163.90
Rural Carrier Benefit Plan (Rural)	800/638-8432	381	382	130.35	213.30	153.14	253.46
SAMBA	800/638-6589	441	442	145.10	356.98	159.59	392.73
Secret Service (SS)	800/424-7474	Y71	Y72	66.81	158.34	80.49	211.17

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.

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%	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

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

Member Survey Results — See page 2 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	○	●	○	◐	○	○

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.

Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialist.

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Alabama								
PrimeHealth of Alabama, Inc. - Southern Alabama and the Montgomery Area		800/236-9421		AA1	AA2	68.38	248.00	
The Oath - A Health Plan for Alabama, Inc. - Birmingham/Other Areas		800/947-5093		DF1	DF2	74.21	248.00	
Arizona								
Aetna Health Inc. - Phoenix/Tucson Areas		800/537-9384		WQ1	WQ2	55.91	157.35	
Health Net of Arizona, Inc. - Maricopa/Pima/Other AZ counties		800/289-2818		A71	A72	62.98	195.75	
PacifiCare Health Plans - Maricopa/Pima/parts of Apache Junction		800/531-3341		A31	A32	62.83	220.20	
California								
Aetna Health Inc. - Southern California Area		800/537-9384		2X1	2X2	51.99	121.45	5
Blue Cross- HMO - Most of California		800/235-8631		M51	M52	57.02	145.48	72
Blue Shield of CA Access+ - Most of California		800/880-8086		SJ1	SJ2	60.70	150.59	
CIGNA HealthCare of California - Northern/Southern California		800/244-6224		9T1	9T2	63.18	139.00	
Health Net - Most of California		800/522-0088		LB1	LB2	62.31	147.51	68.1
Kaiser Permanente - Northern California		800/464-4000		591	592	57.58	137.46	74
Kaiser Permanente - Southern California		800/464-4000		621	622	60.65	140.17	70
PacifiCare Health Plans - Most of California		800/531-3341		CY1	CY2	50.58	131.89	
UHP Healthcare - LA/Orange/San Bernardino Counties		800/544-0088		C41	C42	43.19	92.03	
Universal Care - Southern California		800/257-3087		6Q1	6Q2	45.50	120.16	56
Colorado								
Kaiser Permanente - Denver/Colorado Springs Areas		800/632-9700		651	652	63.21	161.17	
PacifiCare of Colorado-High -Denver/Colorado Springs/Ft.Collins		800/877-9777		D61	D62	70.45	253.00	
PacifiCare of Colorado-Std - Denver/Colorado Springs/Ft.Collins		800/877-9777		D64	D65	41.87	108.40	

Prescription drugs \bar{N} Generic, Brand Name, and Non-formulary shows Member Survey Results \bar{N} See page 2 for a description. what you pay for prescriptions when you use a plan pharmacy. Non-formulary Accredited \bar{N} The National Committee for Quality Assurance (N); refers to prescriptions that are not on the plan's preferred list. Some plans charge the Joint Commission on Accreditation of Healthcare Organizations (J); different amounts for some drugs and for mail orders. In many plans, if you get and/or URAC (U). See pages 3 and 6 for details. A lower number means a the brand name instead of the generic drug, you also pay the difference between better accreditation. the two.

Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results h above average, * average, f below average					
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Alabama												
PrimeHealth of Alabama, Inc.		\$15	\$25	\$150/day x 4	\$10	\$20	\$40	h	h	*	*	
The Oath - A Health Plan for Alabama, Inc.		\$20	\$20	\$100	\$10	\$20	* \$30	h	h	*	*	
Arizona												
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	* \$40	f	f	f	*	
Health Net of Arizona, Inc.		\$10	\$10	\$100/day x 5	\$10	\$30	f \$45	f	f	f	f	
PacifiCare Health Plans		\$10	\$20	None	\$10	\$20	f \$20	f	*	*	*	
California												
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	f \$40	f	f	f	f	
Blue Cross- HMO		\$10	\$10	None	\$5	\$10	f 50% f	f	*	*	*	
Blue Shield of CA Access+		\$10	\$10	None	\$5	\$10	* \$25	f	*	*	*	
CIGNA HealthCare of California		\$15	\$25	\$250	\$7	\$15	f \$35	f	f	f	f	
Health Net		\$10	\$10	\$100	\$10	\$20	f \$35	f	f	f	f	
Kaiser Permanente		\$15	\$15	None	\$10	\$25	* \$25*	f	f	*	*	
Kaiser Permanente		\$10	\$10	None	\$10	\$25	* \$25*	f	f	h	*	
PacifiCare Health Plans		\$10	\$20	None	\$10	\$20	* \$20	f	f	f	*	
UHP Healthcare		\$10	\$10	None	\$10	\$20	\$20					
Universal Care		\$10	\$10	\$100/day x 3	\$10	\$20	* \$30	f	*	*	*	
Colorado												
Kaiser Permanente		\$10	\$20	\$100	\$10	\$20	* \$20*	f	f	*	*	
PacifiCare of Colorado-High		\$10	\$20	\$100	\$10	\$20	f \$30	*	*	*	*	
PacifiCare of Colorado-Std		\$15	\$30	\$300	\$10	\$30	f \$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.

Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Connecticut								
ConnectiCare - All of Connecticut	800/251-7722		TE1	TE2	60.74	159.09	72.	
District of Columbia								
Aetna Health Inc.-High -Washington, DC Area	800/537-9384		JN1	JN2	73.39	176.10		
Aetna Health Inc.-Std - Washington, DC Area	800/537-9384		JN4	JN5	51.94	121.54		
CareFirst BlueChoice - Washington, D.C. Metro Area	866/520-6099		2G1	2G2	69.10	155.45		
Kaiser Permanente - Washington, DC Area	301/468-6000		E31	E32	57.98	143.23		
MD-IPA - Washington, DC Area	800/251-0956		JP1	JP2	65.30	156.74	75.	
Florida								
A-Med Health Plan (North Florida) - Tampa	800/882-8633		EM1	EM2	66.56	248.10	7.	
A-Med Health Plan (South Florida) - Broward, Dade and Palm Beach	800/882-8633		ML1	ML2	0.00	0.00		
Capital Health Plan - Tallahassee Area	850/383-3311		EA1	EA2	61.67	174.52	7.	
Foundation Health - Southern Florida	800/441-5501		5E1	5E2	43.36	119.26	49.	
Healthplan Southeast - North Florida	850/668-3000		RK1	RK2	0.00	0.00	70.	
Humana Medical Plan - South Florida	888/393-6765		EE1	EE2	57.69	144.22	64.	
JMH Health Plan - Broward-Dade counties	800/721-2993		J81	J82	0.00	0.00	5.	
Total Health Choice - Broward/Dade/Palm Beach Counties	305/408-5823		4A1	4A2	51.05	127.11		
Vsta Healthplan - South Florida	866/847-8235		3N1	3N2	58.80	172.18	74.6.	
Georgia								
Aetna Health Inc. - Atlanta and Athens Areas	800/537-9384		2U1	2U2	60.62	159.22		
Kaiser Permanente - Atlanta Area	800/611-1811		F81	F82	57.24	145.32	62.	

Prescription drugs \bar{N} 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 \bar{N} See page 2 for a description. Accredited \bar{N} The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See pages 3 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 h above average, * average, f below average								
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing			
Connecticut															
ConnectiCare	\$10	\$10	None	\$10	\$20	h	35	h	h	*	h	h			
District of Columbia															
Aetna Health Inc.-High	\$15	\$20	\$150/day x 3	\$10	\$25	*	\$40	*	*	*	*	*			
Aetna Health Inc.-Std	\$20	\$25	\$250/day x 3	\$10	\$25	*	\$40	*	*	*	*	*			
CareFirst BlueChoice	\$20	\$30	None	\$10	\$20	*	\$35	f	f	f	f	f			
Kaiser Permanente	\$10	\$20	\$100	\$10	\$20	Net	\$20	\$40	Net	\$20	\$40	Net	f	h	*
MD-IPA	\$10	\$20	None	\$8	\$17	\$33	h	*	*	h	*	*			
Florida															
A-Med Health Plan (North Florida)	\$20	\$30	\$100/day x 5	\$15	\$30	f	\$50	f	*	*	*	*			
A-Med Health Plan (South Florida)	\$15	\$15	\$100	\$10	\$20	*	\$30	f	*	*	*	*			
Capital Health Plan	\$10	\$10	\$100	\$7	\$20	h	35	h	*	*	h	h			
Foundation Health	\$10	\$15	\$200	\$7	\$14	f	34	f	f	f	f	*			
Healthplan Southeast	\$10	\$10	Nothing	\$7	\$20	\$35									
Humana Medical Plan	\$10	\$20	\$100/day x 3	\$5	\$20	\$20/\$40	\$100	f	f	*	*	*			
JMH HEALTH PLAN	\$10	\$10	None	\$5	50%	50%									
Total Health Choice	\$10	\$10	\$100	\$5	\$15	\$15									
Vista Healthplan	\$10	\$20	\$250	\$10	\$20	f	40	*	f	*	*	*			
Georgia															
Aetna Health Inc.	\$20	\$25	\$250/day x 3	\$10	\$25	*	\$40	f	*	*	*	*			
Kaiser Permanente	\$10	\$10	\$100	\$10	\$10	Com	\$10	\$10	Com	h	*	*	h	*	

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.

Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Guam								
PacifiCare Asia Pacific-High -Guam/N. Mariana Islands/Palau		671/647-3526		JK1	JK2	79.65	282.27	
PacifiCare Asia Pacific-Std - Guam/N. Mariana Islands/Palau		671/647-3526		JK4	JK5	59.79	157.90	
Hawaii								
HMSA - All of Hawaii	808/948-6499		871	872	58.27	129.70	65.25	
Kaiser Permanente-High -Islands of Hawaii/Maui/Oahu/Kauai		808/432-5955		631	632	66.20	142.32	
Kaiser Permanente-Std - Islands of Hawaii/Maui/Oahu/Kauai		808/432-5955		634	635	50.53	108.63	
Idaho								
Group Health Cooperative - Kootenai and Latah		888/901-4636		VR1	VR2	64.60	180.28	
Illinois								
BlueCHOICE - Madison and St. Clair counties		800/634-4395		9G1	9G2	66.45	143.85	
Group Health Plan - Southern/Metro East/Central		800/755-3901		MM1	MM2	111.06	213.80	
Health Alliance HMO - Central/E.Central/N.West/South/West IL		800/851-3379		FX1	FX2	87.51	215.0	
Humana Health Plan Inc.-High -Chicago Area		888/393-6765		751	752	59.07	141.68	7
Humana Health Plan Inc.-Std - Chicago Area		888/393-6765		754	755	0.00	0.00	5
John Deere Health Plan - Bloomington/Joliet/Moline/Peoria/Rock Island		800/247-9110		YH1	YH2	68.69	223.9	
Mercy Health Plans/Premier Health Plans - Southwest Illinois		800/327-0763		7M1	7M2	78.48	191.62	
OSF HealthPlans - Central/Central-Northwestern Illinois		800/673-5222		9F1	9F2	61.54	163.34	
PersonalCare's HMO - Central Illinois		800/431-1211		GE1	GE2	48.96	125.90	6
Unicare HMO - Chicagoland Area		888/234-8855		171	172	45.53	141.95	66.
Union Health Service - Chicago Area		312/829-4224		761	762	52.58	130.42	58

Prescription drugs Ñ 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 Ñ See page 2 for a description. Accredited Ñ The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See pages 3 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 h above average, * average, f below average					
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Guam												
PacifiCare Asia Pacific-High		\$10	\$10	None	\$5	\$20	*	\$20	f	h	*	*
PacifiCare Asia Pacific-Std		\$15	\$15	\$150	\$5	\$20	*	\$20	f	h	*	*
Hawaii												
HMSA	- In-Network - Out-of-Network	20% 30%	20% 30%	None 30%	\$5 \$5+20%	\$15 +\$15+20%	\$15 +\$15	or 50% or 50%+	h	h	h	h
Kaiser Permanente-High		\$10	\$10	None	\$10	\$10	h	\$10	*	*	h	*
Kaiser Permanente-Std		\$15	\$15	None	\$10	\$10	h	\$10	*	*	h	*
Idaho												
Group Health Cooperative		\$15	\$15	\$200/day x 3	\$15	\$25	*	\$50	h	*	h	h
Illinois												
BlueCHOICE		\$10	\$10	None	\$7	\$12	\$25					
Group Health Plan		\$10	\$20	\$100	\$8	\$20	*	\$35	*	h	*	*
Health Alliance HMO		\$15	\$15	\$100	\$10	\$20	h	\$40	*	h	h	h
Humana Health Plan Inc.-High		\$10	\$20	\$100/day x 3	\$5/\$15	\$15/\$35	*	25%	f	*	f	f
Humana Health Plan Inc.-Std		\$15	\$25	\$250/day x 3	\$10/\$25	\$25/\$45	*	25%	f	*	f	f
John Deere Health Plan		\$15	\$15	\$100	\$10	\$20	h	\$35	h	h	h	h
Mercy Health Plans/ Premier Health Plans	- In-Network Out-of-Network	\$10 30%	\$20 30%	None 30%	\$10 N/A	\$20 N/A	h N/A	\$35 N/A	h	h	h	h
OSF HealthPlans		\$20	\$20	\$500	\$10	\$20	h	\$40	h	h	*	h
PersonalCare's HMO		\$20	\$20	\$100/day X 5	\$10	\$20	h	\$50	h	*	h	*
Unicare HMO		\$15	\$15	None	\$5	\$15	f	\$25	f	*	*	f
Union Health Service		\$10	\$10	None	\$15	\$15	N/A					

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

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

Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialist.

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Indiana								
Advantage Health Plan, Inc. - Most of Indiana	800/553-8933			6Y1	6Y2	66.39	155.89	
Aetna Health Inc. - Southeastern Indiana	800/537-9384			RD1	RD2	94.38	290.94	7
Arnett HMO - Lafayette Area	765/448-7440			G21	G22	67.84	221.56	75.0
Health Alliance HMO - Fountain/Vermillion/Warren Counties	800/851-3379			FX1	FX2	87.51	215.08	
Humana Health Plan - Southern Indiana	888/393-6765			D21	D22	67.61	192.11	81
Humana Health Plan Inc.-High -Lake/Porter/LaPorte Counties	888/393-6765			751	752	59.07	141.68	
Humana Health Plan Inc.-Std - Lake/Porter/LaPorte Counties	888/393-6765			754	755	0.00	0.00	
M*Plan - Indiana Metropolitan Areas	317/571-5320			IN1	IN2	90.26	209.62	130.0
Physicians Health Plan of Northern Indiana - Northeast Indiana	260/432-6690			DQ1	DQ2	66.27	148.91	
Unicare HMO - Lake/Porter Counties	888/234-8855			171	172	45.53	141.95	66
Iowa								
Avera Health Plans - Northwestern Iowa	888/322-2115			AV1	AV2	56.98	130.78	6
Coventry Health Care of Iowa - Central Iowa/Cedar Rapids/Sioux City	800/257-4692			SV1	SV2	63.18	198.00	
Health Alliance HMO - Central and Eastern Iowa	800/851-3379			FX1	FX2	87.51	215.08	
John Deere Health Plan - Central/Eastern Iowa	800/247-9110			YH1	YH2	68.69	223.92	
Kansas								
Coventry Health Care of Kansas - Wichita/Salina Areas	800/664-9251			7W1	7W2	65.65	185.64	
Coventry Health Care of Kansas - Kansas City - Kansas City Area	800/969-3343			HA1	HA2	47.42	122.00	
Humana Health Plan, Inc.-High -Kansas City Area	888/393-6765			MS1	MS2	61.58	147.74	
Humana Health Plan, Inc.-Std - Kansas City Area	888/393-6765			MS4	MS5	46.93	112.58	
Preferred Plus of Kansas - S. Central Area	800/660-8114			VA1	VA2	86.99	311.30	
Kentucky								
Humana Health Plan - Louisville Area	888/393-6765			D21	D22	67.61	192.11	81
United Healthcare of Ohio, Inc. - Northern Kentucky	800/231-2918			3U1	3U2	110.28	257.27	

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.

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Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/copay	Prescription drugs			Member Survey Results h above average, * average, f below average					
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Indiana												
Advantage Health Plan, Inc.		\$15	\$30	\$400	\$10	\$30	f	\$50	*	*	f	f
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	*	\$40	*	*	*	*
Arnett HMO		\$10	\$10	None	\$5	\$15	h	\$30	h	h	*	h
Health Alliance HMO		\$15	\$15	\$100	\$10	\$20	h	\$40	*	h	h	h
Humana Health Plan		\$15	\$25	\$250/day x 3	\$10/\$25	\$25/\$45	h	\$45	25%	f	f	*
Humana Health Plan Inc.-High		\$10	\$20	\$100/day x 3	\$5/\$15	\$15/\$35	*	25%	f	*	f	f
Humana Health Plan Inc.-Std		\$15	\$25	\$250/day x 3	\$10/\$25	\$25/\$45	*	25%	f	*	f	f
M*Plan	\$10	\$15	\$250	\$5/\$10	\$15	\$15	\$50	*	h	h	*	*
Physicians Health Plan of Northern Indiana		\$10	\$10	20% of \$2500	\$5	\$5	h	\$15	h	\$40	h	h
Unicare HMO		\$15	\$15	None	\$5	\$15	\$25					
Iowa												
Avera Health Plans		\$10	\$15	\$100/day x 3	\$10	\$20	\$35	or 50%				
Coventry Health Care of Iowa		\$10	\$10	None	\$5	\$15	f	\$50	h	*	f	*
Health Alliance HMO		\$15	\$15	\$100	\$10	\$20	h	\$40	*	h	h	h
John Deere Health Plan		\$15	\$15	\$100	\$10	\$20	h	\$35	h	h	h	h
Kansas												
Coventry Health Care of Kansas		\$15	\$15	\$100/day x 3	\$5	\$15	\$45					
Coventry Health Care of Kansas - Kansas City		\$15	\$15	\$100/day x 3	\$10	\$20	f	\$20*	\$50	*	f	f
Humana Health Plan, Inc.-High		\$10	\$20	\$100/day x 3	\$5/\$20	\$20/\$40	*	25%	*	f	f	f
Humana Health Plan, Inc.-Std		\$15	\$25	\$250/day x 3	\$10/\$25	\$25/\$45	*	25%	*	f	f	f
Preferred Plus of Kansas		\$10	\$10	\$50/day x 10	\$5	\$15	\$15					
Kentucky												
Humana Health Plan		\$15	\$25	\$250/day x 3	\$10/\$25	\$25/\$45	25%	f	f	*	f	f
United Healthcare of Ohio, Inc.		\$15	\$15	\$250	\$10	\$15	*	\$80	h	*	*	*

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.

Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialist.

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Louisiana								
Coventry Healthcare Louisiana - New Orleans Area		800/341-6613		BJ1	BJ2	62.56	145.31	
Coventry Healthcare Louisiana - Baton Rouge Area		800/341-6613		JA1	JA2	78.82	191.44	
Vantage Health Plan - Monroe Area	888/823-1910			AQ1	AQ2	87.01	318.21	95
Vantage Health Plan - Shreveport/Alexandria Areas	888/823-1910			MV1	MV2	104.95	366.36	
Maryland								
Aetna Health Inc.-High -North/Central/Southern Maryland		800/537-9384		JN1	JN2	73.39	176.10	
Aetna Health Inc.-Std - North/Central/Southern Maryland		800/537-9384		JN4	JN5	51.94	121.54	
CareFirst BlueChoice - All of Maryland	866/520-6099			2G1	2G2	69.10	155.45	11
Kaiser Permanente - Baltimore/Washington, DC Areas		301/468-6000		E31	E32	57.98	143.23	
MD-IPA - All of Maryland	800/251-0956		JP1	JP2		65.30	156.74	75.18
Massachusetts								
Blue Chip, Coord Hlth Partners - Southeastern Massachusetts		401/459-5500		DA1	DA2	72.69	244.5	
ConnectiCare - Counties Hampden, Hampshire, Franklin		800/251-7722		TE1	TE2	60.74	159.09	
Fallon Community Health Plan - Central/Eastern Massachusetts		800/868-5200		JV1	JV2	88.49	172.4	

Prescription drugs. 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.

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Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results h above average, * average, f below average					
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Louisiana												
Coventry Healthcare Louisiana		\$15	\$15	\$100/day x 3		\$10	\$20	f \$45	f	*	f	f
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					
Vantage Health Plan		\$15	\$15	\$250	\$10	\$20	\$35					
Maryland												
Aetna Health Inc.-High		\$15	\$20	\$150/day x 3		\$10	\$25 *	\$40	*	*	*	*
Aetna Health Inc.-Std		\$20	\$25	\$250/day x 3		\$10	\$25 *	\$40	*	*	*	*
CareFirst BlueChoice		\$20	\$30	None	\$10	\$20	* \$35	f	f	f	f	
Kaiser Permanente		\$10	\$20	\$100	\$10	\$20	Net \$20 \$40	Net \$20 \$40	Net f	h	h	*
MD-IPA	\$10	\$20	None	\$8	\$17	\$33	h	*	*	h	*	
Massachusetts												
Blue Chip, Coord Hlth Partners	- In-Network - Out-of-Network	\$15 30%	\$25 30%	\$500 None	\$7 \$40 + 20%	\$25 \$40 + 20%	* \$40 + 20%	\$40 \$40 + 20%	h	*	*	*
ConnectiCare		\$10	\$10	None	\$10	\$20	\$35					
Fallon Community Health Plan		\$10	\$10	None	\$5	\$15	h \$35	h	h	h	h	*

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Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Michigan								
Bluecare Network of MI - Cheboygan and Roscommon Counties Area		800/662-6667		G71	G72	250.66	686	
Bluecare Network of MI - Midland County Area		800/662-6667		K51	K52	65.38	247.10	
Bluecare Network of MI - Kalamazoo County Area		800/662-6667		KF1	KF2	116.59	420.72	
Bluecare Network of MI - Genesee County Area		800/662-6667		KN1	KN2	70.10	299.75	
Bluecare Network of MI - Kent County Area		800/662-6667		KR1	KR2	71.11	333.53	
Bluecare Network of MI - Mid Michigan		800/662-6667		LN1	LN2	133.75	348.50	14
Bluecare Network of MI - Southeast MI		800/662-6667		LX1	LX2	48.26	144.35	5
Grand Valley Health Plan - Grand Rapids Area		616/949-2410		RL1	RL2	63.35	228.34	
Health Alliance Plan - Southeastern Michigan/Flint Area		800/422-4641		521	522	67.02	226.24	
HealthPlus MI - Flint/Saginaw Areas		800/332-9161		X51	X52	67.31	175.99	88
M-Care - Mid and Southeastern Michigan		800/658-8878		EG1	EG2	54.97	145.66	6
OmniCare - Southeastern Michigan		800/477-6664		KA1	KA2	55.60	139.56	65
The Wellness Plan - Detroit/Flint Areas		800/875-9355		K31	K32	49.31	134.13	5
Total Health Care - Greater Detroit/Flint Areas		800/826-2862		N21	N22	57.22	143.99	
Minnesota								
Avera Health Plans - Southwestern Minnesota		888/322-2115		AV1	AV2	56.98	130.78	
HealthPartners Classic - Minneapolis/St. Paul/St. Cloud Areas		952/883-5000		531	532	99.39	263.21	
HealthPartners Primary Clinic Plan - Minneapolis/St. Paul/St. Cloud Areas		952/883-5000		HQ1	HQ2	147.55	37	

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Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/copay	Prescription drugs			Member Survey Results h above average, * average, f below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	
Michigan													
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	*	*	*	
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	*	*	*	
Bluecare Network of MI		\$15	\$15	\$250	\$10	\$20	*	\$20	h	*	*	*	
Grand Valley Health Plan		\$10	\$10	None	\$5	\$5	h	\$5	*	h	*	h	*
Health Alliance Plan		\$10	\$10	None	\$10	\$20	*	\$30	*	*	h	*	*
HealthPlus MI		\$10	\$10	None	\$5	\$10	h	\$10	h	h	h	h	h
M-Care	\$10	\$10	None	\$10	\$20	\$30	*	*	*	*	h	h	
OmniCare	\$10	\$10	None	\$2	\$2	\$2	f	f	f	*	*	f	
The Wellness Plan		\$10	\$10	None	\$5	\$5	f	\$5	f	f	f	f	
Total Health Care		\$10	Nothing	None	Nothing	Nothing	f	Nothing	f	f	f	*	
Minnesota													
Avera Health Plans		\$10	\$15	\$100/dayx3	\$10	\$20	\$35	or 50%					
HealthPartners Classic		\$15	\$15	\$100	\$12	\$12	*	\$24	*	*	*	*	
HealthPartners Primary		\$20	\$20	\$200	\$12	\$12	*	\$24	*	*	*	*	

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Missouri								
BlueCHOICE - StLouis/Central/SW Areas		800/634-4395		9G1	9G2	66.45	143.85	
Coventry Health Care of Kansas - Kansas City - Kansas City Area		800-969-3343			HA1	HA2	47.42	12
Group Health Plan - St. Louis Area		800/755-3901		MM1	MM2	111.06	213.80	12
Humana Health Plan, Inc.-High -Kansas City Area		888/393-6765		MS1	MS2	61.58	147.74	
Humana Health Plan, Inc.-Std - Kansas City Area		888/393-6765		MS4	MS5	46.93	112.58	
Mercy Health Plans/Premier Health Plans - East/Central;Southwest Missouri	800/836-0402	800/327-0763;			7M1	7M2	78.48	19
Montana								
New West Health Plan - Most of Montana		800/290-3657		NV1	NV2	0.00	0.00	7 JCAHO 1
Nevada								
Health Plan of Nevada - Las Vegas/Reno Areas		800/777-1840		NM1	NM2	52.98	135.67	
PacificCare Health Plans - Clark County		800/531-3341		K91	K92	63.96	167.48	67
New Jersey								
Aetna Health Inc. - All of New Jersey		800/537-9384		P31	P32	99.71	326.47	8
AmeriHealth HMO - All of New Jersey		800/454-7651		FK1	FK2	68.61	170.12	8
GHI Health Plan - Northern New Jersey		212/501-4444		801	802	100.27	296.68	1
New Mexico								
Cimarron Health Plan - All of New Mexico		800/473-0391		PX1	PX2	61.37	161.50	7
Lovelace Health Plan - All of New Mexico		800/244-6224		Q11	Q12	60.85	158.21	NCQA JCAHO 1
Presbyterian Health Plan - All NM counties except Otero & S. Eddy		505/923-5678			P21	P22	58.74	153.

Prescription drugs Ñ 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.

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Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/copay	Prescription drugs			Member Survey Results h above average, * average, f below average					
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Missouri												
BlueCHOICE	\$10	\$10	None	\$7	\$12	*\$25	*	h	h	*	*	
Coventry Health Care of Kansas - Kansas City	\$15	\$15	\$100/day x 3	\$10	\$10	f	\$20*	\$50	*	f	f	
Group Health Plan	\$10	\$20	\$100	\$8	\$20	*	\$35	*	h	*	*	
Humana Health Plan, Inc.-High	\$10	\$20	\$100/day x 3	\$5/\$20	\$20/\$40	*	25%	*	f	f	f	
Humana Health Plan, Inc.-Std	\$15	\$25	\$250/day x 3	\$10/\$25	\$25/\$45	*	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 h	N/A	*	*	*	h	h
Montana												
New West Health Plan	\$15	\$15	\$100	\$10	\$20	\$20						
Nevada												
Health Plan of Nevada	Nothing	\$10	\$100	\$5	\$20	f	\$35	f	f	f	*	
PacifiCare Health Plans	\$10	\$20	None	\$10	\$20	f	\$20	f	f	f	*	
New Jersey												
Aetna Health Inc.	\$20	\$25	\$250/day x 3	\$10	\$25	*	\$40	*	*	*	*	
AmeriHealth HMO	\$30	\$35	\$200/day x 3	\$20	\$40	f	50%	*	*	*	f	
GHI Health Plan - In-Network - Out-of-Network	\$15 50% of sch.	\$15 50% of sch.	None	\$10 None	\$20 N/A	\$50 N/A	h N/A	*	*	*	*	
New Mexico												
Cimarron Health Plan	\$10	\$10	None	\$5	\$10	*	\$25	f	f	*	*	
Lovelace Health Plan	\$15	\$25	\$250	\$7	\$15	\$35	*	*	*	*	*	
Presbyterian Health Plan	\$10	\$10	None	\$5	\$15	*	\$35	f	f	*	h	

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.

Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
New York								
Aetna Health Inc. - NYC Area and Dutchess/Sullivan/Ulster		800/537-9384		JC1	JC2	60.71	152.68	
Blue Choice - Rochester Area	800/462-0108		MK1	MK2	73.78	232.09	73.78	
Capital District Physicians Health Plan - Albany/Cooperstown Areas		518/641-3700		PW1	PW2	64.41	175.00	
Capital District Physicians Health Plan - Hudson Valley Area		518/641-3700		QB1	QB2	66.99	203.97	
Capital District Physicians Health Plan - Capital District Area		518/641-3700		SG1	SG2	63.81	169.78	
GHI Health Plan - All of New York	212/501-4444		801	802	100.27	296.68	128.00	
GHI HMO Select - Brnx/Brklyn/Manhat/Queen/Richmon/Westche		877/244-4466		6V1	6V2	69.44	214.30	
GHI HMO Select - Capital/Hudson Valley Regions		877/244-4466		X41	X42	61.87	159.51	
HIP of Greater New York-High -New York City Area		800/HIP-TALK		511	512	59.00	223.99	
HIP of Greater New York-Std - New York City Area		800/HIP-TALK		514	515	0.00	0.00	
HMO Blue - Utica/Rome/Central New York Areas		800/722-7884		AH1	AH2	67.03	202.67	
HMO-CNY - Syracuse/Binghamton/Elmira Areas		800/828-2887		EB1	EB2	73.32	272.69	
Independent Health Assoc - Western New York		800/453-1910		QA1	QA2	50.89	141.88	
MVP Health Care - Eastern Region	888/687-6277		GA1	GA2	62.13	160.48	62.13	
MVP Health Care - Central Region	888/687-6277		M91	M92	64.13	178.36	69.00	
MVP Health Care - Mid-Hudson Region	888/687-6277		MX1	MX2	70.23	241.51	70.23	
Preferred Care - Rochester Area	800/950-3224		GV1	GV2	64.36	203.51	50.00	
Univera Healthcare - Western New York (Southern Counties)		716/847-0881		KQ1	KQ2	0.00	0.00	
Univera Healthcare - Western New York		716/847-0881		Q81	Q82	55.63	157.78	
Vetra Health Plans - Queens/Nassau/Suffolk Counties		800/406-0806		J61	J62	109.42	358.19	

Prescription drugs Ñ 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 Ñ See page 2 for a description. Accredited Ñ The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See pages 3 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 h above average, * average, f below average						
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	
New York													
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	*	\$40	*	f	*	*	
Blue Choice		\$10	\$10	None	\$5	\$15	h	\$30	h	h	h	*	h
Capital District Physicians Health Plan		\$10	\$10	\$100	\$5	\$20	h	\$20	h	h	h	h	h
Capital District Physicians Health Plan		\$10	\$10	\$100	\$5	\$20	h	\$20	h	h	h	h	h
Capital District Physicians Health Plan		\$10	\$10	\$100	\$5	\$20	h	\$20	h	h	h	h	h
GHI Health Plan - In-Network - Out-of-Network	\$15 50% of sch.	\$15 50% of sch.	None 50% of sch.	None	\$10	\$20	h	\$50 N/A	h N/A	*	*	*	*
GHI HMO Select		\$10	\$10	None	\$10	\$20	f	\$30	f	f	f	f	f
GHI HMO Select		\$10	\$10	None	\$10	\$20	f	\$30	f	f	f	f	f
HIP of Greater New York-High		\$10	\$10	None	\$10	\$15	*	\$40	f	*	*	*	f
HIP of Greater New York-Std		\$10	\$20	\$500	\$10	\$20	*	\$40	f	*	*	*	f
HMO Blue		\$15	\$15	\$240	\$10	\$25	h	\$40	h	h	h	*	*
HMO-CNY		\$10	\$10	None	\$5	\$20	h	\$35	h	h	*	f	*
Independent Health Assoc		\$15	\$15	None	\$10	\$20	h	\$35	h	h	h	h	h
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
MVP Health Care		\$15	\$15	\$240	\$5	\$20	h	\$40	h	h	h	h	h
Preferred Care		\$15	\$15	None	\$10	\$20	h	\$35	h	h	h	h	h
Univera Healthcare		\$15	\$15	\$250	\$5	\$15	h	\$35	h	h	h	h	h
Univera Healthcare		\$15	\$15	\$250	\$5	\$15	*	\$35	h	h	h	*	h
Vetra Health Plans		\$10	\$10	None	\$5	\$10	h	\$10	h	*	*	h	*

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.

Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialist.

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
North Dakota								
Heart of America HMO - Northcentral North Dakota		701/776-5848		RU1	RU2	57.51	147.79	
Ohio								
Aetna Health Inc. - Cleveland Area	800/537-9384			7D1	7D2	81.71	241.86	75
Aetna Health Inc. - Greater Cincinnati Area	800/537-9384			RD1	RD2	94.38	290.94	75
AultCare HMO - Stark/Carroll/Holmes/Tuscarawas/Wayne Co	330/438-6360			3A1	3A2	51.58	129.2	
Blue HMO - Most of Ohio	800/228-4375		R51	R52	79.02	201.73	86.23	
Health Plan of the Upper Ohio Valley-High -Eastern Ohio	800/624-6961			U41	U42	63.55	215.04	
Health Plan of the Upper Ohio Valley-Std - Eastern Ohio	800/624-6961			U44	U45	0.00	0.00	
HMO Health Ohio - Northeast Ohio	800/522-2066		L41	L42	69.77	229.75	72.	
Kaiser Permanente - Cleveland/Akron Areas	800/686-7100			641	642	63.79	156.55	
Paramount Health Care - Northwest/North Central Ohio	800/462-3589			U21	U22	70.28	261.34	
SummaCare Health Plan - Cleveland, Akron Areas	330/996-8700			5W1	5W2	54.47	149.81	
SuperMed HMO - Northeast Ohio	800/522-2066		5M1	5M2	101.99	319.17	98	
United Healthcare of Ohio, Inc. - Cincinnati/Dayton/Springfield Areas	800/231-2918			3U1	3U2	110.28	257.2	
Oklahoma								
PacifiCare Health Plans - Central/Northeastern Oklahoma		800/531-3341		2N1	2N2	55.48	145.07	
Oregon								
Kaiser Permanente-High -Portland/Salem Areas		800/813-2000		571	572	78.52	182.73	
Kaiser Permanente-Std - Portland/Salem Areas		800/813-2000		574	575	65.00	149.17	
PacifiCare Health Plans - Metro Portland/Salem/Corvallis/Eugene		800/531-3341		7Z1	7Z2	149.61	317.2	

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Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results h above average, * average, f below average					
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
North Dakota												
Heart of America HMO		\$10	Nothing	None	50%	50%	50%					
Ohio												
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	* \$40	*	*	*	*	
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	* \$40	*	*	*	*	
AultCare HMO		\$10	\$10	None	\$5	\$10	h\$10	h	h	h	h	h
Blue HMO		\$10	\$10	None	\$10	\$20	*\$30	*	h	*	*	*
Health Plan of the Upper Ohio Valley-High		\$10	\$10	None	\$10	\$20	h\$35	h	h	h	h	h
Health Plan of the Upper Ohio Valley-Std		\$10	\$20	None	\$15	\$30	h\$50	h	h	h	h	h
HMO Health Ohio		\$10	\$10	None	\$10	\$20	* \$20	*	*	*	f	f
Kaiser Permanente		\$10	\$10	None	\$5	\$15	h \$15	h	*	*	h	*
Paramount Health Care		\$10	\$20	\$300	\$5	\$15	h \$25	h	*	*	h	h
SummaCare Health Plan		\$10	\$10	None	\$8	\$15	h \$30	h	h	h	h	f
SuperMed HMO		\$10	\$10	None	\$10	\$20	* \$20	*	*	*	f	f
United Healthcare of Ohio, Inc.		\$15	\$15	\$250	\$10	\$15	* \$80	h	*	*	*	*
Oklahoma												
PacifiCare Health Plans		\$10	\$20	None	\$10	\$20	* \$20	f	*	*	f	h
Oregon												
Kaiser Permanente-High		\$10	\$10	None	\$10	\$20	* \$20	f	f	h	*	*
Kaiser Permanente-Std		\$15	\$15	None	\$15	\$30	* \$30	f	f	h	*	*
PacifiCare Health Plans		\$10	\$20	None	\$10	\$20	f \$20	*	*	f	*	*

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Pennsylvania								
Aetna Health Inc. - Philadelphia and Southeastern PA		800/537-9384		P31	P32	99.71	326.47	
Health Net of Pennsylvania - Scranton/Wilkes Barre Areas		877/747-9585		2K1	2K2	69.97	202.84	
HealthAmerica Pennsylvania - Greater Pittsburgh Area		800/735-4404		261	262	62.50	165.85	
HealthAmerica Pennsylvania - Central Pennsylvania		800/788-8445		SW1	SW2	67.24	215.30	
HealthGuard - Berks/Cmbrlnd/Dauphine/Lanc/Lebanon/York		800/822-0350		NQ1	NQ2	53.93	140.24	
Keystone Health Plan Central - Harrisburg/Northern Region/Lehigh Valley		800/622-2843		S41	S42	102.55	277.00	
Keystone Health Plan East - Philadelphia Area		800/227-3115		ED1	ED2	69.66	250.22	
UPMC Health Plan - Western Pennsylvania Area		888/876-2756		8W1	8W2	50.66	129.22	
Puerto Rico								
Humana Health Plans of Puerto Rico - Puerto Rico		800/314-3121		ZJ1	ZJ2	0.00	0.00	
Triple-S - All of Puerto Rico		787/749-4777	891	892	49.37	106.04	51.84	
Rhode Island								
Blue Chip, Coord Hlth Partners - All of Rhode Island		401/459-5500		DA1	DA2	72.69	244.94	
South Dakota								
Avera Health Plans - Eastern and Central South Dakota		888/322-2115		AV1	AV2	56.98	130.78	
Sioux Valley Health Plan - Eastern/Central/Rapid City Areas		800/752-5863		AU1	AU2	121.68	230.71	NCOA JCAHO 1

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Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/ copay	Prescription drugs			Member Survey Results h above average, * average, f below average					
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Pennsylvania												
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	*	\$40	h	*	*	*
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
HealthAmerica Pennsylvania		\$10	\$15	None	\$8	\$14	h	\$35	h	h	*	h
HealthGuard	\$10	\$20	None	\$10	\$25	h	\$40	h	h	*	*	h
Keystone Health Plan Central		\$10	\$10	None	\$10	\$25	h	\$40	h	h	h	h
Keystone Health Plan East		\$10	\$15	None	\$5	\$15	f	\$25	*	*	*	*
UPMC Health Plan		\$10	\$10	None	\$5	\$15	*	\$35	h	*	*	*
Puerto Rico												
Humana Health Plans of Puerto Rico	- In-Network - Out-of-Network	\$5 \$8	\$5 \$8	None \$50	\$2.50 N/A	\$5 N/A	\$5 N/A	\$5 N/A				
Tripe-S	- In-Network - Out-of-Network	\$7.50 \$7.50 + 10%	\$10 \$10 + 10%	None None	\$2 25%	\$5/\$10 25%	\$10 or 20% 25%	h or 20% 25%	f	h	*	*
Rhode Island												
Blue Chip, Coord Hlth Partners	- In-Network - Out-of-Network	\$15 30%	\$25 30%	\$500 None	\$7 \$40 + 20%	\$25 \$40 + 20%	*	\$40 \$40 + 20%	h	*	*	*
South Dakota												
Avera Health Plans		\$10	\$15	\$100/dayx3	\$10	\$20	\$35	or 50%				
Sioux Valley Health Plan	- In-Network - Out-of-Network	\$20 40%	\$20 40%	\$100 40%	\$10 N/A	\$20 N/A	\$35 N/A	h	h	h	*	*

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Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Tennessee								
Aetna Health Inc. - Nashville/Middle Tennessee Areas		800/537-9384		6J1	6J2	67.90	272.80	
Aetna Health Inc. - Memphis Area	800/537-9384		UB1	UB2	56.09	199.61	69	
HealthSpring-High -Nashville/Middle Tennessee Area		615/291-5030		6K1	6K2	63.04	218.59	
HealthSpring-Std - Nashville/Middle Tennessee Area		615/291-5030		6K4	6K5	0.00	0.00	
Texas								
Amcare Health Plans - Houston/EI Paso Areas		800/782-8373		2V1	2V2	55.73	145.96	
Amcare Health Plans - Austin/San Antonio/Dallas/Ft Worth Areas		800/782-8373		ZG1	ZG2	55.12	144.3	
FIRSTCARE - Waco Area	800/884-4901		6U1	6U2	82.66	158.26	66.9	
FIRSTCARE - West Texas	800/884-4901		CK1	CK2	115.51	219.50	145	
HMO Blue Texas - Houston	800/833-5318		YM1	YM2	64.78	158.57	75.0	
Humana Health Plan of Texas-High -San Antonio Area		888/393-6765		UR1	UR2	55.79	143.40	
Humana Health Plan of Texas-Std - San Antonio Area		888/393-6765		UR4	UR5	0.00	0.00	
Mercy Health Plans/Premier Health Plans - Webb/Zapata/Duval/Jim Hogg Counties		800/617-3433		HM1	HM2	68.84		
PacifiCare Health Plans - San Antonio/Dallas/Ft Worth		800/531-3341		GF1	GF2	53.95	141.06	
Utah								
Altius Health Plans - Wasatch Front	800/377-4161		9K1	9K2	105.76	215.08	11	

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Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/copay	Prescription drugs			Member Survey Results h above average, * average, f below average					
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
Tennessee												
Aetna Health Inc.	\$20	\$25	\$250/day x 3	\$10	\$25	f	\$40	*	*	*	f	
Aetna Health Inc.	\$20	\$25	\$250/day x 3	\$10	\$25	f	\$40	*	*	*	f	
HealthSpring-High	\$15	\$25	\$250	\$10	\$20	\$35						
HealthSpring-Std	\$20	\$20	\$250	\$10	\$20	50%						
Texas												
Amcare Health Plans	\$10	\$10	None	\$5	\$15	f	50%	f	*	f	f	
Amcare Health Plans	\$10	\$10	None	\$5	\$15	f	50%	f	*	f	f	
FIRSTCARE	\$15	\$25	\$100	\$10	\$20	*	\$40	*	*	h	h	*
FIRSTCARE	\$15	\$25	\$100	\$10	\$20	*	\$40	h	*	h	h	h
HMO Blue Texas	\$20	\$20	\$100/day x 4	\$10	\$25	f	\$40	f	f	f	f	
Humana Health Plan of Texas-High	\$10	\$20	\$100/day x 3	\$5/\$20	\$20/\$40	f	25%	f	*	*	*	
Humana Health Plan of Texas-Std	\$15	\$25	\$250/day x 3	\$10/\$25	\$25/\$45	f	25%	f	*	*	*	
Mercy Health Plans/Premier - In-Network - Out-of-Network	\$10 40%	\$10 40%	None 40%	\$7 N/A	\$12 N/A	h N/A	\$25 N/A	*	f	h	*	*
PacifiCare Health Plans	\$10	\$20	None	\$10	\$20	f	\$20	f	*	f	f	
Utah												
Altius Health Plans	\$10	\$15	None	\$10	\$20	*	\$40	*	*	*	f	f

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Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
Vermont								
MVP Health Care - All of Vermont	888/687-6277			VW1	VW2	193.35	563.00	14
Virginia								
Aetna Health Inc.-High -N.VA/Fredericksburg Areas	800/537-9384			JN1	JN2	73.39	176.10	
Aetna Health Inc.-Std - N.VA/Fredericksburg Areas	800/537-9384			JN4	JN5	51.94	121.54	
CareFirst BlueChoice - Northern Virginia	866/520-6099			2G1	2G2	69.10	155.45	1
Kaiser Permanente - Washington, DC Area	301/468-6000			E31	E32	57.98	143.23	
MD-IPA - N.VA/Cntrl VA/Richmond/Tidewater/Roanoke	800/251-0956			JP1	JP2	65.30	156.74	
Optima Health Plan - Peninsula/Southside Hampton Roads	800/206-1060			9R1	9R2	85.32	219.57	
Piedmont Community Healthcare - Lynchburg Area	888/674-3368			2C1	2C2	79.58	183.69	
Washington								
Aetna Health Inc. - Western/Southeast Washington	800/537-9384			8J1	8J2	59.98	155.95	
Group Health Cooperative - Most of Western Washington	888/901-4636			541	542	69.85	157.61	
Group Health Cooperative - Central WA/Spokane/Pullman	888/901-4636			VR1	VR2	64.60	180.28	
Kaiser Permanente-High -Vancouver/Longview	800/813-2000			571	572	78.52	182.73	
Kaiser Permanente-Std - Vancouver/Longview	800/813-2000			574	575	65.00	149.17	
KPS Health Plans-High -Most of Western Washington	800/552-7114			VT1	VT2	174.35	342.39	
KPS Health Plans-Std - Most of Western Washington	800/552-7114			VT4	VT5	78.41	158.66	
PacifiCare Health Plans - Clark County	800/531-3341			7Z1	7Z2	149.61	317.20	1
PacifiCare Health Plans - Puget Sound/Most West WA	800/531-3341			WB1	WB2	71.52	259.30	

Prescription drugs Ñ 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 Ñ See page 2 for a description. Accredited Ñ The National Committee for Quality Assurance (N); the Joint Commission on Accreditation of Healthcare Organizations (J); and/or URAC (U). See pages 3 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 h above average, * average, f below average									
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing				
Vermont																
MVP Health Care		\$15	\$15	\$240	\$5	\$20	h	\$40	h	h	h	h	h			
Virginia																
Aetna Health Inc.-High		\$15	\$20	\$150/day x 3	\$10	\$25	*	\$40	*	*	*	*	*			
Aetna Health Inc.-Std		\$20	\$25	\$250/day x 3	\$10	\$25	*	\$40	*	*	*	*	*			
CareFirst BlueChoice		\$20	\$30	None	\$10	\$20	*	\$35	f	f	f	f	f			
Kaiser Permanente		\$10	\$20	\$100	\$10	\$20	Net	\$20	\$40	Net	\$20	\$40	Net	f	h	*
MD-IPA	\$10	\$20	None	\$8	\$17	\$33	h	*	*	h	*	*	*			
Optima Health Plan		\$10	\$20	\$250	\$10	\$20	*	\$40	h	*	*	h	h			
Piedmont Community Healthcare		\$20	\$20	None	\$10	\$20	\$20									
	- In-Network	40%	30%	None	\$10	\$20	\$20									
	- Out-of-Network			None	\$10	\$20	\$20									
Washington																
Aetna Health Inc.		\$20	\$25	\$250/day x 3	\$10	\$25	f	\$40	*	*	f	*	*			
Group Health Cooperative		\$15	\$15	\$200/day x 3	\$15	\$25	*	\$50	h	*	h	h	h			
Group Health Cooperative		\$15	\$15	\$200/day x 3	\$15	\$25	*	\$50	h	*	h	h	h			
Kaiser Permanente-High		\$10	\$10	None	\$10	\$20	*	\$20	f	f	h	*	*			
Kaiser Permanente-Std		\$15	\$15	None	\$15	\$30	*	\$30	f	f	h	*	*			
KPS Health Plans-High		\$10	\$10	\$100/day x 10	\$5	50%	h	50%	h	h	h	h	h			
KPS Health Plans-Std		\$20	\$20	None	\$5	\$20	h	100%	50%	h	h	h	h			
PacifiCare Health Plans		\$10	\$20	None	\$10	\$20	*	\$20	*	*	*	*	*			
PacifiCare Health Plans		\$10	\$20	None	\$10	\$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.

Specialist Office Copay shows what you pay for each office visit to a specialist. Contact your plan to find out what providers it considers specialists.

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

Plan name & location	Telephone number	Enrollment code		Premium You Paid in 2002		Premium You Will Pay in 2003		Accredited
		Self only	Self & family	Self only	Self & family	Self only	Self & family	
West Virginia								
Health Plan of the Upper Ohio Valley-High -Northern/Central West Virginia	800/624-6961			U41	U42	63.55	215	
Health Plan of the Upper Ohio Valley-Std - Northern/Central West Virginia	800/624-6961			U44	U45	0.00	0.0	
Wisconsin								
Dean Health Plan - South Central Wisconsin	800/279-1301			WD1	WD2	64.11	208.32	
Group Health Cooperative - South Central Wisconsin	608/251-3356			WJ1	WJ2	62.92	191.49	
Group Health Cooperative/Eau Claire - West Central Wisconsin	715/552-4300			WT1	WT2	168.26	497.	
HealthPartners Classic - West Central Wisconsin	952/883-5000			531	532	99.39	263.27	
HealthPartners Primary Clinic Plan - West Central Wisconsin	952/883-5000			HQ1	HQ2	147.55	378.9	
Wyoming								
WINhealth Partners - Wyoming	307/638-7700			PV1	PV2	62.39	191.64	66.9

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.

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Plan name	Primary care doctor office copay	Specialist office copay	Hospital per stay deductible/copay	Prescription drugs			Member Survey Results h above average, * average, f below average					
				Generic	Brand Name	Non-formulary	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing
West Virginia												
Health Plan of the Upper Ohio Valley-High		\$10	\$10	None	\$10		\$20	h \$35	h	h	h	h
Health Plan of the Upper Ohio Valley-Std		\$10	\$20	None	\$15		\$30	h \$50	h	h	h	h
Wisconsin												
Dean Health Plan		\$10	\$10	None	\$10	30% to 1500	N/A	h	*	h	h	h
Group Health Cooperative		\$20	\$20	None	\$6	\$12	h \$12	h	*	h	h	h
Group Health Cooperative/Eau Claire		\$10	\$10	None	\$10	\$20	h \$20	h	h	h	h	h
HealthPartners Classic		\$15	\$15	\$100	\$12	\$12	* \$24	*	*	*	*	*
HealthPartners Primary		\$20	\$20	\$200	\$12	\$12	* \$24*	*	*	*	*	*
Wyoming												
WINhealth Partners		\$10	\$10	None	\$10	\$15	\$40					

