The **2011**

Guide To Federal Benefits

For Individuals Receiving Compensation from the Office of Workers' Compensation Programs (OWCP)

Visit us at: www.opm.gov/insure

Healthcare and Insurance

RI 70 6
Revised November 2010

Summary Information

	New Hires Can Enroll	Federal Benefits Open Season	How to Enroll	OPM's Program Website
FEHB	Within 60 days from new hire date	Annual – November 8 to December 13, 2010	Varies by agency; automated enrollment or via SF 2809	**www.opm.gov/insure/health**
FEDVIP	Within 60 days from new hire date	Annual – November 8 to December 13, 2010	Go to www.BENEFEDS.com or call 1-877-888-3337	**www.opm.gov/insure/dental** **www.opm.gov/insure/vision**
FEGLI	Within 31 days from new hire date for optional insurance; automatically enrolled in Basic insurance until you take action to cancel*	No annual Open Season	Varies by agency; automated enrollment or via SF 2817 for new hires Others provide medical information on SF 2822	**www.opm.gov/insure/life**
FLTCIP	Apply (not necessarily enroll) within 60 days from new hire date with abbreviated underwriting	No annual Open Season	Go to www.LTCFEDS.com or call 1-800-582-3337	**www.opm.gov/insure/ltc**

** At press time, new FEGLI regulations were awaiting enactment. These proposed regulations expand the time limit to 60 days. Visit www.opm.gov/insure/life for the latest updates.*

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Introduction to Federal Benefits and This Guide

As a Federal employee, the benefits available to you represent a significant piece of your compensation package. They may provide important insurance coverage to protect you and your family and, in some cases, offer tax advantages that reduce the burden in paying for some health products and services, or dependent or elder care services.

The purpose of this Guide is to provide you basic information about the benefits offered to you as a Federal employee, and assist you in making informed choices about these benefits as you move through your career and prepare for retirement.

Benefits Programs included in this Guide

In addition to your Civil Service or Federal Employees Retirement System benefits and the Thrift Savings Plan, the Federal government offers other benefits programs to eligible retirees and/or employees. This Guide includes information on the additional programs:

- Federal Employees Health Benefits Program
- Federal Employees Dental and Vision Insurance Program
- Federal Employees' Group Life Insurance Program
- Federal Long Term Care Insurance Program

If you are a new Federal employee or have recently been appointed to a position that makes you eligible for benefits, this Guide will walk you through the benefits offered, and provide information on how and when to make your choices. If you are a seasoned employee or retiree, it will provide the most current information regarding the benefit programs, and will support you as you make decisions during the annual Open Season, or experience life events that cause you to reconsider previous choices.

Additional Information

You will find references throughout this Guide to websites or other locations to obtain more detailed information than is available here. We encourage you to access these sites to become a more educated decision-maker and consumer of Federal benefit programs.

Health Reform Changes for Federal Benefit Programs Effective January 1, 2011

On March 23, 2010, President Obama signed the Affordable Care Act, (ACA), Public Law 111-148. Several provisions of the ACA will affect eligibility and benefits under the Federal Employees Health Benefits (FEHB) Program beginning January 1, 2011. Please read the information below carefully.

Federal Employees Health Benefits (FEHB) Program

Please read the following section carefully as the actions you take will impact when your child's FEHB coverage begins under this new law.

What Are the Changes to FEHB Program Dependent Eligibility Rules Under the ACA?

All changes are effective on January 1, 2011.

Children	Effect of ACA
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but **NOT** their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent–child relationship to be eligible for coverage up to age 26.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Foster Children	Foster children are eligible for coverage up to age 26.

Children **do not** have to live with their parent, be financially dependent upon their parent or be students to be covered up to age 26. There is also no requirement that the child have prior or current insurance coverage. FEHB Program plans will send notice to all their enrollees of the coverage eligibility changes as a part of that plan's Open Season communications.

In cases where children have employer-provided health insurance and are covered under their parent's Self and Family enrollment, the children's employer-provided health insurance will be the primary payer. FEHB will be the secondary payer.

How Do I Add a Newly Eligible Child To My Enrollment?

What you must do:

- If you currently have a Self and Family enrollment and you do not change to another health plan or option during Open Season, contact your FEHB plan and give them information on your newly eligible child. Do not complete an SF 2809, Health Benefits Election Form, or enter dependent information in your agency's self-service enrollment system to add your child to an existing Self and Family enrollment. Your child will be covered on January 1, 2011.

- If you currently have a Self Only enrollment and you have newly eligible children, you must change your enrollment from Self Only to Self and Family if you want your children to be covered. You must use an SF 2809 or an agency self-service enrollment system to make this change.

- If you are not currently enrolled and you want FEHB coverage since your children are now eligible, you must enroll for Self and Family coverage to provide coverage for your children. You must use an SF 2809 or an agency self-service enrollment system to make this change.

Important: If you are enrolling or changing your enrollment, be sure to include all children up to age 26 when completing your SF 2809 or using your agency's self-service enrollment system.

How can I enroll or change my enrollment so that my child is covered January 1st?

Be aware: The effective date of coverage for your newly eligible children depends upon the event used to enroll or change enrollment.

If you are an employee who gets paid biweekly (this applies to most Federal employees) or you are an Office of Workers' Compensation (OWCP) recipient, and you want you child covered on January 1, 2011, then you must enroll or change your enrollment as a "change in family status" – qualifying life event (QLE). The qualifying life event code to use on the SF 2809 is '1C' for employees and '2B' for OWCP recipients.

You may change your enrollment from 31 days before to 60 days after January 1, 2011. Your change to Self and Family will take effect on the first day of the pay period that includes January 1, 2011. Your child will be covered on January 1, 2011. If you make your QLE change after January 1st, your child will be covered retroactively to January 1, 2011 and you will pay retroactive premiums back to the effective date of the enrollment or change.

If you enroll or change your enrollment as an Open Season change, it will take effect on the first day of the first pay period that begins in 2011. For most employees, this will be **January 2, 2011**. For the Office of Workers' Compensation, this will be **January 16, 2011**. For a few other agencies, the date may be different.

The table below shows the different date of coverage for most employees and OWCP recipients enrolling in FEHB or changing from a Self Only to a Self and Family enrollment as a "change in family status" – QLE change or as an Open Season change.

Please visit www.opm.gov/insure for the most up-to-date information.

Effective Date of Coverage for Newly Eligible Children		
Enrollee	**Change in Family Status (QLE Change):**	**Open Season Change:**
Most Employees	January 1, 2011	January 2, 2011
OWCP Recipients	January 1, 2011	January 16, 2011

For United States Postal Service employees, CSRS/FERS annuitants, Temporary Continuation of Coverage (TCC) enrollees and former spouses, an enrollment or change in enrollment made either as a "change in family status" QLE or as an Open Season change will provide coverage of eligible children on January 1, 2011. This is also true for other agencies and other retirement systems with a pay period that begins on January 1, 2011.

If you have a Self Only enrollment and would like your newly eligible child to be covered, you must change to a Self and Family enrollment. If you do not change to a Self and Family enrollment as a "change in family status" QLE or an Open Season change then your child will not be covered.

How Does This Affect Eligibility For Temporary Continuation of Coverage (TCC)?
Children who lose coverage due to reaching age 26 are eligible for TCC for up to 36 months even if they previously had TCC.

If you are a child of an FEHB enrollee and you are now enrolled under Temporary Continuation of Coverage (TCC), you may no longer need your TCC enrollment since you will be covered under your parent's Self and Family enrollment. Once you are assured of coverage under your parent's Self and Family enrollment, you may want to cancel your TCC enrollment. To cancel your TCC, contact the National Finance Center at:

USDA, National Finance Center
DPRS Billing Unit
PO Box 61760
New Orleans, LA 70161-1760

If you have additional questions, please contact the National Finance Center at 800-242-9630 or nfc.dprs@usda.gov.

What is a Grandfathered Health Plan Under ACA?
The Affordable Care Act requires that health plans include certain consumer protections and benefits coverage that affect some FEHB plan benefits for 2011. All plans in the FEHB Program have complied with all required provisions. However, certain protections and coverage terms depend upon whether the plan is considered a "grandfathered health plan" under the Act.

A grandfathered health plan may preserve basic health coverage that was in effect when the law was enacted. If an FEHB plan indicates that it is a grandfathered plan that means certain benefit features including cost sharing, premium payments and covered services have not significantly changed from last year.

Please visit www.opm.gov/insure for the most up-to-date information.

Health Reform Changes for Federal Benefit Programs Effective January 1, 2011

While grandfathered health plans must comply with certain benefit requirements under the ACA, being a grandfathered plan also means that plan may not have included all benefit protections and coverage terms that apply to other plans. Information on a plan's specific benefit changes under the ACA will be available in the plan's brochure.

How Does the ACA Affect Benefits for High Deductible Health Plans?
Beginning January 1, 2011, currently eligible over-the-counter (OTC) products that are medicines or drugs will not be eligible for reimbursement from your Health Savings Account (HSA) or your Health Reimbursement Arrangement (HRA) – unless – you have a prescription for that item written by your physician. The only exception is insulin - you will not need a prescription from January 1, 2011 forward. Other currently eligible OTC items that are not medicines or drugs will not require a prescription.

Effective January 1, 2011, the 10% penalty for non-eligible medical expenses paid from an HSA will increase to 20%.

Other Federal Benefits Programs
Other Federal benefits programs are not affected by the Affordable Care Act for 2011. The Act has made no changes to the Federal Employees Dental and Vision Insurance Program (FEDVIP), the Federal Employees' Group Life Insurance Program (FEGLI) or the Federal Long Term Care Insurance Program (FLTCIP). Health care reform does not extend coverage for children until age 26 or provide coverage for married dependent children under these programs.

Please visit www.opm.gov/insure for the most up-to-date information.

Federal Benefits Open Season Snapshot

Current Employees

During Open Season, you have the opportunity to make changes in the Federal Employees Health Benefits (FEHB) Program and the Federal Employees Dental and Vision Insurance Program (FEDVIP). You can use this chart to assist you with the decision-making process of selecting plans and enrolling in these benefit programs.

	If Currently Enrolled in the Program	If Not Enrolled in the Program
FEHB	1. Check your plan's 2011 premiums and satisfaction survey results in Appendix E; 2. Examine your plan's 2011 brochure for benefit and enrollment/service area changes; 3. Check Appendix E for any new plans and plan options available to you; 4. If satisfied with your plan's rates, survey results and benefits for 2011, **do nothing** – your enrollment will continue automatically; 5. If **not** satisfied with your current plan for 2011, see Appendix B for guidance on choosing another plan.	1. See page 11 for general information on FEHB (including eligibility) and Appendix B for guidance on choosing a plan; 2. If you decide to enroll, examine the 2011 brochure of each plan you consider to ensure the benefits and premiums meet your needs and the plan is available in your area; 3. Contact the human resources office of your agency for information on how to enroll.
FEDVIP	1. Check your plan's 2011 premiums in Appendix K and examine your plan's 2011 brochure for benefit and enrollment/service area changes; 2. If also enrolled in FEHBP, check your 2011 FEHBP brochure for any changes in dental and/or vision benefits; 3. If satisfied with your plan's rates and benefits for 2011, **do nothing** – your enrollment will continue automatically; 4. If **not** satisfied with your current plan for 2011, see page 15 for guidance on choosing another plan and for information on how to change your enrollment; 5. If you no longer want FEDVIP, you must cancel during Open Season by contacting BENEFEDS. After Open Season you cannot cancel; see Appendix H for details.	1. See page 15 for general information on FEDVIP (including eligibility) and for guidance on choosing a FEDVIP plan; 2. If you decide to enroll, examine the 2011 brochure of the plans in which you are interested to ensure the benefits and premiums meet your needs and the plan is available in your area; 3. See page 17 for information on how to enroll.

Federal Benefits Facts

FEHB

- When you retire, you are eligible to continue health benefits coverage if you meet all of the following requirements:
  - you are entitled to retire on an immediate annuity under a retirement system for civilian employees (including the Federal Employees Retirement System (FERS) Minimum Retirement Age (MRA) + 10 retirement); and
  - you have been continuously enrolled (or covered as a family member) in any FEHB plan(s) for the 5 years of service immediately before the date your annuity starts, or for the full period(s) of service since your first opportunity to enroll (if less than 5 years).
- The 5 year requirement period can include the following:
  - the time you are covered as a family member under another person's FEHB enrollment; or
  - the time you are covered under the Uniformed Services Health Benefits Program (also known as TRICARE) as long as you were covered under an FEHB enrollment at the time of your retirement.
- As an annuitant, you are entitled to the same benefits and Government contributions as Federal employees enrolled in the same plan.
- The event of retirement is not a qualifying life event (QLE); however, there are other opportunities to change FEHB enrollment including during Open Season or when you experience a QLE.
- If you are not enrolled in FEHB (or covered as a family member) at the time of your retirement, you cannot enroll when you retire.
- If you are enrolled in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) at the time of your retirement, you can still contribute to your HSA provided you have no other insurance coverage other than those specifically allowed, and are not claimed as a dependent on someone else's tax return. Some examples of other coverage that would cause ineligibility are: Medicare, TRICARE, other non-high deductible health insurance, or having received VA benefits within the previous three months. If you don't qualify for an HSA, your plan will enroll you in a Health Reimbursement Arrangement (HRA).
- If you cancel your FEHB enrollment as an annuitant, you will never be able to re-enroll in FEHB **unless** you had suspended your FEHB enrollment because you are now covered by a Medicare Advantage plan, TRICARE or CHAMPVA, or Medicaid or similar State-sponsored program of medical assistance, or Peace Corps Volunteer coverage.
- If you want your surviving family members to continue your health benefits enrollment after your death, you must be enrolled for Self and Family at the time of your death, and at least one family member must be entitled to an annuity as your survivor.
- Consider whether you need to sign-up for Medicare when you become eligible.

Federal Benefits Facts *continued*

FEDVIP

- There is no 5 year requirement for continuing FEDVIP coverage into retirement.
- Your coverage will continue as a retiree. Retirees may also enroll during the annual Federal Benefits Open Season or when you experience a qualifying life event (QLE). Keep in mind that **retirement is not a QLE**.
- In most cases, changing from payroll deduction to annuity deduction is automatic, but may take one to three months to occur.
- BENEFEDS cannot deduct premiums from your annuity while you are receiving "special" or "interim" pay. Once your annuity is finalized, premium deductions will begin. If you miss one or more premium payments before your annuity is final, BENEFEDS will make double deductions until any balance due is paid. They will notify you before deducting this additional premium amount. Once there is no past due balance, the amount of premium deducted will return to the regular monthly premium.

FEGLI

- When you retire, you are eligible to continue your FEGLI life insurance coverage(s) if you retire on an immediate annuity and had the coverage for:
  - the five years of service immediately before the starting date of your annuity or, for annuitants retiring under FERS who postpone receiving their annuity, the five years immediately before their separation date for annuity purposes, or
  - all period(s) of service during which that coverage was available to you if it is less than five years, and
  - you (or your assignees) do not convert the coverage to a private policy.
- If you are eligible, you will choose via Standard Form (SF) 2818 how you wish your coverage(s) to continue during your retirement.
- If you are not enrolled in FEGLI at the time of your retirement, you cannot enroll when you retire.
- You cannot newly elect or increase existing coverage after you retire. You may only reduce or cancel coverage.
- Your premiums are subject to change in the future. Your premium could change based on your age and the experience of the Program. You will be notified if there is any change in your deductions from your annuity.

FLTCIP

- Your coverage continues into retirement provided you continue to pay premiums.
- If you pay premiums via payroll deduction, then shortly before you retire, you should notify Long Term Care Partners (LTCP) at 1-800-582-3337 to make other arrangements for premium payment.
- You may elect annuity deduction if you desire. LTCP cannot deduct your premium from "special" or "interim" pay. LTCP will send you a direct bill during this time. Premium deduction will begin from your annuity once it is finalized.

How to Change Enrollment

Do not cancel your enrollment before reading this section.

If you are enrolled and want to change your enrollment in Open Season, use the postcard on the back cover of this booklet to request a registration form to make a change. (Your health plan will send you its brochure. You can use the postcard to order brochures for other plans.)

Cut the postcard along the perforated lines, fill in the information, and mail it to the OWCP address printed on the card. If you order brochures, you will be given another form to make a change.

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 by you 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 Advantage health plan under the Social Security Act or because you are eligible under Medicaid or a similar state-sponsored program of medical assistance for the needy.

For more information on how to suspend your FEHB enrollment, contact the OWCP district office that handles your case.

Time limitations and other restrictions apply. For instance, you must submit documentation that you are suspending FEHB to enroll in a Medicare Advantage health plan or furnish proof of eligibility for coverage under the Medicaid program or similar State-sponsored program of medical assistance for the needy, in case you wish to re-enroll in the FEHB Program at a later time.

If you have suspended FEHB coverage for either one of these reasons (and had 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 Advantage health plan's service area, the Medicare Advantage health plan is discontinued, or you involuntarily lose coverage under the Medicaid Program or similar State-sponsored program of medical assistance for the needy. If you cancelled your coverage for any other reason, you **cannot** reenroll.

Federal Employees Health Benefits (FEHB) Program

What does this Program offer?

The FEHB Program offers a wide variety of plans and coverage to help you meet your health care needs. It is group coverage available to employees, retirees and their eligible family members. If you continuously maintain your FEHB enrollment, or are covered by another FEHB enrollment as a family member, or a combination of both, for the five years of service immediately preceding your retirement, and you retire on an immediate annuity, you can continue to participate in the FEHB Program after retirement. The benefits you receive as a retiree are the same coverage Federal employees receive and at the same cost. If you leave government employment before retiring, the Program offers temporary continuation of coverage (TCC) and an opportunity to convert your enrollment to non-group (private) coverage.

If you are currently enrolled in the FEHB and do not want to change plans or enrollment type, you do not need to do anything. Your enrollment will continue automatically.

Appendix E includes a comparison chart of all the plans in the FEHB with information comparing basic benefits and costs.

Key FEHB facts

- The FEHB Program is part of the annual Federal Benefits Open Season.
- FEHB coverage continues each year. You do not need to re-enroll each year. If you are happy with your current coverage, do nothing. Please note that your premiums and benefits may change.
- You can choose from Consumer-Driven and High Deductible plans that offer catastrophic risk protection with higher deductibles, health savings/reimbursable accounts and lower premiums, or Health Maintenance Organizations or Fee-for-Service plans with comprehensive coverage and higher premiums.
- There are no waiting periods and no pre-existing condition limitations, even if you change plans.
- If you are an active Federal employee, you can use your Health Care Flexible Spending Account or Limited Expense Health Care Flexible Spending Account with your FEHB plan.
- If you participate in premium conversion, enrollment changes can only be made during Open Season or if you experience a qualifying life event. Premium conversion allows Federal employees to use pre-tax dollars to pay their FEHB premiums.
- All nationwide FEHB plans offer international coverage.
- There are separate and/or different provider networks for each plan.
- Utilizing an in-network provider will reduce your out-of-pocket costs.

What enrollment types are available?

- Self Only, which covers only the enrolled employee;
- Self and Family, which covers the enrolled employee and all eligible family members.

How much does it cost?

The premiums for your enrollment are shared by you and your Federal agency or retirement system. The government pays the lesser of: 72% of the average total premium of all plans weighted by the number of enrollees in each, or 75% of the premium for the specific plan you choose. If you are an employee, you automatically pay your share of the premium through a payroll deduction using pre-tax dollars, unless you elect not to participate in Premium Conversion. The charts in Appendix E provide cost information for all plans in the FEHBP.

Am I eligible to enroll?

Most employees are eligible; those who are not eligible usually have limited appointments of short duration, or work sporadically only during certain seasons or when needed by their Federal agency. If you have an appointment other than a career or career conditional appointment and your agency has not provided you information about enrollment, you should contact your human resources office for information.

When you retire, you are eligible to continue health benefits coverage if you retire on an immediate annuity under a retirement system for civilian employees (including FERS MRA + 10 retirement) and you have been continuously enrolled (or covered as a family member) in any FEHB plan(s) for the 5 years of service immediately before the date your annuity starts, or for the full period(s) of service since your first opportunity to enroll (if less than 5 years).

If you suspend your FEHB coverage as a retiree because you are covered by TRICARE or CHAMPVA, a Medicare Advantage Plan, Medicaid, or Peace Corps volunteer coverage, you may re-enroll under certain conditions. (You should contact your retirement system for information on your eligibility.) **If you are not enrolled in or covered as a family member under FEHB when you retire, you will not be able to enroll after retirement.**

Compensationers are generally not eligible to enroll in FEHB if you did not have it at the time you began receiving benefits from OWCP.

When can I enroll?

If you are a new employee who is eligible for FEHB or an employee who has become newly eligible to enroll, you may enroll within 60 days of becoming eligible. You may also enroll during the annual Open Season held from the Monday of the second full work week in November through the Monday of the second full work week in December. Furthermore, you may enroll, change your enrollment type, or change plans outside of Open Season if you experience a qualifying life event such as a change in family or other insurance coverage status. Appendix C contains more specific information about qualifying life events that permit employees to enroll or change enrollment in the FEHB Program.

For new or newly eligible employees who elect to enroll, coverage will be effective on the first day of the first pay period that begins after your agency receives your enrollment. An Open Season enrollment or change is effective on the first day of the first full pay period that begins in January.

Federal Employees Health Benefits (FEHB) Program

How do I enroll?

You may be able to enroll using the Health Benefits Election Form (SF 2809) or through an agency self-service system such as Employee Express, MyPay, Employee Personal Page, or EBIS. Contact the human resources office of your employing agency for details.

How do I get more information about this Program?

Visit the FEHBP online at www.opm.gov/insure/health for information including:

- How to compare and choose among health plans
- Health plan websites and plan brochures
- How to file a disputed claim request
- Getting quality healthcare
- Medicare and FEHB

Did You Know… Health Information Technology can improve your health!

What is Health Information Technology? Health Information Technology (HIT) allows doctors and hospitals to manage medical information and to securely exchange information among patients and providers. In a variety of ways, HIT has a demonstrated benefit in improving health care quality, preventing medical errors, reducing costs, and decreasing paperwork.

What are examples of HIT at work?

- You can go online to review your medical, pharmacy, and laboratory claims information;
- If you complete a Health Risk Assessment (HRA), your health plan can identify you as a candidate for case management or disease management and offer suggestions on healthy lifestyle strategies and how to reduce or eliminate health risks. Health plans can provide you with tips and educational material about good health habits, information about routine care that is age and gender appropriate.
- Physicians can have the very best clinical guidelines at their fingertips for managing and treating diseases;
- While with a patient, a physician can enter a prescription on a computer where potential allergies and adverse reactions are shown immediately;
- Computer alerts are sent to physicians to remind them of a patient's preventive care needs and to track referrals and test results.

One feature of HIT is the **Personal Health Record (PHR)**. The electronic version of your medical records allows you to maintain and manage health information for yourself and your family in a private and secure electronic environment. Some health plans include your medical claims data in your PHR, which gives a more complete picture of your health status and history.

You can also find a PHR on OPM's website at www.opm.gov/insure/health/phr/tools.asp. This PHR is a fillable and downloadable form that you complete yourself and save on your home computer. We encourage you to take a look at this PHR option and, if you determine it will fulfill your record-keeping needs, take advantage of this opportunity.

Price/cost transparency is another element of health information technology. For example, many health plans allow you to use online tools that will show what the plan will pay on average for a specific procedure or for a specific prescription drug. You can also review healthcare quality indicators for physician and hospital services.

The health plans listed on our HIT website at www.opm.gov/insure/health/reference/hittransparency.asp have taken steps to help you become a better consumer of health care and have met OPM's HIT, quality and price/cost transparency standards.

No one is more responsible for your health care than you – HIT tools can help.

Federal Employees Dental and Vision Insurance Program (FEDVIP)

What does this Program offer?

The Federal Employees Dental and Vision Insurance Program provides comprehensive dental and vision insurance at competitive group rates. There are seven dental plans and three vision plans from which to choose. FEDVIP features nationwide, international, and regional plans.

A dental or vision insurance plan is much like a health insurance plan; you may be required to meet a deductible and provide a copay or coinsurance payments for your dental or vision services. With any plan choice, you should look at all the information and find a plan that will best fit your needs. You should also review your FEHB plan brochure to determine what dental and/or vision coverage the FEHB plan provides.

If you are currently enrolled in FEDVIP and you take no action during Open Season, your current coverage will continue in 2011, provided you remain eligible for the program. ***Please Note:*** your premiums and benefits may change for 2011.

Key FEDVIP facts

- FEDVIP is part of the annual Federal Benefits Open Season.
- FEDVIP is separate and different from the FEHB Program.
- The new health care law does not change the age or unmarried requirement for dependents in FEDVIP.
- FEDVIP coverage continues each year. You do not need to re-enroll each year. If you do not want to change plans or enrollment type, do nothing.
- You can only cancel FEDVIP coverage during Open Season, upon deployment to active military duty or upon transfer to another agency where you enroll in their dental and/or vision plan and the agency pays at least 50% of the premium. You cannot cancel just because you retire or because you can no longer afford the premiums.
- If you are enrolled in an FEHB plan, it is a requirement under the FEDVIP law that your FEHB plan function as the first payer. The FEDVIP plan is always the secondary payer to the FEHB plan.
- You can use your Flexible Spending Account (FSA) with FEDVIP. You can submit your FEDVIP copayments and deductibles as eligible expenses against your FSA account.
- Cancellation of coverage can only be made during Open Season, upon deployment to active military duty, or upon transferring to an eligible position.
- All nationwide FEDVIP plans provide international coverage.
- There are separate and/or different provider networks for each plan.
- Utilizing an in-network provider will reduce your out-of-pocket costs.
- There are no pre-existing condition limitations for enrollment.
- There is no opportunity to convert to a private plan when your FEDVIP coverage ends.

Appendix I lists the available dental and vision insurance plans along with basic benefit information.

Federal Employees Dental and Vision Insurance Program (FEDVIP)

How much does it cost?

You pay the entire premium. There is no government contribution to the premium. If you are an active employee, your premiums are taken from your salary on a pre-tax basis if your salary is sufficient to make the premium withholding. When you retire, premiums are withheld from your monthly annuity check on a post-tax basis if your annuity is sufficient.

Premiums for the nationwide dental plans and one regional dental plan are based on where you live. This is called your rating region. Your home ZIP code is used to find your rating region. Rating regions vary by carrier. The vision plans do not have rating regions. Enrolling in a FEDVIP plan will not reduce your FEHB premium.

See Appendices J and K to find 1) the rating region assigned to the area where you live by the different dental plans and 2) the related premium you will pay or go to our website at www.opm.gov/insure/dental and www.opm.gov/insure/vision.

Am I eligible to enroll?

In general, Federal employees eligible for FEHB coverage (whether or not actually enrolled) and retirees (regardless of FEHB status) are eligible to enroll in a dental and/or vision plan. Former spouses and deferred annuitants are NOT eligible to enroll. Anyone receiving an insurable interest annuity who is not also an eligible family member is NOT eligible to enroll.

When can I enroll?

If you are a new employee eligible for FEDVIP, or an employee who has become newly eligible to enroll, you may enroll within 60 days of first becoming eligible. This is a one-time opportunity outside of Open Season to enroll. There is a separate 60-day enrollment period for dental and vision. For example: you may enroll in a dental plan on day 30 and a vision plan on day 59. Once you enroll, your 60 day opportunity for that type of plan ends.

An eligible employee or retiree may also enroll during the annual Federal Benefits Open Season, which runs from the Monday of the second full work week in November through the Monday of the second full work week in December. An eligible employee or retiree may enroll, cancel, or change enrollment type or options during Open Season. They may enroll or make changes outside of Open Season if they experience a qualifying life event (QLE) such as a change in family or other insurance coverage status. Please see Appendix H for more information about QLEs that permit employees and retirees to enroll or make changes in FEDVIP.

If you enroll during Open Season, premiums are deducted beginning the first full pay period on or after January 1. For new or newly eligible employees who elect to enroll, coverage is effective the first day of the pay period following the one in which BENEFEDS receives your enrollment. An Open Season enrollment or change is effective January 1.

How do I enroll?

You may enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM. For those without access to a computer, please call 1-877-888-FEDS (1-877-888-3337) (TTY number, 1-877-889-5680).

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

What should I consider in making my decision to participate in this Program?

There are questions you should ask yourself when deciding to enroll in FEDVIP or selecting a FEDVIP plan. By considering these questions thoroughly, you will be able to determine if FEDVIP is a good option for you.

1. Does my FEHB plan provide dental or vision coverage?

2. Does the FEDVIP plan coordinate benefits with the FEHB plan and how is the coordination of benefits calculated?

3. How affordable is the plan?
   - How much will it cost me on a bi-weekly or monthly basis? Can I afford that for an entire year?
   - Must I pay a deductible?
   - If I use a FEDVIP provider outside of the network, how much will I pay to get care?
   - How frequently can I visit the dentist and how much do I have to pay at each visit?
   - Will the plan provide benefits if I am also covered by another dental or vision plan?

4. Do I have access to any provider?
   - Does the plan give me the freedom to choose my own dentist or am I restricted to a panel of dentists selected by the plan?
   - Are there enough of the kinds of dentists I want to see?
   - Where will I go for care? Are these places near where I work or live?
   - Do I need to get permission before I see a dental specialist?
   - Will the plan allow referrals to specialists? Will my dentist and I be able to choose the specialist?

5. Does the plan provide coverage for specialty services?
   - Are dentures, orthodontics, implants or replacement of missing teeth covered?
   - What are the plan's limitations or exclusions?
   - Are there annual limits on the types of services included?

Federal Employees Dental and Vision Insurance Program (FEDVIP)

How do I find my premium rate?

If you live outside the United States:
Go to Appendix K for your dental and vision premium rates.

If you live inside the United States:
Go to Appendix K for your vision premium rate. To find your bi-weekly or monthly dental premium, you must first find your rating area on the chart in Appendix J. Some plans may have changed their rating regions for the upcoming plan year.

Please Note: If you are currently enrolled and have moved or your postal service has assigned you a new ZIP code, your rating region may have changed.

1. To find your dental rating area:
   a. Go to the chart in Appendix J.
   b. Find your state and your corresponding Zip code (1st 3 digits).
   c. Look under the plan name and you will find your rating area.
2. To find your bi-weekly or monthly dental premium, match your rating area with your desired FEDVIP plan on the chart in Appendix K.

Making an informed choice

- Before selecting a plan that best suits your needs, ask your carrier or access the OPM website for a copy of the plan brochure.
- If you have questions about coverage, exclusions, limitations or payment of benefits, ask the plan before making your plan selection.
- Find out which plan your provider participates in and why. Keep in mind that if your provider leaves the plan, this is not a qualifying life event allowing a change or cancellation.

How do I get more information about this Program?

Visit FEDVIP online at www.opm.gov/insure/dental and www.opm.gov/insure/vision for information including:

- How to enroll
- FEDVIP plan websites, brochures, and provider searches
- Dental premium rates
- Vision premium rates

What Happens to My Life Insurance Coverage When I am on Compensation?

During your first 12 months in nonpay status while you are receiving workers' compensation from the Department of Labor, you remain covered as an employee. When you separate from service or end 12 months of nonpay status (whichever happens first), your FEGLI as an employee stops. However, you may be able to continue your life insurance as a compensationer. You may continue it if you meet all of the following requirements:

- On the day you separate from service or on the day you end 12 months of nonpay status, you are still receiving compensation payments;
- The Department of Labor has determined that you are unable to return to duty;
- You have been insured for the 5 years of service immediately before the date compensation starts, or for the full period(s) of service during which you were eligible to be insured if less than 5 years; and
- You have not converted your life insurance coverage to an individual policy. (if you have already converted the coverage before it is determined you are eligible to continue your coverage, you must void the conversion policy. To void the conversion policy, contact the insurance company. That company will send you a refund of any premiums you have already paid for the conversion policy.)

Note: The year of continued coverage while in nonpayment status cannot be counted toward meeting the 5-year requirement. You must meet the 5 -year/all opportunity requirement as of the date compensation begins.

Basic Insurance in Retirement/Compensation

The amount of your Basic insurance in retirement is your BIA (Basic Insurance Amount) at the time you separated as an employee. This amount continues until you reach age 65, after which it may reduce based on the election options described below. You will not have Accidental Death and Dismemberment coverage in retirement.

When you retire, you must choose the type of reduction you want by completing a Continuation of Life Insurance Coverage as a Retiree or Compensationer (SF 2818) provided by your human resources office. For Basic insurance, you must choose 75% Reduction, 50% Reduction, or No Reduction. You can change to 75% Reduction at any time; your coverage will be as if you had originally elected 75% Reduction and your "extra premium" will stop. You will not receive a refund of premiums.

- ***What is 75% Reduction?***
  This means your Basic insurance will reduce by 2% of the pre-retirement amount each month. The reduction starts at the beginning of the second month after your 65th birthday or at retirement, whichever is later. Your Basic insurance will continue to reduce until 25% of the pre-retirement amount remains. Your Basic insurance is free once it starts to reduce.
- ***What is 50% Reduction?***
  This means your Basic insurance will reduce by 1% of the pre-retirement amount each month. The reduction starts at the beginning of the second month after your 65th birthday or at retirement, whichever is later. Your Basic insurance will continue to reduce until 50% of the pre-retirement amount remains. When you turn 65, your "regular" premium for Basic insurance stops, but you continue to pay an extra premium for this choice. See page 21 for these premiums.
- ***What is No Reduction?***
  This means your Basic insurance will not reduce. When you turn 65, your "regular" premium for Basic insurance stops, but you continue to pay an extra premium for this choice. See page 21 for these premiums.

Optional Insurance in Retirement/Compensation

The amount of your Optional insurance in retirement depends on the options you had at the time you separated as an employee. This amount continues until you reach age 65, unless you elect No Reduction (for Option B and Option C only.)

- **Option A - Standard:**

  If you are eligible to continue Option A into retirement, it will reduce by 2% of the pre-retirement amount each month until it reaches 25% of the pre-retirement amount. The reduction starts at the beginning of the second month after your 65th birthday or at retirement, whichever is later. Option A is free once it starts to reduce. You cannot choose No Reduction for Option A.

  If you are eligible to continue Option B and/or Option C into retirement, you must choose whether you want these options to reduce, as explained below.

- **Option B - Additional:**

  If you retire before age 65, you have two choices at retirement: Full Reduction for all of your multiples or No Reduction for all of your multiples. At age 65, or at retirement, if later, you will be able to choose the number of multiples that will reduce.*

  If you choose Full Reduction, the value of your Full Reduction Option B multiples will reduce by 2% of the pre-retirement amount each month for 50 months, at which time coverage on those multiples will end. The reduction starts at the beginning of the second month after your 65th birthday or at retirement, whichever is later. Option B Full Reduction multiples are free once the reductions start.

  If you choose No Reduction, the value of your No Reduction Option B multiples will not reduce. You will continue to pay the full premium for all No Reduction multiples until you die, change those multiples to Full Reduction, or cancel those multiples. If you choose No Reduction, you can change to Full Reduction at any time (unless you assigned your coverage. Then, only your assignee can change). However, if you change to Full Reduction after you reach age 65, the level of coverage you have will be as if you had originally elected Full Reduction. You will not receive a refund of premiums.

- **Option C - Family:**

  If you retire before age 65, you have two choices at retirement: Full Reduction for all of your multiples or No Reduction for all of your multiples. At age 65, or at retirement, if later, you will be able to choose the number of multiples that will reduce.*

** At press time, new FEGLI regulations were awaiting enactment. These proposed regulations allow the employee to choose the number of multiples to reduce or not reduce at the time of retirement. For example, if the employee has three multiples, he can elect to have two with Full Reduction and one with No Reduction. There will be no second election at age 65. Visit www.opm.gov/insure/life for the latest updates.*

If you choose Full Reduction, the value of your Full Reduction Option C multiples will reduce by 2% of the pre-retirement amount each month for 50 months, at which time coverage on those multiples will end. The reduction starts at the beginning of the second month after your 65th birthday or at retirement, whichever is later. Option C Full Reduction multiples are free once the reductions start.

If you choose No Reduction, the value of your No Reduction Option C multiples will not reduce. You will continue to pay the full premium for all No Reduction multiples until you die, change those multiples to Full Reduction, or cancel those multiples. If you choose No Reduction, you can change to Full Reduction at any time. However, if you change to Full Reduction after you reach age 65, the level of coverage you have will be as if you had originally elected Full Reduction. You will not receive a refund of premiums.

Basic Insurance — Compensationers*
Cost For Each $1,000 Of Your Basic Insurance Amount[1] Every 28 Days

You Have Full Coverage To Age 65 Then:	**Before You Reach Age 65 You Pay the TOTAL of BOTH the Regular Premium and the Extra Premium**			**After You Reach Age 65,[2] Continuing for Life**
	Regular Premium	Extra Premium for 50% or No Reduction	Total Cost	
75% Reduction — reduces 2% of the BIA' each month after you reach age 65[3], until 25% of the amount at retirement remains.	$0.30	N/A	$0.30	N/A
50% Reduction — reduces 1% of the BIA' each month after you reach age 65[3], until 50% of the amount at retirement remains.	$0.30	$0.56	$0.86	$0.56
No Reduction—100% of the BIA[1] remains for life.	$0.30	$1.68	$1.98	$1.68

** These are the current rates as of this publication date. They may change in future years. For more information, see the FEGLI website at www.opm.gov/insure/life.*

[1] Basic Insurance Amount (BIA)— Your final annual rate of basic pay, rounded to the next even $1,000, plus $2,000 (or a minimum of $10,000) (or the post-election BIA you had after your election of a partial Living Benefit). Your BIA does not include the Extra Benefit or Accidental Death and Dismemberment coverage.

[2] The regular premium automatically stops on the first day of the month after you reach age 65. If you retire after reaching 65, you do not pay the regular premium.

[3] The reduction starts at the beginning of the second month after your 65th birthday or at retirement, whichever is later.

Federal Long Term Care Insurance Program (FLTCIP)

What does this Program offer?

The FLTCIP offers insurance that helps cover the costs of certain long term care services. Long term care is the assistance you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment, such as Alzheimer's disease. Long term care can be provided in a facility, like a nursing home, but is most often provided at home.

Key FLTCIP facts

- The FLTCIP is **not** part of the annual Federal Benefits Open Season.
- You must apply and answer questions about your health to find out if you are eligible to enroll.
- You can apply for coverage at any time using the full underwriting application; you do not have to wait for an Open Season.
- New/newly eligible employees and their spouses and newly married spouses of employees can apply with abbreviated underwriting (fewer questions about their health) within 60 days of becoming eligible.
- Qualified family members including same-sex domestic partners can also apply, with full underwriting.
- Once enrolled, you can keep your coverage even if you are no longer in an eligible group (for example, you leave your job with the Federal Government).

How much does it cost?

If you are approved for coverage, your premium is based on your age on the date your application is received and on the benefit options you select. You may pay your premiums through deductions from pay or annuity, by automatic bank withdrawal, or by direct bill.

PLEASE NOTE: Your premiums do not change because you get older or your health changes after your coverage becomes effective. However, premiums are not guaranteed. We may only increase premiums if you are among a group of enrollees whose premium is determined to be inadequate.

Am I eligible to apply?

Most Federal employees are eligible to apply for coverage; those who are not eligible usually have limited appointments of short duration, or work sporadically only during certain seasons or when needed by their Federal agency. If you are eligible for the FEHB Program you are eligible to apply for coverage under the FLTCIP, even if you are not enrolled in the FEHB Program. Retirees are eligible to apply. Spouses, adult children, and same-sex domestic partners of eligible employees and retirees may also apply, as well as parents, parents-in-law, and stepparents of employees (but not of retirees).

Federal Long Term Care Insurance Program (FLTCIP)

How do I apply?

You apply by completing an application found at www.ltcfeds.com or by calling 1-800-LTC-FEDS. You must pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.

If you are a new or newly eligible employee, you (and your spouse, if applicable) have 60 days to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have 60 days to apply using abbreviated underwriting.

You and your qualified relatives, including same-sex domestic partners may apply anytime using the full underwriting application.

What should I consider in making my decision to participate in this Program?

Remember that FEHB plans do not cover the cost of long term care. While Medicare covers some care in nursing homes and at home, it does so only for a limited time, subject to restrictions. The need for long term care can strike anyone at any age and the cost of care can be substantial.

Be sure to visit www.ltcfeds.com for the most up-to-date information about the FLTCIP before deciding whether to apply.

How do I get more information about this Program?

Call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Appendix A
FEHB 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. You can choose Self Only coverage just for you, or Self and Family coverage for you, your spouse, and children under age 26. Under certain circumstances, your FEHB enrollment may cover your disabled child 26 years old or older who is incapable of self-support.

A choice of plans and options. The FEHB Program offers Fee-for-Service plans, plans offering a Point-of-Service product, Health Maintenance Organizations, High Deductible Health Plans, and Consumer-Driven Health Plans.

A Government contribution. The Government pays 72 percent of the average premium of all plans toward the total cost of your premium, but not more than 75 percent of the total premium for any plan.

Salary deduction. You pay your share of the premium through a payroll deduction and have the choice of doing so using pretax dollars.

Annual enrollment opportunities. Each year you can enroll or change your health plan enrollment during Open Season. Open Season runs from the Monday of the second full work week in November through the Monday of the second full work week in December. Other events allow for certain types of changes throughout the year; see your human resources office or retirement system for details.

Continued group coverage. The FEHB Program offers continued FEHB coverage:

* for you and your family when you retire from Federal service (normally you need to be covered under the FEHB Program for the five years of service immediately before you retire),
* for your former spouse if you divorce and he or she has a qualifying court order (see your human resources office for more information),
* for your family if you die, or
* for you and your family when you move, transfer, go on leave without pay, or enter military service (certain rules about coverage and premium amounts apply; see your human resources office).

Coverage after FEHB ends. The FEHB Program offers temporary continuation of coverage (TCC) and conversion to non-group (private) coverage:

* for you and your family if you leave Federal service (including when you are not eligible to carry FEHB into retirement),
* for your covered child if he or she turns age 26, or
* for your former spouse if you divorce and he or she does not have a qualifying court order (see your human resources office for more information).

If you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB plan to cover you. If not, the plan must give you one on request. This certificate may be important to qualify for benefits if you join a non-FEHB plan.

Appendix B
Choosing an FEHB Plan

What type of health plan is best for you?

You have some basic questions to answer about how you pay for and access medical care. Here are the different types of plans from which to choose.

	Choice of doctors, hospitals, pharmacies, and other providers	Specialty care	Out-of-pocket costs	Paperwork
Fee-for-Service w/PPO (Preferred Provider Organization)	You must use the plan's network to reduce your out-of-pocket costs. Not using PPO providers means only some or none of your claims will be paid.	Referral not required to get benefits.	You pay fewer costs if you use a PPO provider than if you don't.	Some, if you don't use network providers.
Health Maintenance Organization	You generally must use the plan's network to reduce your out-of-pocket costs.	Referral generally required from primary care doctor to get benefits.	Your out-of-pocket costs are generally limited to copayments.	Little, if any.
Point-of-Service	You must use the plan's network to reduce your out-of-pocket costs. You may go outside the network but you will pay more.	Referral generally required to get maximum benefits.	You pay less if you use a network provider than if you don't.	Little, if you use the network. You have to file your own claims if you don't use the network.
Consumer-Driven Plans	You may use network and non-network providers. You will pay more by not using the network.	Referral not required to get maximum benefits from PPOs.	You will pay an annual deductible and cost-sharing. You pay less if you use the network.	Some, if you don't use network providers.
High Deductible Health Plans w/Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA)	Some plans are network only, others pay something even if you do not use a network provider.	Referral not required to get maximum benefits from PPOs.	You will pay an annual deductible and cost-sharing. You pay less if you use the network.	If you have an HSA or HRA account, you may have to file a claim to obtain reimbursement.

Appendix B
Choosing an FEHB Plan

What should you consider when choosing a plan?
Having a variety of plans to choose from is a good thing, but it can make the process confusing. We have a tool on our website that will help you narrow your plan choice based on the benefits that are important to you; go to www.opm.gov/insure/health/search/plansearch.aspx. You can also find help in selecting a plan using tools provided by PlanSmartChoice and Consumer's Checkbook at www.opm.gov/insure/health/planinfo/index.asp.

Ask yourself these questions:

1. **How much does the plan cost?** This includes the premium you pay.

2. **What benefits does the plan cover?** Make sure the plan covers the services or supplies that are important to you, and know its limitations and exclusions.

3. **What are my out of pocket costs?** Does the plan charge a deductible (the amount you must first pay before the plan begins to pay benefits)? What is the copayment or coinsurance (the amount you share in the cost of the service or supply)?

4. **Who are the doctors, hospitals, and other care providers I can use?** Your costs are lower when you use providers who are part of the plan; these are "in-network" providers.

5. **How well does my plan provide quality care?** Quality care varies from plan to plan, and here are three sources for reviewing quality.

   * Member survey results – evaluations by current plan members are posted within the health plan benefit charts in this Guide.

   * Effectiveness of care – how a plan performs in preventing or treating common conditions is measured by the Healthcare Effectiveness Data and Information Set and is found at www.opm.gov/insure/health/planinfo/quality/hedis.aspx.

   * Accreditation – evaluations of health plans by independent accrediting organizations. Check the cover of your health plan's brochure for its accreditation level or go to http://reportcard.ncqa.org/plan/external/plansearch.aspx.

Appendix B
Choosing an FEHB Plan

Definitions

Brand name drug - A prescription drug that is protected by a patent, supplied by a single company, and marketed under the manufacturer's brand name.

Coinsurance - The amount you pay as your share for the medical services you receive, such as a doctor's visit. Coinsurance is a percentage of the plan's allowance for the service (you pay 20%, for example).

Copayment - The amount you pay as your share for the medical services you receive, such as a doctor's visit. A copayment is a fixed dollar amount (you pay $15, for example).

Deductible - The dollar amount of covered expenses an individual or family must pay before the plan begins to pay benefits. There may be separate deductibles for different types of services. For example, a plan can have a prescription drug benefit deductible separate from its calendar year deductible.

Formulary or Prescription Drug List - A list of both generic and brand name drugs, often made up of different cost-sharing levels or tiers, that are preferred by your health plan. Health plans choose drugs that are medically safe and cost effective. A team including pharmacists and physicians determines the drugs to include in the formulary.

Generic Drug - A generic medication is an equivalent of a brand name drug. A generic drug provides the same effectiveness and safety as a brand name drug and usually costs less. A generic drug may have a different color or shape than the brand name, but it must have the same active ingredients, strength, and dosage form (pill, liquid, or injection).

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.

Out-of-Network - You receive treatment from doctors, clinics, health centers, hospitals, and medical practices other than those with whom the plan has an agreement at additional cost. Members who receive services outside the network may pay all charges.

Premium Conversion - A program to allow Federal employees to use pre-tax dollars to pay health insurance premiums to the Federal Employees Health Benefits (FEHB) Program. Based on Federal tax rules, employees can deduct their share of health insurance premiums from their taxable income, which reduces their taxes.

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

Qualifying Life Events - An event that may allow participants in the FEHB Program to change their health benefits enrollment outside of an Open Season. These events also apply to employees under premium conversion and include such events as change in family status, loss of FEHB coverage due to termination or cancellation, and change in employment status.

Additional definitions are located at the beginning of the sections introducing the different types of health plans.

Appendix C
Qualifying Life Events (QLEs) that May Permit a Change in Your FEHB Enrollment

Premium Conversion allows employees who are eligible for FEHB the opportunity to pay their share of FEHB premiums with pre-tax dollars. Premium conversion plans are governed by the Internal Revenue Code, and IRS rules govern when a participant may change his or her enrollment outside of the annual Open Season. When an employee experiences a qualifying life event, changes to the employee's FEHB enrollment may be permitted. Individuals who don't participate in Premium Conversion (retirees and employees who waived participation) may cancel their enrollment or change to Self Only at any time.

Below is a brief list of the more common QLEs. Be aware that time limits apply for requesting changes. A complete listing of QLEs can be found at www.opm.gov/forms/pdf_fill/sf2809.pdf. For more details about these and other QLEs, contact the human resources office of your employing agency.

	From Not Enrolled to Enrolled	**From Self Only to Self and Family**	**From One Plan or Option to Another**	**Cancel or Change to Self Only**
Change in family status that results in increase or decrease in number of eligible family members.	Yes	Yes	Yes	Yes
Any change in employee's employment status that could result in entitlement to coverage.	Yes	Not Applicable	Not Applicable	Not Applicable
Employee restored to civilian position after serving in uniformed services.	Yes	Yes	Yes	Yes
Employee (or covered family member) enrolled in an FEHB health maintenance organization (HMO) moves or becomes employed outside the geographic area from which the FEHB carrier accepts enrollment or, if already outside the area, moves further from this area.	Not Applicable	Yes	Yes	Not Applicable
Employee or eligible family member loses coverage under FEHB or another group insurance plan.	Yes	Yes	Yes	Yes
Enrolled employee or eligible family member gains coverage under FEHB or another group insurance plan.	No	No	No	Yes

Appendix D
FEHB Member Survey Results

Each year Federal Employees Health Benefits plans with 500 or more subscribers mail the Consumers Assessment of Healthcare Providers and Systems (CAHPS)[1] to a random sample of plan members. For Health Maintenance Organizations (HMO)/Point-of-Service (POS) and High Deductible Health Plans (HDHP) and Consumer-Driven Health Plans (CDHP), the sample includes all commercial plan members, including non-Federal members. For Fee-for-Service (FFS)/Preferred Provider Organization (PPO) plans, the sample includes Federal members only. The CAHPS survey asks questions to evaluate members' satisfaction with their health plans. Independent vendors certified by the National Committee for Quality Assurance administer the surveys.

OPM reports each plan's scores on the various survey measures by showing the percentage of satisfied members on a scale of 0 to 100. Also, we list the national average for each measure. Since we offer HMO plans, FFS/PPO plans, HDHP, and CDHP plans, we compute a separate national average for each plan type.

Survey findings and member ratings are provided for the following key measures of member satisfaction:

- Overall Plan Satisfaction – This measure is based on the question, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?" We report the percentage of respondents who rated their plan 8 or higher.

- Getting Needed Care – How often was it easy to get an appointment, the care, tests, or treatment you thought you needed through your health plan?

- Getting Care Quickly – When you needed care right away, how often did you get care as soon as you thought you needed? Not counting the times you needed care right away, how often did you get an appointment at a doctor's office or clinic as soon as you thought you needed?

- How Well Doctors Communicate – How often did your personal doctor explain things in a way that was easy to understand? How often did your personal doctor listen carefully to you, show respect for what you had to say, and spend enough time with you?

- Customer Service – How often did the written materials or the Internet provide the information you needed about how your health plan works? How often did your health plan's customer service give you the information or help you needed? How often were the forms from your health plan easy to fill out?

- Claims Processing – How often did your health plan handle your claims quickly and correctly?

- Plan Information on Costs – How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment, or for specific prescription drug medicines?

In evaluating plan scores, you can compare individual plan scores against other plans and against the national averages. Generally, new plans and those with fewer than 500 FEHB subscribers do not conduct CAHPS. Therefore, some of the plans listed in the Guide will not have survey data.

[1] *CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).*

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Appendix E
FEHB Plan Comparison Charts

Nationwide Fee-for-Service Plans
(Pages 32 through 35)

Fee-for-Service (FFS) plans with a Preferred Provider Organization (PPO) – A Fee-for-Service plan provides flexibility in using medical providers of your choice. You may choose medical providers who have contracted with the health plan to offer discounted charges. You may also choose medical providers who do not contract with the plan, but you will pay more of the cost.

Medical providers who have contracts with the health plan (Preferred Provider Organization or PPO) have agreed to accept the health plan's reimbursement. You usually pay a copayment or a coinsurance amount and do not file claims or other paperwork. Going to a PPO hospital does not guarantee PPO benefits for all services received in the hospital, however. Lab work, radiology, and other services from independent practitioners within the hospital are frequently not covered by the hospital's PPO agreement. If you receive treatment from medical providers who are not contracted with the health plan, you either pay them directly and submit a claim for reimbursement to the health plan or the health plan pays the provider directly according to plan coverage, and you pay a deductible, coinsurance or the balance of the billed charge. In any case, you pay a greater amount in out-of-pocket costs.

PPO-only – A PPO-only plan provides medical services only through medical providers that have contracts with the plan. With few exceptions, there is no medical coverage if you or your family members receive care from providers not contracted with the plan.

Fee-for-Service plans open only to specific groups – Several Fee-for-Service plans that are sponsored or underwritten by an employee organization strictly limit enrollment to persons who are members of that organization. If you are not certain if you are eligible, check with your human resource office first.

The Health Maintenance Organization (HMO) and Point-of-Service (POS) section begins on page 37.

The High Deductible Health Plan (HDHP) and Consumer-Driven Health Plan (CDHP) section begins on page 62.

Nationwide Fee-for-Service 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*. 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 **Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

Doctors shows what you pay for inpatient surgical services and for office visits.

Your share of **Hospital Inpatient Room and Board** covered charges is shown.

Plan Name: Open to All	Telephone Number	Enrollment Code		Twice - Biweeky Premium Your Share	
		Self only	Self & family	Self only	Self & family
APWU Health Plan (APWU) -high	800-222-2798	471	472	110.10	248.94
Blue Cross and Blue Shield Service Benefit Plan (BCBS) -std	Local phone #	104	105	172.78	398.40
Blue Cross and Blue Shield Service Benefit Plan (BCBS) -basic	Local phone #	111	112	104.64	245.06
GEHA Benefit Plan (GEHA) -high	800-821-6136	311	312	162.64	383.70
GEHA Benefit Plan (GEHA) -std	800-821-6136	314	315	79.98	181.90
Mail Handlers Benefit Plan (MH) -std	800-410-7778	454	455	202.86	483.20
Mail Handlers Benefit Plan Value (MHV)	800-410-7778	414	415	65.98	157.30
NALC -high	888-636-6252	321	322	148.28	302.14
SAMBA -high	800-638-6589	441	442	249.46	630.42
SAMBA -std	800-638-6589	444	445	115.80	264.44
Plan Name: Open Only to Specific Groups					
Compass Rose Health Plan (CRHP) -high	800-634-0069	421	422	117.80	285.82
Foreign Service Benefit Plan (FS) -high	202-833-4910	401	402	113.98	282.62
Panama Canal Area Benefit Plan (PCABP) -high*	800-424-8196	431	432	94.44	197.12
Rural Carrier Benefit Plan (Rural) -high	800-638-8432	381	382	160.98	266.72

Prescription Drug Payment Levels Plans use a variety of terms to define what you pay for prescription drugs such as *generic, brand name, Tier I, Tier II, Level I, etc*. The 2 to 3 payment levels that plans use follow: **Level I** includes most generic drugs, but may include some preferred brands. **Level II** may include generics and preferred brands not included in Level I. **Level III** includes all other covered drugs, with some exceptions for specialty drugs. Many plans are basing how much you pay for prescription drugs on what they are charged.

Mail Order Discounts If your plan has a Mail Order progrram and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order), your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

The prescription drug copayments or coinsurances described in this chart do not represent the complete range of cost-sharing under these plans. Many plans have variations in their prescription drug benefits (e.g., you pay the greater of a dollar amount or a percentage, or you pay one amount for your first prescription and then a different amount for refills). **You must read the plan brochure for a complete description of prescription drug and all other benefits.**

Plan	Benefit Type	Medical-Surgical – You Pay								
		Deductible			Copay ($)/Coinsurance (%)					
		Per Person		Hospital Inpatient	Doctors		Hospital Inpatient R&B	Prescription Drugs		
		Calendar Year	Prescription Drug		Office Visits	Inpatient Surgical Services		Level I	Level II / Level III	Mail Order Discounts
APWU -high	PPO	$275	None	None	$18	10%	10%	$8	25%/25%	Yes
	Non-PPO	$500	None	$300	30%+diff.	30%+diff.	30%	50%	50%/50%	Yes
BCBS -std	PPO	$350	None	$250	$20	15%	Nothing	20%	30%/30%	Yes
	Non-PPO	$350	None	$350	35%	35%	35%	45% +	45%+/45%+	Yes
BCBS -basic	PPO	None	None	$150/day x 5	$25	$150	Nothing	$10	$40/$50 or 50%	N/A
GEHA -high	PPO	$350	None	$100	$20	10%	Nothing	$5	25% Max $150/N/A	Yes
	Non-PPO	$350	None	$300	25%	25%	Nothing	$5	25% Max $150 +/N/A	Yes
GEHA -std	PPO	$350	None	None	$10	15%	15%	$5	50% Max $200/N/A	Yes
	Non-PPO	$350	None	None	35%	35%	35%	$5	50% Max $200 +/N/A	Yes
MH -std	PPO	$400	None	$200	$20	10%	Nothing	$10	30%($200 max)/50%($200 max)	Yes
	Non-PPO	$600	None	$500	30%	30%	30%	50%	50%/50%	Yes
MH Value	PPO	$600	None	None	$30	20%	20%	$10	50%/50%	Yes
	Non-PPO	$900	Not Covered	None	40%	40%	40%	Not Covered	Not Covered	Yes
NALC -high	PPO	$300	None	$200	$20	15%	Nothing	20%	30%/30%	Yes
	Non-PPO	$300	None	$350	30%	30%	30%	45% 45%+	45%+/45%+	Yes
SAMBA -high	PPO	$300	None	$200	$20	10%	Nothing	$10	15%($55 max)/30%($90 max)	Yes
	Non-PPO	$300	None	$300	30%	30%	30%	$10	15%($55 max)/30%($90 max)	Yes
SAMBA -std	PPO	$350	None	$200	$20	15%	Nothing	$10	25%($70 max)/35%($100 max)	Yes
	Non-PPO	$350	None	$300	30%	30%	30%	$10	25%($70 max)/35%($100 max)	Yes
CRHP	PPO	$300	None	$150	$10	10%	Nothing	$5	$30/30% or $45	Yes
	Non-PPO	$300	None	$350	30%	30%	30%	$5	$30/30% or $45	Yes
FS	PPO	$300	None	Nothing	10%	10%	Nothing	$10	25%/30%+$50 min	Yes
	Non-PPO	$300	None	$200	30%	30%	20%	$10	25%/30%+$50 min	Yes
PCABP	POS	None	None	$25	$5	Nothing	Nothing	20%	20%/20%	No
	FFS	None	None	$100	50%	50%	50%	20%	20%/20%	No
Rural	PPO	$350	$200	$100	$20	10%	Nothing	30%	30%/30%	Yes
	Non-PPO	$400	$200	$300	25%	20%	20%	30%	30%/30%	Yes

*The Panama Canal Area Plan provides a Point-of-Service product within the Republic of Panama.

Nationwide Fee-for-Service Plans

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. See Appendix D for a fuller explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• How often was it easy to get an appointment, the care, tests, or treatment you thought you needed through your health plan?
Getting Care Quickly	• When you needed care right away, how often did you get care as soon as you thought you needed? • Not counting the times you needed care right away, how often did you get an appointment at a doctor's office or clinic as soon as you thought you needed?
How Well Doctors Communicate	• How often did your personal doctor explain things in a way that was easy to understand? • How often did your personal doctor listen carefully to you, show respect for what you had to say, and spend enough time with you?
Customer Service	• How often did written materials or the Internet provide the information you needed about how your health plan works? • How often did your health plan's customer service give you the information or help you needed? • How often were the forms from your health plan easy to fill out?
Claims Processing	• How often did your health plan handle your claims quickly and correctly?
Plan Information on Costs	• How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment, or for specific prescription drug medicines?

		Member Survey Results						
Plan Name: Open to All	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
FFS National Average		**78.9**	**92.1**	**92.2**	**94.4**	**89.7**	**92.6**	**74.6**
APWU Health Plan -high	47 47	78.4	91.8	93.6	94.6	86.4	89.7	76.9
Blue Cross and Blue Shield Service Benefit Plan -std	10 10	80.5	93.9	92.5	94.9	89.7	95.6	73.8
Blue Cross and Blue Shield Service Benefit Plan -basic	11	73.9	93.1	89.6	94.9	92	94.6	73
GEHA Benefit Plan -high	31 31	85.8	93.9	92.1	95.1	93.3	97	76.7
GEHA Benefit Plan -std	31 31	76.6	90.5	90	94.4	90.1	93.9	73.4
Mail Handlers Benefit Plan -std	45 45	78.8	92.4	91.8	94.6	90.4	94.1	69
Mail Handlers Benefit Plan Value	41 41	52.4	84.6	89	94.1	86.6	84.5	66.5
NALC -high	32 32	84.8	94	92.8	93.4	89.7	94.5	77.8
SAMBA -high	44 44	85.9	94.7	94.1	95.7	90.9	94.9	79.2
SAMBA -std	44 44	82.6	93.6	93.9	95.2	93.1	93.8	77.7
Plan Name: Open Only to Specific Groups								
FFS National Average		**78.9**	**92.1**	**92.2**	**94.4**	**89.7**	**92.6**	**74.6**
Compass Rose Health Plan	42 42	86.4	93.9	95.1	93.6	92.4	94.9	78.2
Foreign Service Benefit Plan	40 40	75.7	87.1	92.7	93	83.5	84.9	68.6
Panama Canal Area Benefit Plan	43 43							
Rural Carrier Benefit Plan	38 38	83.9	95.2	94	95.7	91.1	94	77.4

Fee-for-Service Plans – Blue Cross and Blue Shield Service Benefit Plan – Member Survey Results for Select States

Again this year we are providing more detailed information regarding the quality of services provided by our health plans. We are including the results of the Member Satisfaction survey at the *state level* for eight local Blue Cross Blue Shield (BCBS) Plans.

			Member Survey Results						
Plan Name	**Location**	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
	FFS National Average		**78.9**	**92.1**	**92.2**	**94.4**	**89.7**	**92.6**	**74.6**
Blue Cross and Blue Shield Service - Standard Benefit Plan - Basic	Arizona	10 11	79.5 72.8	93 88.9	91 85	92.5 90.5	86.5 88.7	93.4 94.5	75.1 64.9
Blue Cross and Blue Shield Service - Standard Benefit Plan - Basic	California	10 11	79 66.9	91.9 88.3	87.5 81.4	94.4 91.2	86.4 86.6	93.9 86.1	68.9 65.7
Blue Cross and Blue Shield Service - Standard Benefit Plan - Basic	District of Columbia	10 11	75.8 65.2	92.6 86.8	91.9 86.1	95 88.2	86.9 82.6	90.1 90.3	67.4 61.9
Blue Cross and Blue Shield Service - Standard Benefit Plan - Basic	Florida	10 11	85.1 74.7	93.5 90.6	90.1 89.4	94.5 91.5	89.2 87.5	92.5 91.2	77.5 69.2
Blue Cross and Blue Shield Service - Standard Benefit Plan - Basic	Illinois	10 11	79.8 72.9	93 89.7	92.9 87.1	95.1 92.9	88 86.5	94.2 94.5	72.7 69.7
Blue Cross and Blue Shield Service - Standard Benefit Plan - Basic	Maryland	10 11	80.2 74.1	93.6 91.3	92.2 89.6	93 93	93.1 90.1	97.3 96.2	72.8 69.7
Blue Cross and Blue Shield Service - Standard Benefit Plan - Basic	Texas	10 11	84.7 76.5	93.8 91.2	89.4 88.5	93.9 92.1	88.4 90.1	95.6 94.2	74.1 66.7
Blue Cross and Blue Shield Service - Standard Benefit Plan - Basic	Virginia	10 11	81.8 70.1	91.6 90.2	91 86.4	94.4 91.8	91.6 87.8	96.3 94.3	73.2 70.4

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Appendix E
FEHB Plan Comparison Charts

Health Maintenance Organization Plans and Plans Offering a Point-of-Service Product (Pages 38 through 61)

Health Maintenance Organization (HMO) – A Health Maintenance Organization provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service you receive and free you from completing paperwork or being billed for covered services. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work.

- The HMO provides a comprehensive set of services – as long as you use the doctors and hospitals affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and sometimes a copayment for in-hospital care.
- Most HMOs ask you to choose a doctor or medical group as your primary care physician (PCP). Your PCP provides your general medical care. In many HMOs, you must get authorization or a "referral" from your PCP to see other providers. The referral is a recommendation by your physician for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures that you see the right provider for the care appropriate to your condition.
- Medical care from a provider not in the plan's network is not covered unless it's emergency care or your plan has an arrangement with another plan.

Plans Offering a Point-of-Service (POS) Product – A Point-of-Service plan is like having two plans in one – an HMO and an FFS plan. A POS allows you and your family members to choose between using, (1) a network of providers in a designated service area (like an HMO), or (2) Out-of-Network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non-HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

The tables on the following pages highlight what you are expected to pay for selected features under each plan. *Always consult plan brochures before making your final decision.*

Primary care/Specialist office visit copay – Shows what you pay for each office visit to your primary care doctor and specialist. Contact your plan to find out what providers it considers specialists.

Hospital per stay deductible – Shows the amount you pay when you are admitted into a hospital.

Prescription drugs – Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand, Level I, Level II, Tier I, Tier II, etc. In capturing these differences we use the following: **Level I** includes most generic drugs, but may include some preferred brands. **Level II** may include generics and preferred brands not included in Level I. **Level III** includes all other covered drugs with some exceptions for specialty drugs. The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

Mail Order Discount – If your plan has a mail order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through mail order), your plan's response is "yes." If the plan does not have a mail order program or it is not superior to its pharmacy benefit, the plan's response is "no."

Member Survey Results – See Appendix D for a description.

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Arizona					
Aetna Open Access -high- Phoenix and Tucson Areas	877-459-6604	WQ1	WQ2	134.90	391.98
Health Net of Arizona, Inc. -high- Maricopa/Pima/Other AZ counties	800-289-2818	A71	A72	117.34	379.66
Health Net of Arizona, Inc. -std- Maricopa/Pima/Other AZ counties	800-289-2818	A74	A75	105.44	266.82
Arkansas					
QualChoice - high - All of Arkansas	800-235-7111	DH1	DH2	135.24	354.90
QualChoice - std - All of Arkansas	800-235-7111	DH4	DH5	96.82	226.74
California					
Aetna HMO - Los Angeles and San Diego Areas	877-459-6604	2X1	2X2	101.14	249.14
Anthem Blue Cross - HMO -high- Most of California	800-235-8631	M51	M52	181.66	517.04
Blue Shield of CA Access+HMO -high- Southern Region	800-880-8086	SI1	SI2	121.88	284.08
Health Net of California -high- Northern Region	800-522-0088	LB1	LB2	390.10	929.42
Health Net of California -std- Northern Region	800-522-0088	LB4	LB5	354.32	846.68
Health Net of California -high- Southern Region	800-522-0088	LP1	LP2	148.22	370.12
Health Net of California -std- Southern Region	800-522-0088	LP4	LP5	119.60	298.20
Kaiser Foundation Health Plan of California -high- Northern California	800-464-4000	591	592	212.68	562.24
Kaiser Foundation Health Plan of California -std- Northern California	800-464-4000	594	595	120.12	316.36
Kaiser Foundation Health Plan of California -high- Southern California	800-464-4000	621	622	110.52	255.44
Kaiser Foundation Health Plan of California -std- Southern California	800-464-4000	624	625	70.82	163.68
PacifiCare of California -high- Most of California	866-546-0510	CY1	CY2	109.38	249.70
Colorado					
Kaiser Foundation Health Plan of Colorado -high- Denver/Boulder/Southern Colorado	800-632-9700	651	652	139.68	324.32
Kaiser Foundation Health Plan of Colorado -std- Denver/Boulder/Southern Colorado	800-632-9700	654	655	74.02	167.28

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		64.2	84.7	85.6	93.1	84	87.4	67.2
Arizona												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	61.3	86.6	83.1	89.9	86.9	87.9	66.7
Health Net of Arizona, Inc.-High	$15/$30	$200/day X 3	$10	$30/$50	Yes	66.8	90.7	84.1	93.1	82.3	87.3	63
Health Net of Arizona, Inc.-Std	$15/$40	$250/day X 3	$10	$40/$70	Yes	66.8	90.7	84.1	93.1	82.3	87.3	63
Arkansas												
QualChoice- In-Network	$20/$30 preventive $0	$100max$500	$0	$40/$60	Yes							
QualChoice- Out-Network	40%/40%	40%	N/A	N/A	N/A							
QualChoice- In-Network	$20/$40 preventive $0	$200max$1,000	$5	$40/$60	Yes							
California												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	52.4	76.2	75.8	88.4	79.3	92.1	67.5
Anthem Blue Cross - HMO-High	$25/$25	$200/day x 3	$10/$35/45%	$35 or 45%/45%	Yes	60.8	81.9	77.5	88.5	66	85.4	57.6
Blue Shield of CA Access+HMO-High	$20/$30	$150/day x 3	$10	$35/$50	Yes	64.9	83.8	80.9	90.3	81.7	85.3	63.5
Health Net of California-High	$15/$30	$100/day x 3	$10	$35/$50	Yes	64.9	82	80.4	92	77.7	83.6	57.1
Health Net of California-Std	$30/$50	$300	$15	$35/$60	Yes	64.9	82	80.4	92	77.7	83.6	57.1
Health Net of California-High	$15/$30	$100/day x 3	$10	$35/$50	Yes	64.9	82	80.4	92	77.7	83.6	57.1
Health Net of California-Std	$30/$50	$300	$15	$35/$60	Yes	64.9	82	80.4	92	77.7	83.6	57.1
Kaiser Foundation HP-High	$15/$15	$250	$10	$30/$30	Yes	69	83.5	82.2	91.3	80.3	80.2	59.8
Kaiser Foundation HP-Std	$30/$30	$500	$15	$35/$35	Yes	69	83.5	82.2	91.3	80.3	80.2	59.8
Kaiser Foundation HP-High	$15/$15	$250	$10	$30/$30	Yes	72	80	79.4	91.9	78.4	78	63.4
Kaiser Foundation HP-Std	$30/$30	$500	$15	$35/$35	Yes	72	80	79.4	91.9	78.4	78	63.4
PacifiCare of California-High	$20/$30	$100/day x 5	$10	$35/$60	Yes	63.2	76.2	81.5	90.6	77	86.1	64.4
Colorado												
Kaiser Foundation HP-High	$20/$30	$250	$10	$25/$50	Yes	63.1	79.4	87.1	92.7	80.8	92	68.5
Kaiser Foundation HP-Std	$25/$45	$250/day x 3	$15	$35/$70	Yes	63.1	79.4	87.1	92.7	80.8	92	68.5

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Delaware					
Aetna Open Access -high- Kent/New Castle/Sussex areas	877-459-6604	P31	P32	406.78	1045.34
Aetna Open Access -basic- Kent/New Castle/Sussex areas	877-459-6604	P34	P35	214.42	521.52
District of Columbia					
Aetna Open Access -high- Washington, DC Area	877-459-6604	JN1	JN2	321.38	721.22
Aetna Open Access -basic- Washington, DC Area	877-459-6604	JN4	JN5	109.14	255.42
CareFirst BlueChoice -high- Washington, D.C. Metro Area	866-296-7363	2G1	2G2	139.40	318.48
Kaiser Foundation Health Plan Mid-Atlantic States -high- Washington, DC area	877-574-3337	E31	E32	124.70	309.90
Kaiser Foundation Health Plan Mid-Atlantic States -std- Washington, DC area	877-574-3337	E34	E35	76.28	175.42
M.D. IPA -high- Washington, DC area	877-835-9861	JP1	JP2	122.04	306.64
Florida					
Av-Med Health Plan -high- Broward, Dade and Palm Beach	800-882-8633	ML1	ML2	118.94	334.00
Av-Med Health Plan -std- Broward, Dade and Palm Beach	800-882-8633	ML4	ML5	110.16	264.38
Capital Health Plan-high- Tallahassee area	850-383-3311	EA1	EA2	94.40	250.16
Coventry Health Care of Florida -high- Southern Florida	800-441-5501	5E1	5E2	110.62	339.16
Coventry Health Care of Florida -std- Southern Florida	800-441-5501	5E4	5E5	95.46	247.36
Humana, Inc. -high- South Florida	888-393-6765	EE1	EE2	152.48	348.12
Humana, Inc. -std- South Florida	888-393-6765	EE4	EE5	112.48	253.10
Humana, Inc. -high- Tampa	888-393-6765	LL1	LL2	219.98	499.94
Humana, Inc. -std- Tampa	888-393-6765	LL4	LL5	118.12	265.76
Georgia					
Aetna Open Access -high- Atlanta and Athens Areas	877-459-6604	2U1	2U2	213.62	511.28
Humana Employers Health of Georgia, Inc. -high- Columbus	888-393-6765	CB1	CB2	119.44	268.74
Humana Employers Health of Georgia, Inc. -std- Columbus	888-393-6765	CB4	CB5	107.50	241.86
Humana Employers Health of Georgia, Inc. -high- Atlanta	888-393-6765	DG1	DG2	137.30	313.92
Humana Employers Health of Georgia, Inc. -std- Atlanta	888-393-6765	DG4	DG5	119.44	268.74
Humana Employers Health of Georgia, Inc. -high- Macon	888-393-6765	DN1	DN2	118.42	266.42
Humana Employers Health of Georgia, Inc. -std- Macon	888-393-6765	DN4	DN5	112.48	253.10
Kaiser Foundation Health Plan of GA, Inc. -high- Atlanta, Athens, Columbus, Macon, Savannah	888-865-5813	F81	F82	121.80	296.00
Kaiser Foundation Health Plan of GA, Inc. -std- Atlanta, Athens, Columbus, Macon, Savannah	888-865-5813	F84	F85	82.56	188.66

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		64.2	84.7	85.6	93.1	84	87.4	67.2
Delaware												
Aetna Open Access-High	$20/$35	$150/day x 5	$10	$35/$65	Yes	62.6	86.2	85.2	92.8	86.8	88.6	65.5
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	62.6	86.2	85.2	92.8	86.8	88.6	65.5
District of Columbia												
Aetna Open Access-High	$15/$30	$150/day x3	$5	$35/$65	Yes	58.9	83	84.5	90	88.8	85.5	65.2
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$65	Yes	58.9	83	84.5	90	88.8	85.5	65.2
CareFirst BlueChoice-High	$25/$35	$150/ day x 3	$10	$30/$50	Yes	53.3	81.6	81.1	90.2	68.5	81.7	51.3
Kaiser Foundation HP-High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	71.1	81.2	83.6	88.9	81.2	84.8	70
Kaiser Foundation HP-Std	$20/$30	$250/day x 3	$12/$22Net	$35/$55/$50/$70	Yes	71.1	81.2	83.6	88.9	81.2	84.8	70
M.D. IPA-High	$25/$35	$150/day x 3	$7	$25/$60/$100	No	58	79.1	86.6	89.7	83.9	88.8	63.8
Florida												
Av-Med Health Plan-High	$15/$40	$150/day x 5	$15	$30/$50/30%	No	78.1	85.1	86.7	92.5	86.6	87.4	59.6
Av-Med Health Plan-Std	$25/$45	$175/day x 5	$20	$40/$60/30%	No	78.1	85.1	86.7	92.5	86.6	87.4	59.6
Capital Health Plan-High	$15/$25	$250	$15	$30/$50	No	84	89.5	90.3	92.3	93	94.3	81.4
Coventry Health Care of Florida-High	$15/$30	Ded+$150x3 days	$20	$40/$60/20%	Yes	52.9	79.3	77.3	90.3	83.2	83	61.5
Coventry Health Care of Florida-Standard	$20/$45	Ded+$175x5 days	$10	$45/$65/20%	Yes	52.9	79.3	77.3	90.3	83.2	83	61.5
Humana, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	60.5	84.9	80.2	90.9	81.2	81.4	60.3
Humana, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes	60.5	84.9	80.2	90.9	81.2	81.4	60.3
Humana, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana, Inc.-Standard	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Georgia												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	60.9	87.5	83.9	92.7	87.6	87.3	64.5
Humana Employers Health of Georgia, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	49.9	85.6	84	95.8	89.1	82.5	70.5
Humana Employers Health of Georgia, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	49.9	85.6	84	95.8	89.1	82.5	70.5
Humana Employers Health of Georgia, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Employers Health of Georgia, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Kaiser Foundation HP-High	$10/$25	$250	$10/$16 Comm	$30/$36 Comm	Yes	63.1	82.4	79.8	91.3	78.2	83.3	62.9
Kaiser Foundation HP-Std	$20/$30	$250/day x 3	$20/$26 Comm	$30/$36 Comm	Yes	63.1	82.4	79.8	91.3	78.2	83.3	62.9

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Guam					
TakeCare -high- Guam/N.MarianaIslands/Belau(Palau)	671-647-3526	JK1	JK2	114.90	399.76
TakeCare -std- Guam/N.MarianaIslands/Belau(Palau)	671-647-3526	JK4	JK5	101.94	269.18
Hawaii					
HMSA -high- All of Hawaii	808-948-6499	871	872	104.36	232.28
Kaiser Foundation Health Plan of Hawaii -high- Hawaii/Kauai/Lanai/Maui/Molokai/Oahu	808-432-5955	631	632	117.44	252.50
Kaiser Foundation Health Plan of Hawaii -std- Hawaii/Kauai/Lanai/Maui/Molokai/Oahu	808-432-5955	634	635	52.06	111.92
Idaho					
Altius Health Plans -high- Southern Region	800-377-4161	9K1	9K2	192.82	411.22
Altius Health Plans -std- Southern Region	800-377-4161	DK4	DK5	91.88	202.14
Group Health Cooperative -high- Kootenai and Latah	888-901-4636	541	542	169.12	332.50
Group Health Cooperative -std- Kootenai and Latah	888-901-4636	544	545	85.76	193.62
Illinois					
Aetna Open Access -high- Chicago Area	877-459-6604	IK1	IK2	196.64	535.58
Blue Preferred Plus POS -high- Madison and St. Clair counties	888-811-2092	9G1	9G2	162.96	327.16
Health Alliance HMO -high- Central/E.Central/N. Cent/South/West	800-851-3379	FX1	FX2	150.44	384.98
Humana Benefit Plan of Illinois Inc. formerly OSF -high- Central/Central Northwestern	888-393-6765	9F1	9F2	267.06	605.94
Humana Benefit Plan of Illinois Inc. formerly OSF -std- Central/Central Northwestern	888-393-6765	AB4	AB5	119.44	268.74
Humana Health Plan Inc. -high- Chicago	888-393-6765	751	752	229.82	522.10
Humana Health Plan Inc. -std- Chicago	888-393-6765	754	755	112.48	253.10
Union Health Service -high- Chicago area	312-829-4224	761	762	109.28	253.70
United Healthcare of the Midwest -high- Southwest llinois	877-835-9861	B91	B92	139.66	311.26
UnitedHealthcare Plan of the River Valley Inc. -high- West Central Illinois	800-747-1446	YH1	YH2	105.66	258.86

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
HMO/POS National Average						**64.2**	**84.7**	**85.6**	**93.1**	**84**	**87.4**	**67.2**
Guam												
TakeCare-High	$20/$40	$100/day for 5 days	$10	$15/$25/$50	No	62.6	74.4	63	88.3	73.2	73.1	59.8
TakeCare-Std	$25/$40	$150/day for 5 days	$15	$20/$40/$80	No	62.6	74.4	63	88.3	73.2	73.1	59.8
Hawaii												
HMSA- In-Network	$15/$15	$100	$7	$30/$65	Yes	83.7	90	88.7	94.2	87.1	94.8	71.9
HMSA- Out-Network	30%/30%	30%	$7 + 20%	$30+20%/ $65+20%	No	83.7	90	88.7	94.2	87.1	94.8	71.9
Kaiser Foundation HP-High	$15/$15	None	$15	$15/$15	Yes	69.1	81.2	83.2	94	79	83.5	68.8
Kaiser Foundation HP-Std	$25/$25	10%	$20	$20/$20	Yes	69.1	81.2	83.2	94	79	83.5	68.8
Idaho												
Altius Health Plans-High	$20/$30	$200	$7	$25/$50	Yes	56.8	84.2	87.7	94.6	83.4	87.4	66.8
Altius Health Plans-Std	$20/$35	None	$7	$35/$60	Yes	56.8	84.2	87.7	94.6	83.4	87.4	66.8
Group Health Cooperative-High	$25/$25	$350/day x 3	$20	$40/$60	Yes	67	87	89.9	94.2	87.9	85.4	71.6
Group Health Cooperative-Std	$25+20%/$25+20%	$500/day x 3	$20	$40/$60	Yes	67	87	89.9	94.2	87.9	85.4	71.6
Illinois												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	53.9	76.5	86.4	93.2	81.6	74.7	64.1
Blue Preferred Plus POS In-Network	$25/$25	$500	$10	$30/$40	Yes	69.3	91.5	89.9	94.9	88.5	93.2	66.9
Blue Preferred Plus POS Out-Network	30% after ded	30% after ded.	N/A	N/A	No	69.3	91.5	89.9	94.9	88.5	93.2	66.9
Health Alliance HMO-High	$20/$30	$250/3 days	$15	$30/$50	Yes	82.9	88.2	90.2	95.3	90.8	92.9	76.6
Humana BP of Illinois Inc.-High	$20/$35	$200 x 3	$10	$40/$60	Yes	74.5	92	90.9	95.7	92.1	89.2	76.7
Humana BP of Illinois Inc.-Std	$25/$40	$300 X 3	$10	$40/$60	Yes	74.5	92	90.9	95.7	92.1	89.2	76.7
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	58.8	81.3	80.9	90.5	84.5	84.6	67.5
Humana Health Plan, Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	58.8	81.3	80.9	90.5	84.5	84.6	67.5
Union Health Service-High	$15/$15	None	$15	$30/$30	No							
UHC of the Midwest, Inc.-High	$25/$35	$450	$7	$30/$60	Yes	59.2	87	86.9	94.2	81.7	89.6	61.2
UHC Plan of the River Valley, Inc.-High	$20/$40	20%	$10	$35/$50	Yes	65.4	87.7	86.2	96.4	83.1	91.8	68.5

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Indiana					
Aetna Open Access -high- Northern Indiana Area	877-459-6604	IK1	IK2	196.64	535.58
Health Alliance HMO -high- Western Indiana	800-851-3379	FX1	FX2	150.44	384.98
Humana Health Plan Inc. -high- Lake/Porter/LaPorte Counties	888-393-6765	751	752	229.82	522.10
Humana Health Plan Inc. -std- Lake/Porter/LaPorte Counties	888-393-6765	754	755	112.48	253.10
Humana Health Plan Inc. -high- Southern Indiana	888-393-6765	MH1	MH2	119.44	268.74
Humana Health Plan Inc. -std- Southern Indiana	888-393-6765	MH4	MH5	107.50	241.86
Physicians Health Plan of Northern Indiana -high- Northeast Indiana	260-432-6690	DQ1	DQ2	156.06	343.60
Welborn Health Plans -high- Evansville Area	800-521-0265	W11	W12	132.90	348.58
Iowa					
Coventry Health Care of Iowa -high- Central/Eastern/Western Iowa	800-257-4692	SV1	SV2	115.84	405.72
Coventry Health Care of Iowa -std- Central/Eastern/Western Iowa	800-257-4692	SY4	SY5	83.34	195.86
Health Alliance HMO -high- Central Iowa	800-851-3379	FX1	FX2	150.44	384.98
HealthPartners Open Access Copay-high-Northern Iowa	952-883-5000	V31	V32	268.18	639.86
HealthPartners 3 for Free-std-Northern Iowa	952-883-5000	V34	V35	73.92	170.02
Sanford Health Plan -high- Northwestern Iowa	800-752-5863	AU1	AU2	198.44	480.04
Sanford Health Plan -std- Northwestern Iowa	800-752-5863	AU4	AU5	178.46	433.60
UnitedHealthcare Plan of the River Valley Inc. -high- Eastern Iowa; W. Central Illinois	800-747-1446	YH1	YH2	105.66	258.86
Kansas					
Coventry Health Care of Kansas -high- Kansas City/Wichita/Salina areas	800-969-3343	HA1	HA2	105.04	263.76
Coventry Health Care of Kansas -std- Kansas City/Wichita/Salina areas	800-969-3343	HA4	HA5	89.50	210.30
Humana Health Plan, Inc. -high- Kansas City	888-393-6765	MS1	MS2	343.60	778.10
Humana Health Plan, Inc. -std- Kansas City	888-393-6765	MS4	MS5	118.74	267.16

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		64.2	84.7	85.6	93.1	84	87.4	67.2
Indiana												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	53.9	76.5	86.4	93.2	81.6	74.7	64.1
Health Alliance HMO-High	$20/$30	$250/3 days	$15	$30/$50	Yes	82.9	88.2	90.2	95.3	90.8	92.9	76.6
Humana Health Plan Inc.-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	58.8	81.3	80.9	90.5	84.5	84.6	67.5
Humana Health Plan Inc.-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	58.8	81.3	80.9	90.5	84.5	84.6	67.5
Humana Health Plan Inc.-High	$20/$35	$250/day x 3	$10	$30/$60	Yes							
Humana Health Plan Inc.-Std	$25/$40	$500/day x 3	$10	$30/$60	Yes							
Physicians Health Plan of Northern Indiana-High	$15/$15	20%	$5	$20/$45	Yes	60.3	88.2	84.5	95.2	83.4	92.2	67.5
Welborn Health Plans-High	$20/$20	10%	$10	$35/$55	Yes	58.2	88.1	89.6	94.5	80.6	87	64.7
Iowa												
Coventry Health Care of Iowa-High	$20/$40	None	$10	$40/$65	Yes	56.4	88.4	87.9	94.6	85.1	91.5	61.8
Coventry Health Care of Iowa-Std	$20/$40	None	$10	$40/$65	Yes	56.4	88.4	87.9	94.6	85.1	91.5	61.8
Health Alliance HMO-High	$20/$30	$250/3 days	$15	$30/$50	Yes	82.9	88.2	90.2	95.3	90.8	92.9	76.6
HealthPartners Open Access Copay	$25/$45	10%	$12	$45/$90	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
HealthPartners 3 for Free	$0 for 3, then 20%	20% in/40% out	$6	$30/$60	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
Sanford Health Plan- In-Network	$20/$30	$100/day x 5	$15	$30/$50	N/A	53.3	85.2	87.1	92.8	84.8	88.8	66.8
Sanford Health Plan- Out-Network	40%/40%	40%	N/A	N/A	N/A	53.3	85.2	87.1	92.8	84.8	88.8	66.8
Sanford Health Plan- In-Network	$25/$25	$100/day x 5	$15	$30/$50	No	53.3	85.2	87.1	92.8	84.8	88.8	66.8
Sanford Health Plan- Out-Network	40%/40%	40%	N/A	N/A	No	53.3	85.2	87.1	92.8	84.8	88.8	66.8
UHC Plan of the River Valley, Inc.-High	$20/$40	20%	$10	$35/$50	Yes	65.4	87.7	86.2	96.4	83.1	91.8	68.5
Kansas												
Coventry Health Care of Kansas-High	$20/$50	None	$3/ $12	$40/$65	Yes	59.2	85.6	90	95	80.5	88.7	65
Coventry Health Care of Kansas-Std	$30/$60	None	$3/ $12	$40/$65	Yes	59.2	85.6	90	95	80.5	88.7	65
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$30/$60	Yes	59.1	91.4	88.3	93	88.2	87.3	71
Humana Health Plan, Inc.-Std	$25/$40	$500/day x 3	$10	$30/$60	Yes	59.1	91.4	88.3	93	88.2	87.3	71

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Kentucky					
Humana Health Plan, Inc. -high- Louisville	888-393-6765	MH1	MH2	119.44	268.74
Humana Health Plan, Inc. -std- Louisville	888-393-6765	MH4	MH5	107.50	241.86
Humana Health Plan, Inc. -high- Lexington	888-393-6765	MI1	MI2	115.00	258.76
Humana Health Plan, Inc. -std- Lexington	888-393-6765	MI4	MI5	100.92	227.10
Louisiana					
Coventry Health Care of Louisiana -high- New Orleans area	800-341-6613	BJ1	BJ2	160.10	402.94
Coventry Health Care of Louisiana -std- New Orleans area	800-341-6613	BJ4	BJ5	116.36	272.96
Maryland					
Aetna Open Access -high- Northern/Central/Southern Maryland Areas	877-459-6604	JN1	JN2	321.38	721.22
Aetna Open Access -basic- Northern/Central/Southern Maryland Areas	877-459-6604	JN4	JN5	109.14	255.42
CareFirst BlueChoice -high- All of Maryland	866-296-7363	2G1	2G2	139.40	318.48
Coventry Health Care -high- All of Maryland	800-833-7423	IG1	IG2	98.06	246.12
Coventry Health Care -std- All of Maryland	800-833-7423	IG4	IG5	86.64	216.58
Kaiser Foundation Health Plan Mid-Atlantic States -high- Baltimore/Washington, DC areas	877-574-3337	E31	E32	124.70	309.90
Kaiser Foundation Health Plan Mid-Atlantic States -std- Baltimore/Washington, DC areas	877-574-3337	E34	E35	76.28	175.42
M.D. IPA -high- All of Maryland	877-835-9861	JP1	JP2	122.04	306.64
Massachusetts					
Fallon Community Health Plan -basic- Central/Eastern Massachusetts	800-868-5200	JG1	JG2	205.62	569.88

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction 6	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		64.2	84.7	85.6	93.1	84	87.4	67.2
Kentucky												
Humana Health Plan, Inc. -High	$20/$35	$250/day x 3	$10	$30/$60	Yes							
Humana Health Plan, Inc. -Std	$25/$40	$500/day x 3	$10	$30/$60	Yes							
Humana Health Plan, Inc. -high	$20/$35	$250/day x 3	$10	$30/$60	Yes							
Humana Health Plan, Inc. -Std	$25/$40	$500/day x 3	$10	$30/$60	Yes							
Louisiana												
Coventry Health Care of Louisiana-High	$20/$40	Nothing	$1	$35/$60	Yes	58.4	85.5	79.8	94.7	77.7	88.5	63.6
Coventry Health Care of Louisiana-Std	$25/$50	30%	$1	$35/$60	Yes	58.4	85.5	79.8	94.7	77.7	88.5	63.6
Maryland												
Aetna Open Access-High	$15/$30	$150/day x3	$5	$35/$65	Yes	58.9	83	84.5	90	88.8	85.5	65.2
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$65	Yes	58.9	83	84.5	90	88.8	85.5	65.2
CareFirst BlueChoice-High	$25/$35	$150/ day x 3	$10	$30/$50	Yes	53.3	81.6	81.1	90.2	68.5	81.7	51.3
Coventry Health Care-High	$20/$40	$200/day x 3	$5	$30/$60	Yes	49	80.6	85.7	94.4	76.6	82.5	61.8
Coventry Health Care-Std	$20/$40	$200/day x 3	$15	$30/$60	Yes	49	80.6	85.7	94.4	76.6	82.5	61.8
Kaiser Foundation HP-High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	71.1	81.2	83.6	88.9	81.2	84.8	70
Kaiser Foundation HP-Std	$20/$30	$250/day x 3	$12/$22Net	$35/$55/$50/$70	Yes	71.1	81.2	83.6	88.9	81.2	84.8	70
M.D. IPA-High	$25/$35	$150/day x 3	$7	$25/$60/$100	No	58	79.1	86.6	89.7	83.9	88.8	63.8
Massachusetts												
Fallon Community Health Plan-Basic	$25/$35 preventive $0	$150to$750max	$10	$30/$60	Yes	69.2	83.1	87.1	93.7	83.7	89.7	71.5

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Michigan					
Bluecare Network of MI -high- Traverse City	800-662-6667	H61	H62	132.38	475.28
Bluecare Network of MI -high- Grand Rapids	800-662-6667	J31	J32	159.50	545.68
Bluecare Network of MI -high- East Region	800-662-6667	K51	K52	138.28	331.16
Bluecare Network of MI -high- Southeast Region	800-662-6667	LX1	LX2	109.54	330.88
Grand Valley Health Plan -high- Grand Rapids area	616-949-2410	RL1	RL2	108.66	322.16
Grand Valley Health Plan -std- Grand Rapids area	616-949-2410	RL4	RL5	101.90	264.90
Health Alliance Plan -high- Southeastern Michigan/Flint area	800-556-9765	521	522	120.36	443.78
HealthPlus MI -high- East Central Michigan	800-332-9161	X51	X52	102.78	267.04
Physicians Health Plan of Mid-Michigan -std- Mid-Michigan	517-364-8500	9U4	9U5	196.10	535.42
Minnesota					
HealthPartners Open Access Copay-high-Minnesota	952-883-5000	V31	V32	268.18	639.86
HealthPartners 3 for Free-std-Minnesota	952-883-5000	V34	V35	73.92	170.02
Medica Health Plan -high- Most of Minnesota	800-952-3455	M21	M22	242.90	575.68
Missouri					
Blue Preferred -high- StLouis/Central/SW areas	888-811-2092	9G1	9G2	162.96	327.16
Coventry Health Care of Kansas -high- Kansas City area	800-969-3343	HA1	HA2	105.04	263.76
Coventry Health Care of Kansas -std- Kansas City area	800-969-3343	HA4	HA5	89.50	210.30
Humana Health Plan, Inc. -high- Kansas City	888-393-6765	MS1	MS2	343.60	778.10
Humana Health Plan, Inc. -std- Kansas City	888-393-6765	MS4	MS5	118.74	267.16
United Healthcare of the Midwest -high- St. Louis Area	877-835-9861	B91	B92	139.66	311.26
Montana					
New West Health Services -high- Most of Montana	800-290-3657	NV1	NV2	169.00	394.36
New West Health Services -std- Most of Montana	800-290-3657	NV4	NV5	104.76	247.04

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		64.2	84.7	85.6	93.1	84	87.4	67.2
Michigan												
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes							
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes							
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes	64.6	88	89.3	93.3	83.8	88	68.6
Bluecare Network of MI-High	$15/$25	Nothing	$5	$50/N/A	Yes	64.6	88	89.3	93.3	83.8	88	68.6
Grand Valley Health Plan-High	$10/$10	Nothing	$5	$15/$15	No	77.1	85.6	92.5	93.8	87.4	88.6	78.8
Grand Valley Health Plan-Std	$20/$20	$500 x 3	$10	$40/$40	No	77.1	85.6	92.5	93.8	87.4	88.6	78.8
Health Alliance Plan-High	$10/$20	Nothing	$10	$40/$40	Yes	79.2	87.7	86.8	95.6	80.1	91.6	67.7
HealthPlus MI-High	$10/$20	None	$8	$40/$60	Yes	76.6	89.5	93.2	94	87.3	89.4	71.9
Physicians Health Plan of Mid-Michigan-Std	$20/Nothing	20%	$15	$25/$50	Yes	70.4	91.4	90.4	94.8	87.6	90	68.6
Minnesota												
HealthPartners Open Access Copay	$25/$45	10%	$12	$45/$90	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
HealthPartners 3 for Free	$0 for 3, then 20%	20% in/40% out	$6	$30/$60	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
Medica Health Plan- In-Network	$20/$20	$300	$10	$25/$50/$50	Yes	50.1	81.2	88.9	96	85.9	90.6	54.9
Medica Health Plan- Out-Network	40%/40%	None	40%/$50	40%/$50	No	50.1	81.2	88.9	96	85.9	90.6	54.9
Missouri												
Blue Preferred Plus POS In-Network	$25/$25	$500	$10	$30/$40	Yes	69.3	91.5	89.9	94.9	88.5	93.2	66.9
Blue Preferred Plus POS Out-Network	30% after ded	30% after ded	N/A	N/A	No	69.3	91.5	89.9	94.9	88.5	93.2	66.9
Coventry Health Care of Kansas-High	$20/$50	None	$3/ $12	$40/$65	Yes	59.2	85.6	90	95	80.5	88.7	65
Coventry Health Care of Kansas-Std	$30/$60	None	$3/ $12	$40/$65	Yes	59.2	85.6	90	95	80.5	88.7	65
Humana Health Plan, Inc.-High	$20/$35	$250/day x 3	$10	$30/$60	Yes	59.1	91.4	88.3	93	88.2	87.3	71
Humana Health Plan, Inc.-Std	$25/$40	$500/day x 3	$10	$30/$60	Yes	59.1	91.4	88.3	93	88.2	87.3	71
United Healthcare of the Midwest, Inc.-High	$25/$35	$450	$7	$30/$60	Yes	59.2	87	86.9	94.2	81.7	89.6	61.2
Montana												
New West Health Services- High	$15/$15	$100	$10	$20/$40	Yes	43.1	84.4	87.2	95.7	82.8	82.6	58.7
New West Health Services- POS	30%/30%	30%	N/A	N/A	No	43.1	84.4	87.2	95.7	82.8	82.6	58.7
New West Health Services- std	$25/$25	$150 x 5	$10	$25/$50	Yes							

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Nevada					
Health Plan of Nevada -high- Las Vegas area	800-777-1840	NM1	NM2	72.62	185.98
New Jersey					
Aetna Open Access -high- Northern New Jersey	877-459-6604	JR1	JR2	286.84	683.04
Aetna Open Access -basic- Northern New Jersey	877-459-6604	JR4	JR5	149.20	370.50
Aetna Open Access -high- Southern	877-459-6604	P31	P32	406.78	1045.34
Aetna Open Access -basic- Southern	877-459-6604	P34	P35	214.42	521.52
GHI Health Plan -high- Northern New Jersey	212-501-4444	801	802	200.12	595.72
GHI Health Plan -std- Northern New Jersey	212-501-4444	804	805	98.02	228.84
New Mexico					
Lovelace Health Plan -high- All of New Mexico	800-808-7363	Q11	Q12	119.16	359.84
Presbyterian Health Plan -high- All counties in New Mexico	800-356-2219	P21	P22	170.52	399.90

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
HMO/POS National Average						**64.2**	**84.7**	**85.6**	**93.1**	**84**	**87.4**	**67.2**
Nevada												
Health Plan of Nevada-High	$10/$20	$100	$5	$35/$55	Yes	52.7	68.8	72.2	87.2	74.8	86.1	59.2
New Jersey												
Aetna Open Access-High	$20/$35	$150/day x 5	$10	$35/$65	Yes	54.4	84.8	89.8	90.6	83	83.2	58.4
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	54.4	84.8	89.8	90.6	83	83.2	58.4
Aetna Open Access-High	$20/$35	$150/day x 5	$10	$35/$65	Yes	69.4	85.1	88.8	93.5	86.4	90	75.6
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	69.4	85.1	88.8	93.5	86.4	90	75.6
GHI Health Plan- In-Network	$15/$15	$100	$15	$25/$50	Yes	55.3	84	83	93.8	76.9	83.5	59.7
GHI Health Plan- Out-Network	+50% of sch.	+50% of sch.	N/A	N/A	No	55.3	84	83	93.8	76.9	83.5	59.7
GHI Health Plan-	$25/$25	$250/day x 3	$10	$25/$50	Yes	55.3	84	83	93.8	76.9	83.5	59.7
New Mexico												
Lovelace Health Plan-High	$20/$35	$250	$5	$35/$60/50%	Yes	61.9	80.7	77	91.1	83.5	88.5	68.6
Presbyterian Health Plan-High	$25/$35	$350	$10	$30/$50	Yes	65.3	83.3	82.1	92.1	83.1	86.9	66.7

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
New York					
Aetna Open Access -high- NYC Area/Upstate NY	877-459-6604	JC1	JC2	262.62	727.90
Aetna Open Access -basic- NYC Area/Upstate NY	877-459-6604	JC4	JC5	140.94	412.50
Blue Choice -high- Rochester area	800-462-0108	MK1	MK2	213.18	523.80
Blue Choice -std- Rochester area	800-462-0108	MK4	MK5	123.08	422.66
CDPHP Universal Benefits -high- Upstate, Hudson Valley, Central New York	877-269-2134	SG1	SG2	169.60	536.68
CDPHP Universal Benefits -std- Upstate, Hudson Valley, Central New York	877-269-2134	SG4	SG5	99.32	256.26
GHI HMO Select -high- Brnx/Brklyn/Manhat/Queen/Richmon/Westche	877-244-4466	6V1	6V2	257.32	765.72
GHI HMO Select -high- Capital/Hudson Valley Regions	877-244-4466	X41	X42	293.90	865.46
GHI Health Plan -high- All of New York	212-501-4444	801	802	200.12	595.72
GHI Health Plan -std- Most of New York	212-501-4444	804	805	98.02	228.84
HIP of Greater New York -high- New York City area	800-HIP-TALK	511	512	176.60	617.54
HIP of Greater New York -std- New York City area	800-HIP-TALK	514	515	133.16	502.40
Independent Health Assoc -high- Western New York	800-501-3439	QA1	QA2	119.56	387.64
MVP Health Care -high- Eastern Region	888-687-6277	GA1	GA2	126.50	413.72
MVP Health Care -std- Eastern Region	888-687-6277	GA4	GA5	111.64	310.24
MVP Health Care -high- Western Region	800-950-3224	GV1	GV2	110.22	295.28
MVP Health Care -std- Western Region	800-950-3224	GV4	GV5	103.70	259.48
MVP Health Care -high- Central Region	888-687-6277	M91	M92	151.56	476.04
MVP Health Care -std- Central Region	888-687-6277	M94	M95	120.14	395.64
MVP Health Care -high- Northern Region	888-687-6277	MF1	MF2	177.94	541.54
MVP Health Care -std- Northern Region	888-687-6277	MF4	MF5	137.08	439.32
MVP Health Care -high- Mid-Hudson Region	888-687-6277	MX1	MX2	159.28	494.50
MVP Health Care -std- Mid-Hudson Region	888-687-6277	MX4	MX5	123.04	409.12
Univera Healthcare -high- Western New York (Northern and Southern Counties)	800-427-8490	Q81	Q82	242.94	794.54

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
			HMO/POS National Average			**64.2**	**84.7**	**85.6**	**93.1**	**84**	**87.4**	**67.2**
New York												
Aetna Open Access-High	$20/$35	$150/day x 5	$10	$35/$65	Yes	61.4	81.9	85.7	92.8	82	90.2	60.8
Aetna Open Access-Basic	$15/$35	20% Plan Allow	$5	$35/$65	Yes	61.4	81.9	85.7	92.8	82	90.2	60.8
Blue Choice-High	$20/$20	$240	$10	$30/$50	Yes	59.1	90.5	91.8	95	85.7	91.8	72.4
Blue Choice-Std	$25/$40	$500	$10	$30/$50	Yes	59.1	90.5	91.8	95	85.7	91.8	72.4
CDPHP Universal Benefits, Inc.-High	$20/$30	$100 x 5	25%	25%/25%	No	74.5	90.2	89.6	94.4	90.9	92.4	79
CDPHP Universal Benefits, Inc.-Std	$25/$40	$500+10%	30%	30%/30%	No	74.5	90.2	89.6	94.4	90.9	92.4	79
GHI HMO Select-High	$25/$40	$500	$10	$30/$50	Yes	51.3	80.6	85.9	94.5	81.4	81.7	65
GHI HMO Select-High	$25/$40	$500	$10	$30/$50	Yes	51.3	80.6	85.9	94.5	81.4	81.7	65
GHI Health Plan- In-Network	$15/$15	$100	$15	$25/$50	Yes	55.3	84	83	93.8	76.9	83.5	59.7
GHI Health Plan- Out-Network	+50% of sch.	+50% of sch.	N/A	N/A	No	55.3	84	83	93.8	76.9	83.5	59.7
GHI Health Plan-Std	$25/$25	$250/day x 3	$10	$25/$50	Yes	55.3	84	83	93.8	76.9	83.5	59.7
HIP of Greater New York-High	$10/$10	None	$15	$30/$50	Yes	58	80.2	81.9	91.1	75.2	86	59.3
HIP of Greater New York-Std	$20/$40	$500	$15	$30/$50	Yes	58	80.2	81.9	91.1	75.2	86	59.3
Independent Health Assoc.- In-Network	$20/$20	$250	$10	$20/$35	No	70.7	87.1	91.4	94.1	93.6	93	78.7
Independent Health Assoc.- Out-Network	25%/25%	25%	N/A	N/A	No	70.7	87.1	91.4	94.1	93.6	93	78.7
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
MVP Health Care-High	$25/$25	$500	$5	$35/$70	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
MVP Health Care-Std	$30/$50	$750	$5	$45/$90	Yes	64.7	90.2	89.7	94.2	87.5	88.5	72.9
Univera Healthcare-High	$25/$25	$500	$10	$30/$50	No	56.3	86.8	87.5	94	83.7	89.4	68.4

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
North Dakota					
HealthPartners Open Access Copay-high-Eastern North Dakota	952-883-5000	V31	V32	268.18	639.86
HealthPartners 3 for Free-std-Eastern North Dakota	952-883-5000	V34	V35	73.92	170.02
Heart of America Health Plan -high- Northcentral North Dakota	800-525-5661	RU1	RU2	95.58	245.64
Ohio					
AultCare HMO -high- Stark/Carroll/Holmes/Tuscarawas/Wayne Co.	330-363-6360	3A1	3A2	213.48	603.28
HMO Health Ohio -high- Northeast Ohio	800-522-2066	L41	L42	285.02	710.92
Kaiser Foundation Health Plan of Ohio -high- Cleveland/Akron areas	800-686-7100	641	642	214.04	515.38
Kaiser Foundation Health Plan of Ohio -std- Cleveland/Akron areas	800-686-7100	644	645	93.42	214.86
The Health Plan of the Upper Ohio Valley -high- Eastern Ohio	800-624-6961	U41	U42	115.78	266.28
Oklahoma					
Globalhealth, Inc. -high- Oklahoma	877-280-2990	IM1	IM2	84.62	203.92
Oregon					
Kaiser Foundation Health Plan of Northwest -high- Portland/Salem areas	800-813-2000	571	572	181.74	418.66
Kaiser Foundation Health Plan of Northwest -std- Portland/Salem areas	800-813-2000	574	575	105.76	242.96

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		64.2	84.7	85.6	93.1	84	87.4	67.2
North Dakota												
HealthPartners Open Access Copay	$25/$45	10%	$12	$45/$90	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
HealthPartners 3 for Free	$0 for 3, then 20%	20% in/40% out	$6	$30/$60	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
Heart of America Health Plan-High	$15/$25	None	50%	50%/50%	None							
Ohio												
AultCare HMO-High	$10/$10	None	$10	$20/$35	No	89.8	92.3	92.9	93.5	96.4	91	85.4
HMO Health Ohio-High	$20/$20	$250	$20	$30/$40	Yes	65.2	87.4	88.8	95.2	86.3	90.2	74
Kaiser Foundation Health Plan-High	$15/$15	$200	$10	$25/$25	Yes	63.3	81.8	84.7	93	81.2	88.2	68.9
Kaiser Foundation Health Plan-Std	$25/$40	$500	$15	$40/$40	Yes	63.3	81.8	84.7	93	81.2	88.2	68.9
The Health Plan of the Upper Ohio Valley-High	$10/$20	$250	$15	$30/$50	Yes	75.9	91	89.9	94.9	92.6	95.1	73.2
Oklahoma												
Globalhealth, Inc.-High	$15/$35	$150/day x 3	$10	$30/$40	Yes	51.8	65	82.7	89.8	71.9	76.3	64.1
Oregon												
Kaiser Foundation Health Plan-High	$15/$15	$100	$15	$40/$40	Yes	63.9	76.4	79.8	92.1	81.1	83.7	70.7
Kaiser Foundation Health Plan-Std	$20/$30	$500	$20	$40/$40	Yes	63.9	76.4	79.8	92.1	81.1	83.7	70.7

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Pennsylvania					
Aetna Open Access -high- Philadelphia	800-392-9137	P31	P32	406.78	1045.34
Aetna Open Access -basic- Philadelphia	800-392-9137	P34	P35	214.42	521.52
Aetna Open Access -high- Pittsburgh and Western PA Areas	877-459-6604	YE1	YE2	86.94	239.74
Geisinger Health Plan -std- Northeastern/Central/South Central areas	800-447-4000	GG4	GG5	172.14	418.96
HealthAmerica Pennsylvania -high- Greater Pittsburgh area	866-351-5946	261	262	157.36	410.92
HealthAmerica Pennsylvania -std- Central Pennsylvania	866-351-5946	SW4	SW5	115.00	258.74
UPMC Health Plan -high- Western Pennsylvania	888-876-2756	8W1	8W2	189.58	459.16
UPMC Health Plan -std- Western Pennsylvania	888-876-2756	UW4	UW5	140.92	347.24
Puerto Rico					
Humana Health Plans of Puerto Rico, Inc. -high- Puerto Rico	800-314-3121	ZJ1	ZJ2	75.34	169.52
Triple-S Salud, Inc. -high- All of Puerto Rico	787-774-6060	891	892	74.46	167.54
South Dakota					
HealthPartners Open Access Copay-high-Eastern South Dakota	952-883-5000	V31	V32	268.18	639.86
HealthPartners 3 for Free-std-Eastern South Dakota	952-883-5000	V34	V35	73.92	170.02
Sanford Health Plan -high- Eastern/Central/Rapid City Areas	800-752-5863	AU1	AU2	198.44	480.04
Sanford Health Plan -std- Eastern/Central/Rapid City Areas	800-752-5863	AU4	AU5	178.46	433.60

Plan Name – Location		Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results (with national averages for HMO/POS plans in each category)						
				Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
					HMO/POS National Average		64.2	84.7	85.6	93.1	84	87.4	67.2
Pennsylvania													
Aetna Open Access-High		$20/$35	$150/day x 5	$10	$35/$65	Yes	57.1	83.4	84.9	92.7	85.1	89	69.5
Aetna Open Access-Basic		$15/$35	20% Plan Allow	$5	$35/$65	Yes	57.1	83.4	84.9	92.7	85.1	89	69.5
Aetna Open Access-High		$20/$35	$250/day x 4	$10	$35/$65	Yes	57.1	83.4	84.9	92.7	85.1	89	69.5
Geisinger Health Plan-Std		$20/$35	20%aftrDeduct	30% $5/$15	40% $40/$120/ 50% $60/$180	Yes	67.8	86.3	87.6	93.8	86.6	92.7	72.5
HealthAmerica Pennsylvania-High		$25/$50	15%	$5	$35/$60	N/A	66.8	87.1	87.3	94.3	89.3	93	75.3
HealthAmerica Pennsylvania-Std		$25/$50	15%	$5	$35/$60	Yes	66.8	87.1	87.3	94.3	89.3	93	75.3
UPMC Health Plan-High		$20/$35	10% after ded	$5	$35/$70	Yes	64.7	88.2	86.3	95.8	86.1	93.3	75.1
UPMC Health Plan-Std		$20/$35	20% after ded	$5	$35/$70	Yes	64.7	88.2	86.3	95.8	86.1	93.3	75.1
Puerto Rico													
Humana HP of Puerto Rico -	In-Network	$5/$5	None	$2.50	$10/$15	Yes	76.1	78.1	85	96.4	80.2	79	58.2
Humana HP of Puerto Rico-	Out-Network	$10/$10	$50	N/A	N/A	No	76.1	78.1	85	96.4	80.2	79	58.2
Triple-S Salud, Inc.-	In-Network	$7.50/$10	None	$5	$12/$15 or 20%/$25 or 25% max $100	Yes	75.7	87.1	85.9	95.9	77.1	79	48
Triple-S Salud, Inc.-	Out-Network	$7.50+10%/$10+10%	None	25%	25%/25%	No	75.7	87.1	85.9	95.9	77.1	79	48
South Dakota													
HealthPartners Open Access Copay		$25/$45	10%	$12	$45/$90	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
HealthPartners 3 for Free		$0 for 3, then 20%	20% in/40% out	$6	$30/$60	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
Sanford Health Plan-	In-Network	$20/$30	$100/day x 5	$15	$30/$50	N/A	53.3	85.2	87.1	92.8	84.8	88.8	66.8
Sanford Health Plan-	Out-Network	40%/40%	40%	N/A	N/A	N/A	53.3	85.2	87.1	92.8	84.8	88.8	66.8
Sanford Health Plan-	In-Network	$25/$25	$100/day x 5	$15	$30/$50	No	53.3	85.2	87.1	92.8	84.8	88.8	66.8
Sanford Health Plan-	Out-Network	40%/40%	40%	N/A	N/A	No	53.3	85.2	87.1	92.8	84.8	88.8	66.8

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Tennessee					
Aetna Open Access -high- Memphis Area	877-459-6604	UB1	UB2	117.38	389.18
Texas					
Aetna Open Access -high- Austin and San Antonio Areas	877-459-6604	P11	P12	201.80	610.62
Firstcare -high- West Texas	800-884-4901	CK1	CK2	112.86	546.46
Humana Health Plan of Texas -high- Corpus Christi	888-393-6765	UC1	UC2	122.74	281.20
Humana Health Plan of Texas -std- Corpus Christi	888-393-6765	UC4	UC5	106.86	240.44
Humana Health Plan of Texas -high- San Antonio	888-393-6765	UR1	UR2	348.10	788.26
Humana Health Plan of Texas -std- San Antonio	888-393-6765	UR4	UR5	112.48	253.10
Humana Health Plan of Texas -high- Austin	888-393-6765	UU1	UU2	184.14	419.32
Humana Health Plan of Texas -std- Austin	888-393-6765	UU4	UU5	118.12	265.76
Pacificare of Texas -high- San Antonio	866-546-0510	GF1	GF2	140.14	345.84
Utah					
Altius Health Plans -high- Wasatch Front	800-377-4161	9K1	9K2	192.82	411.22
Altius Health Plans -std- Wasatch Front	800-377-4161	DK4	DK5	91.88	202.14
SelectHealth -high- Urban and Suburban Utah	800-538-5038	SF1	SF2	157.96	334.62
Virgin Islands					
Triple-S Salud, Inc. -high- US Virgin Islands	800-981-3241	851	852	95.12	216.02
Virginia					
Aetna Open Access -high- Northern/Central/Richmond Virginia Areas	877-459-6604	JN1	JN2	321.38	721.22
Aetna Open Access -basic- Northern/Central/Richmond Virginia Areas	877-459-6604	JN4	JN5	109.14	255.42
CareFirst BlueChoice -high- Northern Virginia	866-296-7363	2G1	2G2	139.40	318.48
Kaiser Foundation Health Plan Mid-Atlantic States -high- Northern Virginia/Fredericksburg area	877-574-3337	E31	E32	124.70	309.90
Kaiser Foundation Health Plan Mid-Atlantic States -std- Northern Virginia/Fredericksburg area	877-574-3337	E34	E35	76.28	175.42
M.D. IPA -high- N.VA/Cntrl VA/Richmond	877-835-9861	JP1	JP2	122.04	306.64
Optima Health Plan -high- Hampton Roads and Richmond areas	800-206-1060	9R1	9R2	136.76	370.54
Optima Health Plan -std- Hampton Roads and Richmond areas	800-206-1060	9R4	9R5	86.14	203.84
Piedmont Community Healthcare -high- Lynchburg area	888-674-3368	2C1	2C2	117.64	269.52

Plan Name – Location	Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
			Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
				HMO/POS National Average		64.2	84.7	85.6	93.1	84	87.4	67.2
Tennessee												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	72	87.7	89.5	90.6	87.7	89.2	70
Texas												
Aetna Open Access-High	$20/$35	$250/day x 4	$10	$35/$65	Yes	65.6	87.3	82.4	90.6	85.2	91.9	71.1
Firstcare-High	$20/$55	$150/dayX5	$15	$35/$65	No	61.5	87.8	87.1	93.8	80.9	90	67.8
Humana Health Plan of Texas-High	$20/$35	$250/day x 3	$10	$40/$60	Yes							
Humana Health Plan of Texas-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes							
Humana Health Plan of Texas-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	62.7	85.5	81.4	91.7	87	88.7	61.6
Humana Health Plan of Texas-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	62.7	85.5	81.4	91.7	87	88.7	61.6
Humana Health Plan of Texas-High	$20/$35	$250/day x 3	$10	$40/$60	Yes	52.8	81.3	85.3	93.7	89.5	89.9	69
Humana Health Plan of Texas-Std	$25/$40	$500/day x 3	$10	$40/$60	Yes	52.8	81.3	85.3	93.7	89.5	89.9	69
Pacificare of Texas-High	$20/$40	$250/day x 5	$10	$35/$60	Yes	65.7	85.1	84.5	92.8	83.2	89.1	66.4
Utah												
Altius Health Plans-High	$20/$30	$200	$7	$25/$50	Yes	56.8	84.2	87.7	94.6	83.4	87.4	66.8
Altius Health Plans-Std	$20/$35	None	$7	$35/$60	Yes	56.8	84.2	87.7	94.6	83.4	87.4	66.8
SelectHealth-High	$15/$25	$100	$5	$25/50%	N/A							
Virgin Islands												
Triple-S Salud, Inc.- In-Network	$7.50/$10	None	$5	$12/$15 or 20%/$25 or 25% max $100	Yes							
Triple-S Salud, Inc.- Out-Network	$7.50+10%/$10+10%	None	25%	25%/25%	No							
Virginia												
Aetna Open Access-High	$15/$30	$150/day x3	$5	$35/$65	Yes	58.9	83	84.5	90	88.8	85.5	65.2
Aetna Open Access-Basic	$20/$35	10% Plan Allow	$10	$35/$65	Yes	58.9	83	84.5	90	88.8	85.5	65.2
CareFirst BlueChoice-High	$25/$35	$150/day x 3	$10	$30/$50	Yes	53.3	81.6	81.1	90.2	68.5	81.7	51.3
Kaiser Foundation HP-High	$10/$20	$100	$7/$17 Net	$30/$50/$45/$65	Yes	71.1	81.2	83.6	88.9	81.2	84.8	70
Kaiser Foundation HP-Std	$20/$30	$250/day x 3	$12/$22Net	$35/$55/$50/$70	Yes	71.1	81.2	83.6	88.9	81.2	84.8	70
M.D. IPA-High	$25/$35	$150/day x 3	$7	$25/$60/$100	No	58	79.1	86.6	89.7	83.9	88.8	63.8
Optima Health Plan-High	$5/$0 child<13/$30	$200	$10	$25/$50/$75	Yes	64.5	85.8	89.1	94.6	89.8	90.5	68.3
Optima Health Plan-Std	$20/$30	None	$5	$25/50% up to $3,000	No	64.5	85.8	89.1	94.6	89.8	90.5	68.3
Piedmont- In-Network	$35/$35	20%	$15	$30/$55	Yes							
Piedmont- Out-Network	30%/30%	30%	$15	$30/$55	Yes							

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

See page 37 for an explanation of the columns on these pages.

Plan Name – Location	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Washington					
Group Health Cooperative -high-Western WA/Central WA/Spokane/Pullman	888-901-4636	541	542	169.12	332.50
Group Health Cooperative -std- Western WA/Central WA/Spokane/Pullman	888-901-4636	544	545	85.76	193.62
KPS Health Plans -std- All of Washington	800-552-7114	L11	L12	86.24	186.14
KPS Health Plans -high- All of Washington	800-552-7114	VT1	VT2	213.08	447.18
Kaiser Foundation Health Plan of Northwest -high- Vancouver/Longview	800-813-2000	571	572	181.74	418.66
Kaiser Foundation Health Plan of Northwest -std- Vancouver/Longview	800-813-2000	574	575	105.76	242.96
West Virginia					
The Health Plan of the Upper Ohio Valley -high- Northern/Central West Virginia	800-624-6961	U41	U42	115.78	266.28
Wisconsin					
Dean Health Plan -high- South Central Wisconsin	800-279-1301	WD1	WD2	117.80	370.00
Group Health Cooperative -high- South Central Wisconsin	608-828-4827	WJ1	WJ2	109.46	287.02
HealthPartners Open Access Copay-high-Western Wisconsin	952-883-5000	V31	V32	268.18	639.86
HealthPartners 3 for Free-std-Western Wisconsin	952-883-5000	V34	V35	73.92	170.02
MercyCare HMO-high- South Central Wisconsin	800-895-2421	EY1	EY2	117.82	370.36
Physicians Plus -high- Dane County	800-545-5015	LW1	LW2	112.18	336.34
Wyoming					
Altius Health Plans -high- Uinta County	800-377-4161	9K1	9K2	192.82	411.22
Altius Health Plans -std- Uinta County	800-377-4161	DK4	DK5	91.88	202.14

Plan Name – Location		Primary care/ Specialist office copay	Hospital per stay deductible	Prescription Drugs			Member Survey Results						
				Level I	Level II/ Level III	Mail order discount	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
HMO/POS National Average							**64.2**	**84.7**	**85.6**	**93.1**	**84**	**87.4**	**67.2**
Washington													
Group Health Cooperative-High		$25/$25	$350/day x 3	$20	$40/$60	Yes	67	87	89.9	94.2	87.9	85.4	71.6
Group Health Cooperative-Std		$25+20%	$500/day x 3	$20	$40/$60	Yes	67	87	89.9	94.2	87.9	85.4	71.6
KPS Health Plans-Std	In-Network	$15/3 or 20%/20%	Nothing	$10	$35/$40max $100	Yes	75.6	93.9	92.5	95.1	92	91.3	72.4
KPS Health Plans-	Out-Network	$15/3+40%+diff	Nothing	Not Covered	Not Covered	No	75.6	93.9	92.5	95.1	92	91.3	72.4
KPS Health Plans-High	In-Network	$30/$30	None	$5	$20/50% or $100	No	75.6	93.9	92.5	95.1	92	91.3	72.4
KPS Health Plans-	Out-Network	$30+40%+diff	None	Not covered	N/A	No	75.6	93.9	92.5	95.1	92	91.3	72.4
Kaiser Foundation HP-High		$15/$15	$100	$15	$40/$40	Yes	63.9	76.4	79.8	92.1	81.1	83.7	70.7
Kaiser Foundation HP-Std		$20/$30	$500	$20	$40/$40	Yes	63.9	76.4	79.8	92.1	81.1	83.7	70.7
West Virginia													
HP of the Upper Ohio Valley-High		$10/$20	$250	$15	$30/$50	Yes	75.9	91	89.9	94.9	92.6	95.1	73.2
Wisconsin													
Dean Health Plan-High		$10/$10	None	$10	30%/$75max/50%	Yes	72.4	86.7	89.3	95.2	87.7	88.4	72.2
Group Health Cooperative-High		$10/$10	None	$5	$20/$20	Yes	77.4	81.4	88.3	95.1	91.1	85.8	74.4
HealthPartners Open Access Copay		$25/$45	10%	$12	$45/$90	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
HealthPartners 3 for Free		$0 for 3, then 20%	20% in/40% out	$6	$30/$60	Yes	67.1	86.8	90.1	96	91.8	93.2	67.7
MercyCare HMO-High		$10/$10	Nothing	$10	$20/$50	Yes							
Physicians Plus-High		$10/$10	Nothing	$10	30%/50%	N/A	71.7	88.4	86.8	94.6	88.7	91.3	73.9
Wyoming													
Altius Health Plans-High		$20/$30	$200	$7	$25/$50	Yes	56.8	84.2	87.7	94.6	83.4	87.4	66.8
Altius Health Plans-Std		$20/$35	None	$7	$35/$60	Yes	56.8	84.2	87.7	94.6	83.4	87.4	66.8

Appendix E
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement (Pages 66 through 91)

A High Deductible Health Plan (HDHP) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The HDHP gives you greater flexibility and discretion over how you use your health care benefits.

When you enroll, your health plan establishes for you either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The plan automatically deposits the monthly "premium pass through" into your HSA. The plan credits an amount into the HRA. (This is the "Premium Contribution to HSA/HRA" column in the following charts.)

Preventive care is often covered in full, usually with no or only a small deductible or copayment. Preventive care expenses may also be payable up to an annual maximum dollar amount (up to $300 for instance). As you receive other non-preventive medical care, you must meet the plan deductible before the health plan pays benefits. You can choose to pay your deductible with funds from your HSA or you can choose instead to pay for your deductible out-of-pocket, allowing your savings to continue to grow.

The HDHP features higher annual deductibles (a minimum of $1,200 for Self and $2,400 for Family coverage) and annual out-of-pocket limits (not to exceed $5,950 for Self and $11,900 for Family coverage) than other insurance plans. Depending on the HDHP you choose, you may have the choice of using In-Network and Out-of-Network providers. There may be higher deductibles and out-of-pocket limits when you use Out-of-Network providers. Using In-Network providers will save you money.

Health Savings Account (HSA)

A health savings account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pre-tax basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax free, and that amount is available on a tax free basis to pay medical costs. You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return. If you are enrolled in a High Deductible Health Plan with an HSA you may not participate in a Health Care Flexible Spending Account (HCFSA), but you are permitted to participate in a Limited Expense (LEX) HCFSA. HSA's are subject to a number of rules and limitations established by the Department of the Treasury.

Visit www.ustreas.gov/offices/public-affairs/hsa for more information. The 2011 maximum contribution limits are $3,050 for Self Only coverage and $6,150 for Self and Family coverage. If you are over 55, you can make an additional "catch up" contribution. You can use funds in your account to help pay your health plan deductible.

Appendix E
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

Features of an HSA include:

- Tax-deductible deposits you make to the HSA. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). See IRS Publication 969.
- Tax-deferred interest earned on the account.
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused funds and interest from year to year.
- Portability; the account is owned by you and is yours to keep – even when you retire, leave government service, or change plans.

Health Reimbursement Arrangement (HRA)

Health Reimbursement Arrangements are a common feature of Consumer-Driven Health Plans. They may be referred to by the health plan under a different name, such as personal care account. They are also available to enrollees in High Deductible Health Plans who are not eligible for an HSA. HRAs are similar to HSAs except:

- An enrollee cannot make deposits into an HRA;
- A health plan may impose a ceiling on the value of an HRA;
- Interest is not earned on an HRA; and
- The amount in an HRA is not transferable if the enrollee leaves the health plan.

If you are enrolled in a High Deductible Health Plan with an HRA you may participate in a Health Care Flexible Spending Account (HCFSA).

The plan will credit the HRA different amounts depending on whether you have a Self Only or a Self and Family enrollment. You can use funds in your account to help pay your health plan deductible.

Features of an HRA include:

- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused credits from year to year.
- Credits in an HRA do not earn interest.
- Credits in the HRA are forfeited if you leave federal employment or switch health insurance plans.

Appendix E
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

	Health Savings Account (HSA)	**Health Reimbursement Arrangement (HRA)**
ELIGIBILITY	You must enroll in a High Deductible Health Plan (HDHP). No other general medical insurance coverage is permitted. You cannot be enrolled in Medicare Part A or Part B. You cannot be claimed as a dependent on someone else's tax returns.	You must enroll in a High Deductible Health Plan (HDHP).
FUNDING	The plan deposits a monthly "premium pass through" into your account.	The plan deposits the credit amount directly into your account.
CONTRIBUTIONS	The maximum allowed is a combination of the health plan "premium pass through" and the member contribution up to the maximum contribution amount set by the IRS each year.	Only that portion of the premium specified by the health plan will be contributed. You cannot add your own money to an HRA.
DISTRIBUTIONS	May be used to pay the out-of-pocket medical expenses for yourself, your spouse, or your dependents (even if they are not covered by the HDHP), or to pay the plan's deductible. See IRS Publication 502 for a complete list of eligible expenses.	May be used to pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP, or to pay the plan's deductible. See IRS Publication 502 for a complete list of eligible expenses.
PORTABLE	Yes, you can take this account with you when you change plans, separate from service, or retire.	If you retire and remain in your HDHP you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under that HDHP will be eligible for reimbursement, subject to timely filing requirements. Unused credits are forfeited.
ANNUAL ROLLOVER	Yes, funds accumulate without a maximum cap.	Yes, credits accumulate without a maximum cap.

IMPORTANT REMINDER: This is only a summary of the features of the HDHP/HSA or HRA. Refer to the specific Plan brochure for the complete details covering Plan design, operation, and administration as each Plan will have differences.

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FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

A Consumer-Driven plan provides you with freedom in spending health care dollars the way you want. The typical plan has features such as: member responsibility for certain up-front medical costs, an employer-funded account that you may use to pay these up-front costs, and catastrophic coverage with a high deductible. You and your family receive full coverage for In-Network preventive care.

Appendix E
FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

The tables on the following pages highlight what you are expected to pay for selected features under each plan. The charts are not a complete statement of your out-of-pocket obligations in every individual circumstance. Unlike many regular medical plans, the covered out-of-pocket expenses under a High Deductible Health Plan, including office visit copayments and prescription drug copayments, count toward the calendar year deductible and the catastrophic limit. *You must read the plan's brochure for details.*

Premium Contribution (pass through) to HSA/HRA (or personal care account) shows the amount your health plan automatically deposits or credits into your account on a monthly basis for Self Only/Self and Family enrollments. (Consumer-Driven Health Plans credit accounts annually.) The amount credited under "Premium Contribution" is shown as a monthly amount for comparison purposes only.

Calendar Year (CY) Deductible Self/Family is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles, coinsurance and copayments, before the plan pays catastrophic benefits.

Catastrophic (Cat.) Limit Self/Family is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance and copays, before the Plan pays catastrophic benefits.

Office Visit shows what you pay for a visit to a primary care physician after the deductible is met for other than preventive care.

Inpatient Hospital shows what you pay after the deductible is met for hospital services when an inpatient. The amount could be a daily copayment up to a specified amount (e.g., $50 a day up to three days), a coinsurance amount such as

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
APWU Health Plan -CDHP	866-833-3463	474	475	77.70	174.80
GEHA High Deductible Health Plan -HDHP	800-821-6136	341	342	87.88	200.72
Mail Handlers Benefit Plan Consumer Option -HDHP	800-694-9901	481	482	91.10	206.42

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FEHB Plan Comparison Charts

High Deductible and Consumer-Driven Health Plans With a Health Savings Account or Health Reimbursement Arrangement

20%, or a flat deductible amount (e.g., $200 per admission). This amount does not include charges from physicians or for services that may not be charged by the hospital such as laboratory or radiology.

Outpatient Surgery shows what you pay the doctor for surgery performed on an outpatient basis.

Preventive Services are often covered in full, usually with no or only a small deductible or copayment. Preventive services may also be payable up to an annual maximum dollar amount (e.g., up to $300 per person per year).

Prescription Drugs are catagorized using a variety of terms to define what you pay such as generic, brand, Level I, Level II, Tier I, Tier II, etc. In capturing these differences we use the following: **Level I** includes most generic drugs, but may include some preferred brands. **Level II** may include generics and preferred brands not included in Level I. **Level III** includes all other covered drugs with some exceptions for specialty drugs. The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

High Deductible Health Plans and Consumer Driven Health Plans are much different from the other types of plans shown in this Guide. You can use in-network providers to save money. If you use out-of-network providers, however, you not only pay more of the costs but you are also usually responsible for any difference between the amount billed for a service and what the plan actually allows. (For example, you receive a bill from an out-of-network provider for $100 but the plan allows $85 for the service. You pay the higher copayment for out-of-network care plus the $15 difference between $100 – the billed amount – and the plan's allowance of $85.) In addition, the difference you pay between the billed amount and the plan's allowance does not count toward satisfying the catastrophic limit.

Plan Name	Benefit Type	Premium Contribution Self/Family	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
APWU Health Plan-	In-Network	$100/$200	$600/$1,200	$3,000/$4,500	15%	None	15%	Nothing	25%
APWU Health Plan-	Out-Network	$100/$200	$600/$1,200	$9,000/$9,000	40%+diff.	None	40%+diff.	Nothing up to $1200	N/A
GEHA HDHP-	In-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	5%	5%	5%	Nothing	25%
GEHA HDHP-	Out-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	25%	25%	25%	Ded/25%	25%+
Mail Handlers Benefit Plan Consumer Option-	In-Network	$70/$140	$2,000/$4,000	$5,000/$10,000	$15	$75 day-$750	Nothing	Nothing	$10/$25/$40
Mail Handlers Benefit Plan Consumer Option-	Out-Network	$70/$140	$2,000/$4,000	$7,500/$15,000	40%	40%	40%	Not Covered	Not Covered

High Deductible Health Plans and Consumer-Driven Health Plan Member Survey Results

Member Survey results are collected, scored, and reported by an independent organization – not by the health plans. See Appendix D for a fuller explanation of each survey category.

Overall Plan Satisfaction	• How would you rate your overall experience with your health plan?
Getting Needed Care	• How often was it easy to get an appointment, the care, tests, or treatment you thought you needed through your health plan?
Getting Care Quickly	• When you needed care right away, how often did you get care as soon as you thought you needed? • Not counting the times you needed care right away, how often did you get an appointment at a doctor's office or clinic as soon as you thought you needed?
How Well Doctors Communicate	• How often did your personal doctor explain things in a way that was easy to understand? • How often did your personal doctor listen carefully to you, show respect for what you had to say, and spend enough time with you?
Customer Service	• How often did written materials or the Internet provide the information you needed about how your health plan works? • How often did your health plan's customer service give you the information or help you needed? • How often were the forms from your health plan easy to fill out?
Claims Processing	• How often did your health plan handle your claims quickly and correctly?
Plan Information on Costs	• How often were you able to find out from your health plan how much you would have to pay for a health care service or equipment, or for specific prescription drug medicines?

		Member Survey Results						
High Deductible Health Plans **Plan Name**	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
HDHP National Average		**57.8**	**82.7**	**85.3**	**93.2**	**81.8**	**85.7**	**54.5**
Aetna Health Fund - Nationwide	22	62.9	81.1	85.2	92.6	81.3	86	55.7
GEHA High Deductible Health Plan - Nationwide	34	64.4	85	85.7	93.7	84.4	88.9	61
Mail Handlers Benefit Plan Consumer Option - Nationwide	48	49.5	84.6	85.2	93.7	82.6	83.4	46.2
Consumer-Driven Health Plans **Plan Name**	**Plan Code**	Overall plan satisfaction	Getting needed care	Getting care quickly	How well doctors communicate	Customer service	Claims processing	Plan Information on Costs
CDHP National Average		**56.5**	**83.8**	**85.9**	**93**	**81.8**	**85.1**	**59.6**
Aetna Health Fund - Nationwide	22	62.9	81.1	85.2	92.6	81.3	86	55.7
APWU Health Fund - Nationwide	47	67.1	88.4	87.7	93.6	81.6	84.3	61.3
Humana Coverage First - FL	MJ	41.6	83.8	84.1	92.8	84.3	86.1	62
Humana Coverage First -TX	T2, TU, TV	54.5	84.1	85.2	94	80.2	84.8	62.7

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High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Alabama					
Aetna HealthFund -CDHP- Most of Alabama	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Alabama	877-459-6604	224	225	78.78	172.52
Alaska					
Aetna HealthFund -CDHP- Most of Alaska	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Alaska	877-459-6604	224	225	78.78	172.52
Arizona					
Aetna HealthFund -CDHP- All of Arizona	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Arizona	877-459-6604	224	225	78.78	172.52
Arkansas					
Aetna HealthFund -CDHP- Most of Arkansas	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Arkansas	877-459-6604	224	225	78.78	172.52
California					
Aetna HealthFund -CDHP- Most of California	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of California	877-459-6604	224	225	78.78	172.52
Colorado					
Aetna HealthFund -CDHP- All of Colorado	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Colorado	877-459-6604	224	225	78.78	172.52

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Alabama									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Alaska									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Arizona									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Arkansas									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
California									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Colorado									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Connecticut					
Aetna HealthFund -CDHP- All of Connecticut	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Connecticut	877-459-6604	224	225	78.78	172.52
Delaware					
Aetna HealthFund -CDHP- All of Delaware	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Delaware	877-459-6604	224	225	78.78	172.52
District of Columbia					
Aetna HealthFund -CDHP- All of Washington DC	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Washington DC	877-459-6604	224	225	78.78	172.52
Florida					
Aetna HealthFund -CDHP- Most of Florida	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Florida	877-459-6604	224	225	78.78	172.52
Humana CoverageFirst -CDHP- Tampa Area	888-393-6765	MJ1	MJ2	112.42	252.92
Humana CoverageFirst -CDHP- South Florida Area	888-393-6765	QP1	QP2	107.44	241.76

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Connecticut									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Delaware									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
District of Columbia									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Florida									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Georgia					
Aetna HealthFund -CDHP- Most of Georgia	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Georgia	877-459-6604	224	225	78.78	172.52
Humana CoverageFirst -CDHP- Atlanta Area	888-393-6765	AD1	AD2	105.94	238.38
Humana CoverageFirst -CDHP- Macon Area	888-393-6765	LM1	LM2	107.84	242.64
Kaiser Foundation Health Plan of Georgia Inc. HDHP - Atlanta,Athens,Columbus,Macon,Savannah	888-865-5813	GW1	GW2	76.06	170.98
Guam					
TakeCare -HDHP- Guam/N. Mariana Islands/Belau (Palau)	671-647-3526	KX1	KX2	75.12	197.70
Hawaii					
Aetna HealthFund -CDHP- Hawaii, Honolulu, Kauai and Maui	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Hawaii, Honolulu, Kauai and Maui	877-459-6604	224	225	78.78	172.52
Idaho					
Aetna HealthFund -CDHP- Most of Idaho	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Idaho	877-459-6604	224	225	78.78	172.52
Altius Health Plans -HDHP- Southern Region	800-377-4161	9K4	9K5	80.34	166.46
Illinois					
Aetna HealthFund -CDHP- Most of Illinois	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Illinois	877-459-6604	224	225	78.78	172.52
Humana CoverageFirst -CDHP- Chicago Area	888-393-6765	MW1	MW2	109.20	245.70

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Georgia									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Kaiser Foundation Health Plan- HDHP		$62.50/$125.00	$1,500/$3,000	$3,000/$6,000	20%	20%	20%	Nothing	20%
Guam									
TakeCare-	In-Network	$86.66/$222.08	$3000/$6000	$5,000/$10,000	20%afterDed	20% after Ded	20% after Ded	1st $300/ded	$20/$40/$150
TakeCare-	Out-Network	$86.66/$222.08	$3000/$6000	$10,000/$20,000	30%afterDed	30% after Ded	30% after Ded	1st $300/ded	30% after Ded
Hawaii									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Idaho									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Altius Health Plans		$45.83/$91.66	$1,200/$2,400	$5,000/$10,000	$20	10%	10%	Nothing	$7/$25/$50
Illinois									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Indiana					
Aetna HealthFund -CDHP- All of Indiana	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Indiana	877-459-6604	224	225	78.78	172.52
Bluegrass Family Health -HDHP- Southern Indiana	800-787-2680	KV1	KV2	109.00	218.00
Humana CoverageFirst -CDHP- Lake/Porter/LaPorte Counties	888-393-6765	MW1	MW2	109.20	245.70
Iowa					
Aetna HealthFund -CDHP- All of Iowa	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Iowa	877-459-6604	224	225	78.78	172.52
Coventry Health Care of Iowa -HDHP- Central/Eastern/Western Iowa	800-257-4692	SV4	SV5	75.76	180.82
Kansas					
Aetna HealthFund -CDHP- Most of Kansas	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Kansas	877-459-6604	224	225	78.78	172.52
Coventry Health Care of Kansas (Kansas City)-HDHP- Kansas City/Wichita/Salina Areas	800-969-3343	9H1	9H2	86.56	203.44
Humana CoverageFirst -CDHP- Kansas City Area	888-393-6765	PH1	PH2	99.08	222.96
Kentucky					
Aetna HealthFund -CDHP- Most of Kentucky	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Kentucky	877-459-6604	224	225	78.78	172.52
Bluegrass Family Health -HDHP- Kentucky	800-787-2680	KV1	KV2	109.00	218.00
Humana CoverageFirst -CDHP- Lexington Area	888-393-6765	6N1	6N2	91.38	205.60

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Indiana									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Bluegrass Family Health-	In-Network	$104.17/$208.33	$2,500/$5,000	$5,000/$7,500	0%	0%	0%	Nothing	$10/$30/$30
Bluegrass Family Health-	Out-Network	$104.17/$208.33	$5,000/$10,000	$10,000/$15,000	30%	30%	30%	Ded/30%	N/A
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Iowa									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Coventry Health Care of Iowa		$66.67/$133.34	$1,800/$3,600	$5,000/$10,000	$20	None	10%	$20/$30/10%	$10/$40/$65
Kansas									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Coventry Health Care of Kansas-HDHP		$66.66/$133.33	$3,500/$6,500	$3,000/$6,000	Nothing	None	Nothing	$20/$35/0%	Nothing
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Kentucky									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Bluegrass Family Health-	In-Network	$104.17/$208.33	$2,500/$5,000	$5,000/$7,500	0%	0%	0%	Nothing	$10/$30/$30
Bluegrass Family Health-	Out-Network	$104.17/$208.33	$5,000/$10,000	$10,000/$15,000	30%	30%	30%	Ded/30%	N/A
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Louisiana					
Aetna HealthFund -CDHP- Most of Louisiana	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Louisiana	877-459-6604	224	225	78.78	172.52
Maine					
Aetna HealthFund -CDHP- All of Maine	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Maine	877-459-6604	224	225	78.78	172.52
Maryland					
Aetna HealthFund -CDHP- All of Maryland	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Maryland	877-459-6604	224	225	78.78	172.52
Coventry Health Care-HDHP- All of Maryland	800-833-7423	GZ1	GZ2	85.32	198.22
Massachusetts					
Aetna HealthFund -CDHP- Most of Massachusetts	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Massachusetts	877-459-6604	224	225	78.78	172.52
Michigan					
Aetna HealthFund -CDHP- All of Michigan	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Michigan	877-459-6604	224	225	78.78	172.52
Health Alliance Plan -HDHP- Southeastern Michigan/Flint area	800-556-9765	524	525	89.32	223.52

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Louisiana									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Maine									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Maryland									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Coventry Health Care HDHP	In-Network	$41.67/$83.34	$2,000/$4,000	$4,000/$8,000	$15	Nothing	Nothing	Nothing	$15/$30/$60
Coventry Health Care HDHP	Out-Network	$41.67/$83.34	$2,000/$4,000	$4,000/$8,000	30%	30%	30%	30%	N/A
Massachusetts									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Michigan									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Health Alliance Plan		$62.50/$125	$1,500/$3,000	$5,000/$10,000	$15	$0 aft Ded	$100 aft Ded	$15/$25	$10/$20/$50

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Minnesota					
Aetna HealthFund -CDHP- Most of Minnesota	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Minnesota	877-459-6604	224	225	78.78	172.52
Mississippi					
Aetna HealthFund -CDHP- Most of Mississippi	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Mississippi	877-459-6604	224	225	78.78	172.52
Missouri					
Aetna HealthFund -CDHP- Most of Missouri	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Missouri	877-459-6604	224	225	78.78	172.52
Coventry Health Care of Kansas (Kansas City)-HDHP- Kansas City Area	800-969-3343	9H1	9H2	86.56	203.44
Humana CoverageFirst -CDHP- Kansas City Area	888-393-6765	PH1	PH2	99.08	222.96
Montana					
Aetna HealthFund -CDHP- South/Southeast/Western Montana	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- South/Southeast/Western Montana	877-459-6604	224	225	78.78	172.52
Nebraska					
Aetna HealthFund -CDHP- Most of Nebraska	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Nebraska	877-459-6604	224	225	78.78	172.52

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Minnesota									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Mississippi									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Missouri									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Coventry Health Care of Kansas-HDHP		$66.66/$133.33	$3,500/$6,500	$3,000/$6,000	Nothing	None	Nothing	$20/$35/0%	Nothing
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Montana									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Nebraska									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Nevada					
Aetna HealthFund -CDHP- Las Vegas/Clark and Nye Counties	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Las Vegas/Clark and Nye Counties	877-459-6604	224	225	78.78	172.52
New Hampshire					
Aetna HealthFund -CDHP- All of New Hampshire	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of New Hampshire	877-459-6604	224	225	78.78	172.52
New Jersey					
Aetna HealthFund -CDHP- All of New Jersey	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of New Jersey	877-459-6604	224	225	78.78	172.52
New Mexico					
Aetna HealthFund -CDHP- Albuquerque/Dona Ana/Hobbs Areas	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Albuquerque/Dona Ana/Hobbs Areas	877-459-6604	224	225	78.78	172.52
New York					
Aetna HealthFund -CDHP- Most of New York	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of New York	877-459-6604	224	225	78.78	172.52
Independent Health Assoc -HDHP- Western New York	800-501-3439	QA4	QA5	95.14	242.62

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Nevada									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
New Hampshire									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
New Jersey									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
New Mexico									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
New York									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Independent Health Assoc.-	In-Network	$66.41/$166.67	$2000/$4000	$5000/$10000	$15	Nothing	20%	Nothing	$7/$25/$40
Independent Health Assoc.-	Out-Network	$66.41/$166.67	$2000/$4000	$5000/$10000	40%	40%	40%	Ded/40%	N/A

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
North Carolina					
Aetna HealthFund -CDHP- All of North Carolina	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of North Carolina	877-459-6604	224	225	78.78	172.52
North Dakota					
Aetna HealthFund -CDHP- Most of North Dakota	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of North Dakota	877-459-6604	224	225	78.78	172.52
Ohio					
Aetna HealthFund -CDHP- All of Ohio	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Ohio	877-459-6604	224	225	78.78	172.52
AultCare HMO -HDHP- Stark/Carroll/Holmes/Tuscarawas/Wayne Co.	330-363-6360	3A4	3A5	71.62	143.52
Oklahoma					
Aetna HealthFund -CDHP- Most of Oklahoma	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Oklahoma	877-459-6604	224	225	78.78	172.52
Oregon					
Aetna HealthFund -CDHP- Most of Oregon	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Oregon	877-459-6604	224	225	78.78	172.52

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
North Carolina									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
North Dakota									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Ohio									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
AultCare HMO-	In-Network	74.58/149.58	$2,000/$4,000	$4,000/$8,000	20%	20%	20%	Nothing	20%
AultCare HMO-	Out-Network	74.58/149.58	$4,000/$8,000	$8,000/$16,000	40% UCR	40% UCR	40% UCR	50% UCR	40%
Oklahoma									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Oregon									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Pennsylvania					
Aetna HealthFund -CDHP- All of Pennsylvania	800-392-9137	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Pennsylvania	800-392-9137	224	225	78.78	172.52
HealthAmerica Pennsylvania-HDHP -Greater Pittsburgh Area	866-351-5946	Y61	Y62	109.06	251.94
HealthAmerica Pennsylvania-HDHP -Central Pennsylvania	866-351-5946	YW1	YW2	129.12	295.54
UPMC Health Plan -HDHP- Western Pennsylvania	888-876-2756	8W4	8W5	108.14	240.22
Rhode Island					
Aetna HealthFund -CDHP- All of Rhode Island	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Rhode Island	877-459-6604	224	225	78.78	172.52
South Carolina					
Aetna HealthFund -CDHP- Most of South Carolina	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of South Carolina	877-459-6604	224	225	78.78	172.52
South Dakota					
Aetna HealthFund -CDHP- Rapid City/Sioux Falls Areas	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Rapid City/Sioux Falls Areas	877-459-6604	224	225	78.78	172.52

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Pennsylvania									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
HealthAmerica Pennsylvania-HDHP		$52.09/$104.17	$1,500/$3,000	$4,000/$8,000	$15	None	Nothing	$15/$25	$5/$35/$50
HealthAmerica Pennsylvania-HDHP		$52.09/$104.17	$1,500/$3,000	$4,000/$8,000	$15	None	Nothing	$15/$25	$5/$35/$50
UPMC Health Plan-	In-Network	$104.17/$208.34	$2,500/$5,000	$4,000/$8,000	Nothing	None	Nothing	Nothing	$5/$35/$70
UPMC Health Plan-	Out-Network	$104.17/$208.34	$2,500/$5,000	$5,500/$11,000	20%	20%afterded	20%	20%	N/A
Rhode Island									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
South Carolina									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
South Dakota									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Tennessee					
Aetna HealthFund -CDHP- Most of Tennessee	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Tennessee	877-459-6604	224	225	78.78	172.52
Texas					
Aetna HealthFund -CDHP- Most of Texas	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Texas	877-459-6604	224	225	78.78	172.52
Humana CoverageFirst -CDHP- Corpus Christi Area	888-393-6765	TP1	TP2	96.36	216.80
Humana CoverageFirst -CDHP- San Antonio Area	888-393-6765	TU1	TU2	108.66	244.48
Humana CoverageFirst -CDHP- Austin Area	888-393-6765	TV1	TV2	113.82	256.08
Utah					
Aetna HealthFund -CDHP- Most of Utah	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Utah	877-459-6604	224	225	78.78	172.52
Altius Health Plans -HDHP- Wasatch Front	800-377-4161	9K4	9K5	80.34	166.46
Vermont					
Aetna HealthFund -CDHP- All of Vermont	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Vermont	877-459-6604	224	225	78.78	172.52
Virginia					
Aetna HealthFund -CDHP- Most of Virginia	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Virginia	877-459-6604	224	225	78.78	172.52

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Tennessee									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Texas									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Humana CoverageFirst-	In-Network	$83.33	$1,000/$2,000	$3,000/$6,000	$25	$300/day x 5	$150	Nothing	$10/$40/$60
Humana CoverageFirst-	Out-Network	N/A	$3,000/$6,000	$4,000/$8,000	30%	30%	30%	30%	$10+/$40+/$60+
Utah									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Altius Health Plans		$45.83/$91.66	$1,200/$2,400	$5,000/$10,000	$20	10%	10%	Nothing	$7/$25/$50
Vermont									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Virginia									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+

High Deductible and Consumer-Driven Health Plans

See pages 66-67 for an explanation of the columns on these pages.

Plan Name	Telephone Number	Enrollment Code		Twice - Biweekly Premium Your Share	
		Self only	Self & family	Self only	Self & family
Washington					
Aetna HealthFund -CDHP- Most of Washington	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of Washington	877-459-6604	224	225	78.78	172.52
KPS Health Plans -HDHP- All of Washington	800-552-7114	L14	L15	81.58	178.26
West Virginia					
Aetna HealthFund -CDHP- Most of West Virginia	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- Most of West Virginia	877-459-6604	224	225	78.78	172.52
Wisconsin					
Aetna HealthFund -CDHP- All of Wisconsin	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Wisconsin	877-459-6604	224	225	78.78	172.52
Wyoming					
Aetna HealthFund -CDHP- All of Wyoming	877-459-6604	221	222	115.50	277.04
Aetna HealthFund -HDHP- All of Wyoming	877-459-6604	224	225	78.78	172.52
Altius Health Plans -HDHP- Uinta County	800-377-4161	9K4	9K5	80.34	166.46

Plan Name	Benefit Type	Premium Contribution to HSA/HRA	CY Ded. Self/Family	Cat. Limit Self/Family	Office Visit	Inpatient Hospital	Outpatient Surgery	Preventive Services	Prescription Drugs Levels I, II, III
Washington									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
KPS Health Plans-	In-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	20%	None	20%	Nothing up to $400	$10/$35/50%/$40/ $100max
KPS Health Plans-	Out-Network	$62.50/$125	$1,500/$3,000	$5,000/$10,000	40%	None	40%	Not Covered	Not Covered
West Virginia									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Wisconsin									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Wyoming									
Aetna HealthFund-	In-Network	$83.33/166.66	$1,000/$2,000	$4,000/$8,000	15%	15%	15%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$83.33/166.66	$1,000/$2,000	$5,000/$10,000	40%	40%	40%	Fund/Ded/40%	40%+
Aetna HealthFund-	In-Network	$62.50/$125	$1,500/$3,000	$4,000/$8,000	10%	10%	10%	Nothing	$10/$35/$60
Aetna HealthFund-	Out-Network	$62.50/$125	$2,500/$5,000	$5,000/$10,000	30%	30%	30%	Ded/30%	30%+
Altius Health Plans		$45.83/$91.66	$1,200/$2,400	$5,000/$10,000	$20	10%	10%	Nothing	$7/$25/$50

Appendix F
FEDVIP Program Features

Waiting Periods

Dental - limited only to orthodontic services on most plans; for all other services, you may use your benefits as soon as your coverage becomes effective. There are very few pre-existing condition limitations.

Vision - no waiting period, you may use your benefits as soon as your coverage becomes effective. There are no pre-existing condition limitations.

A Choice of Coverage

Choose between Self Only, Self Plus One or Self and Family.

Contributions

There are no Government contributions. The enrollee pays 100% of the premium.

Salary Deduction

You automatically pay your premium through a payroll deduction using pre-tax dollars; employees cannot elect to waive this pre-tax option and annuitants are not eligible for this option. When premium contributions are withheld on a pre-tax basis, Internal Revenue Service (IRS) guidelines affect your ability to change coverage, i.e., you may cancel or change coverage levels only during an FEDVIP Open Season. You may also make changes throughout the plan year if a qualified life event occurs.

Annual Enrollment Opportunity

Each year, you may enroll or change your dental and/or vision plan enrollment. Open Season runs from the Monday of the second full work week in November through the Monday of the second full work week in December. Other events allow for certain types of changes throughout the year.

Continued Coverage

Eligibility for you or your family member may continue following your retirement or changes in employment status.

Claim Dispute Resolution

The claim review process will differ among plans. Upon written request from the enrollee and as a final option, the carrier will submit a dispute for resolution through a binding arbitration process. OPM will not review nor resolve disputes regarding FEDVIP. Please see your plan brochure for details.

Appendix G
FEDVIP Definitions

Eligible Dependents – Your spouse and unmarried dependent children under age 22. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support. **PLEASE NOTE:** *The new health care law does not change the age or unmarried requirement for dependents under FEDVIP.*

First Payer – Under this rule, the FEHB plan is considered the primary payer and pays first, while the FEDVIP plan is considered the secondary payer. No more than 100% of any claim is paid by both plans.

In-Network Services – Services provided by members of the plan's provider network.

Nationwide Plan – A plan which provides services throughout the United States and around the world.

Out-of-Network Services – Services provided by health care professionals who are not a member of the plan's provider network.

Plan – The insurance company which participates in the FEDVIP program. Also called carrier.

Precertification – Also called predetermination. This is the procedure used by dental offices to determine what services a plan will cover and how much will be paid before the service is rendered.

Provider – A licensed health care professional; for example: dentists, oral surgeons, optometrists and ophthalmologists.

Provider Network – A group of health care providers who have a contract with a specific plan to provide services at an agreed upon cost.

Qualifying Life Event (QLE) – An event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an Open Season. There is no QLE under FEDVIP which allows for cancellation, except upon deployment to active military duty or transfers to certain agencies.

Regional Plan – A plan which provides services only in specified geographic regions.

Usual, Customary and Reasonable – A widely used method, which may vary from company to company, for determining benefit reimbursement levels. The initials simply mean:

Usual. The fee that an individual dentist most frequently charges for a given dental service.

Customary. A fee determined by the insurance company based on the range of usual fees charged by dentists in the same geographic area.

Reasonable. A fee which is justifiable considering special circumstances of the particular care rendered.

Waiting Period – The length of time a person must be covered under the plan before they are eligible for certain benefits. For example, most plans have a 24 month waiting period for orthodontic benefits. This means that you must be covered continuously by the same plan and option for 24 months before your child is eligible for orthodontic coverage.

Appendix H
FEDVIP Qualifying Life Events for Enrollment Changes

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an Open Season.

The following chart lists the QLEs and the enrollment actions you may take.

Qualifying Life Event	From Not Enrolled to Enrolled	Increase Enrollment Type	Decrease Enrollment Type	Cancel	Change from One Plan to Another
Acquiring an eligible family member	**No**	**Yes**	**No**	**No**	**No**
Losing a covered family member	**No**	**No**	**Yes**	**No**	**No**
Losing other dental/vision coverage (eligible or covered person)	**Yes**	**Yes**	**No**	**No**	**No**
Moving out of regional plan's service area	**No**	**No**	**No**	**No**	**Yes**
Going on active military duty, non-pay status (enrollee or spouse)	**No**	**No**	**No**	**Yes**	**No**
Returning to pay status from active military duty (enrollee or spouse)	**Yes**	**No**	**No**	**No**	**No**
Annuity/ compensation restored	**Yes**	**Yes**	**Yes**	**No**	**No**
Transferring to an eligible position	**No**	**No**	**No**	**Yes**	**No**

The time frame for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

- There is no time limit for a change based on moving from a regional plans service area; and
- You cannot request a new enrollment based on a QLE before the QLE occurs except for enrollment due to a loss of dental or vision insurance. You must make the change no later than 60 days after the event.

Generally, enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives and confirms the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date. BENEFEDS is a secure enrollment website sponsored by OPM.

Cancelling an enrollment

You can cancel your enrollment only during the annual Open Season, upon deployment to active military duty, or transfers to certain agencies. An eligible family members coverage also ends upon the effective date of the cancellation.

Appendix I
FEDVIP Plan Comparison Charts

This is a brief summary of the features of the dental and vision plans. Before making a final decision, please read the plan brochures and provider directories thoroughly. All plans are not the same. All benefits are subject to the definitions, limitations, copayments, annual maximums and exclusions set forth in the individual plan brochures. Go to our website at www.opm.gov/insure/dental/rates to find the rating region assigned to the area where you live and the related premium cost you will pay for dental coverage. Go to www.opm.gov/insure/vision/rates to see the premium cost for vision coverage.

Reading the Chart:

The table on the following pages highlights the selected features/classes of dental and/or vision services. Always consult plan brochures before making a decision. The chart does not show all of your possible out-of-pocket costs.

Dental Insurance

The deductibles shown for the dental plans are the amount of covered expenses that you pay before the plan begins to pay. Service Class refers to the level of benefits for each plan. The Service Classes are listed below. Calendar year maximum refers to the annual amount of benefits that you can receive per person.

Please Note: Most plans require that you are continuously enrolled in the same dental plan and/or option for the full waiting period before accessing orthodontia services. There are no other waiting periods for services.

Dental plans provide a comprehensive range of services, including but not limited to the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependents up to age 19.

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements and provider directories.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses (in lieu of eye glasses). Other benefits, such as discounts on lasik surgery, may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements and provider directories.

Appendix I
Federal Employees Dental and Vision Insurance Program (FEDVIP)

Nationwide and International Dental Plans Open to All

Plan Name	Telephone & Website	You pay: Class A	Class B	Class C	Class D	Deductible	Calendar Year Maximum
Aetna High (In-Network Benefits)	1-877-459-6604 www.aetnafeds.com	0%	40%	60%	70%	$0	$3,000 per year per person (high option) in-network $2,000 per year per person (high option) out-of-network $1,500 lifetime max per person (orthodontic services only) 24-month waiting period for orthodontia services
Aetna High (Out-of-Network Benefits)		0%	40%	60%	70%	$0	
GEHA Standard (In-Network Benefits)	1-877-434-2336 www.gehadental.com	0%	45%	65%	50%	$0	$4,000 per year per person (high option) or $1,200 per year per person (standard option) per person $1,500 lifetime max per person (orthodontic services only) 24-month waiting period for orthodontia services
GEHA Standard (Out-of-Network Benefits)		0%	45%	65%	50%	$0	
GEHA High (In-Network Benefits)		0%	20%	50%	50%	$0	
GEHA High (Out-of-Network Benefits)		0%	20%	50%	50%	$0	
MetLife Standard (In-Network Benefits)	1-888-865-6854 www.federaldental.metlife.com	0%	45%	65%	50%	$0	$1,200 standard option in-network annual non-orthodontic maximum per person $1,500 standard option in-network lifetime max per person for orthodontics $600 standard option out-network annual non-orthodontic maximum per person $1,000 standard option out-of-network lifetime max per person for orthodontics $5,000 high option in-network annual non-orthodontic maximum per person $3,000 high option in-network lifetime max per person for orthodontics $5,000 high option out-of-network annual non-orthodontic maximum per person $3,000 high option out-of-network lifetime max per person for orthodontics There is no calendar year deductible for Class D services 24-month waiting period for orthodontia services
MetLife Standard (Out-of-Network Benefits)		40%	60%	80%	50%	$100/person	
MetLife High (In-Network Benefits)		0%	30%	50%	50%	$0	
MetLife High (Out-of-Network Benefits)		10%	40%	60%	50%	$50/person	
United Concordia High (In-Network Benefits)	1-877-438-8224 (Open Season) 1-877-394-8224 (General) www.uccifedvip.com	0%	20%	50%	50%	$0	$3,500 per year per person (high option) $1,500 lifetime max per person (orthodontic services only) 24-month waiting period for orthodontia services
United Concordia High (Out-of-Network Benefits)		20%	40%	60%	50%	$0	

Please Note: Out-of-Network Benefits – members are responsible for paying the difference between the plan's payment and the non-network provider's billed charges.

Appendix I
Federal Employees Dental and Vision Insurance Program (FEDVIP)

Regional Dental Plans *Only Open to Persons Living in Specific Geographic Areas*

						You pay:	**Calendar Year Maximum**
Plan Name	**Telephone & Website**	Class A	Class B	Class C	Class D	**Deductible**	
Humana/CompBenefits High (Open to residents of the Southwestern, Southeastern, Midwestern, and Mid-Atlantic states)	1-877-692-2468 www.Feds.Humana.com	0%	Flat Rate Approx 40%	Flat Rate Approx 54%	Flat Rate Approx 70%	$0	$10,000 per year per person Unlimited lifetime orthodontic coverage Out-of-network benefits **NOT** provided No waiting period for orthodontic services
GHI High (In-network benefits) (Open to NY and Northern NJ residents and parts of CT and PA) GHI High (Out-of-network benefits)	212-501-4444 www.ghi.com	0% 0%	0% 0%	0% 0%	0% 0%	$50 self/$150 self & family/self plus one Class B and Class C	$2,000 per year per person $2,000 lifetime max per person (orthodontic services only) There is no calendar year deductible for Class A and D services Out-of-network benefits available – paid at the same in-network rate 12-month waiting period for orthodontia services
Triple-S Salud High (Open to Puerto Rico residents)	787-774-6060 787-749-4777 1-800-981-3241 TTY 787-792-1370 TTY 1-866-215-1999 www.ssspr.com	0%	30%	60% / 30%	50%	$0	No maximum $1,500 lifetime max per person (orthodontic services only) Out-of-network benefits **NOT** provided 24-month waiting period for orthodontia services

Please Note: Out-of-Network Benefits – members are responsible for paying the difference between the plan's payment and the non-network provider's billed charges.

Appendix I
Federal Employees Dental and Vision Insurance Program (FEDVIP)

Nationwide and International Vision Plans Open to All

The table below highlights the selected features of available vision plans. Always consult plan brochures before making a decision. The chart does not show all of your possible out-of-pocket costs.

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses (in lieu of eye glasses). There are no deductibles or waiting periods. Other benefits such as discounts on lasik surgery may also be available.

Plan Name	Frames	Lenses	Exams	Co-payments	Lens Options Covered	Additional Features
FEP BlueVision Standard	Every 24 months	Every 12 months	Every 12 months	$0	Single Lined Bifocal Lined Trifocal Lenticular UV Coating	Breakage warranty; Laser vision correction discount; low vision coverage. $130 plus 20% of remaining cost frame allowance. Additional lens options covered with a co-pay. Out-of-network benefits **NOT** provided. Flat rate reimbursement in limited access areas and internationally.
FEP BlueVision High	Every 12 months	Every 12 months	Every 12 months	$0	Single Lined Bifocal Lined Trifocal Lenticular Standard Progressives UV Coating	Breakage warranty; Laser vision correction discount; low vision coverage. $150 plus 20% of remaining cost frame allowance. Additional lens options covered with a co-pay. Out-of-network benefits available at a lower rate. Flat rate reimbursement in limited access areas and internationally.
UnitedHealthcare Vision Plan Standard	Every 12 months	Every 12 months	Every 12 months	$10 exam/ $25 material	Single Lined Bifocal Lined Trifocal Lenticular Polycarbonate Scratch-resistant Coating	Low vision; prosthetic eye; vision therapy; Laser vision correction discount. $130 frame allowance. Additional lens option discounts. Out-of-network benefits available– paid at a lower rate. Flat rate reimbursement for international, out-of-network and limited access services.
UnitedHealthcare Vision Plan High	Every 12 months	Every 12 months	Every 12 months	$10 exam/ $10 material	Single Lined Bifocal Lined Trifocal Lenticular Polycarbonate Scratch-resistant Coating Tinted Lenses UV Coating	Low vision; prosthetic eye; vision therapy; Laser vision correction discount. $130 frame allowance. Additional lens option discounts. Out-of-network benefits available– paid at a lower rate. Flat rate reimbursement for international, out-of-network and limited access services.
VSP (Vision Service Plan) Standard	Every 12 months	Every 12 months	Every 12 months	$10 exam/ $20 material	Single Lined Bifocal Lined Trifocal Lenticular Polycarbonate Scratch-resistant Coating	Laser vision correction discount. $120 frame allowance. Additional lenses options covered at a discount. Out-of-network benefits available – paid at a lower rate. Additional lens option and contact lens exam discounts. Additional prescription glasses and sunglasses discounts. FSAFEDS paperless reimbursement available.
VSP (Vision Service Plan) High	Every 12 months	Every 12 months	Every 12 months	$10 exam and glasses	Single Lined Bifocal Lined Trifocal Lenticular Polycarbonate Scratch-resistant Coating Anti-reflective Coating Lenses that transition to light UV Coating Select tints	Laser vision correction discount. $150 frame allowance. Out-of-network benefits available – paid at a lower rate. Additional lens option and contact lens exam discounts. Additional prescription glasses and sunglasses discounts. FSAFEDS paperless reimbursement available

Appendix J
Federal Employees Dental and Vision Insurance Program (FEDVIP)
Dental Rating Regional Chart

Rating Areas

State	State/ZIP (first 3)	Aetna	GEHA Std	GEHA High	MetLife Std	MetLife High	United Concordia	Humana/Comp Benefits	GHI	Triple-S Salud
AK	entire state	5	5	5	5	5	5	#N/A	#N/A	#N/A
AL	356-358	1	1	1	1	1	1	1	#N/A	#N/A
AL	rest of state	2	1	1	1	1	1	1	#N/A	#N/A
AR	entire state	2	1	1	1	1	1	5	#N/A	#N/A
AZ	entire state	3	3	3	1	1	1	2	#N/A	#N/A
CA	900-918, 922-935	3	4	4	5	5	3	4	#N/A	#N/A
CA	919-921	3	4	4	4	4	4	4	#N/A	#N/A
CA	939-941, 943-954	4	5	5	5	5	5	4	#N/A	#N/A
CA	942, 956-958	4	4	4	4	4	4	4	#N/A	#N/A
CA	rest of state	4	4	4	5	5	4	4	#N/A	#N/A
CO	entire state	3	4	4	4	4	3	4	#N/A	#N/A
CT	060-063	5	4	4	5	5	5	#N/A	#N/A	#N/A
CT	064-069	3	5	5	5	5	5	#N/A	1	#N/A
DC	entire state	2	4	4	4	4	4	2	#N/A	#N/A
DE	entire state	2	3	3	3	3	2	#N/A	#N/A	#N/A
FL	327-328, 347	2	2	2	1	1	1	2	#N/A	#N/A
FL	330-334	2	4	4	3	3	3	2	#N/A	#N/A
FL	rest of state	3	2	2	1	1	1	2	#N/A	#N/A
GA	300-303, 311	3	3	3	2	2	1	3	#N/A	#N/A
GA	rest of state	4	2	2	1	1	1	5	#N/A	#N/A
GU	entire state	5	1	1	5	5	5	#N/A	#N/A	#N/A
HI	entire state	4	3	3	4	4	5	#N/A	#N/A	#N/A
IA	entire state	3	1	1	1	1	2	#N/A	#N/A	#N/A
ID	entire state	4	2	2	1	1	2	#N/A	#N/A	#N/A
IL	600-608	2	3	3	4	4	3	1	#N/A	#N/A
IL	620-622	2	2	2	1	1	1	1	#N/A	#N/A
IL	rest of state	3	1	1	1	1	1	1	#N/A	#N/A
IN	460-462	2	2	2	1	1	1	1	#N/A	#N/A
IN	463-464	2	3	3	4	4	3	1	#N/A	#N/A
IN	rest of state	3	1	1	1	1	2	1	#N/A	#N/A
KS	660-662	1	2	2	1	1	2	1	#N/A	#N/A
KS	rest of state	3	1	1	1	1	2	1	#N/A	#N/A
KY	410	2	2	2	1	1	1	1	#N/A	#N/A
KY	rest of state	1	1	1	1	1	1	1	#N/A	#N/A

Appendix J
Federal Employees Dental and Vision Insurance Program (FEDVIP)
Dental Rating Regional Chart

Rating Areas

State	State/ZIP (first 3)	Aetna	GEHA Std	GEHA High	MetLife Std	MetLife High	United Concordia	Humana/Comp Benefits	GHI	Triple-S Salud
LA	entire state	2	2	2	1	1	1	5	#N/A	#N/A
MA	entire state	5	4	4	5	5	5	#N/A	#N/A	#N/A
MD	206-218	2	4	4	4	4	4	2	#N/A	#N/A
MD	219	2	3	3	3	3	2	#N/A	#N/A	#N/A
MD	rest of state	2	2	2	2	2	4	#N/A	#N/A	#N/A
ME	entire state	5	3	3	2	2	3	#N/A	#N/A	#N/A
MI	480-485	3	3	3	3	3	2	#N/A	#N/A	#N/A
MI	rest of state	3	2	2	2	2	3	#N/A	#N/A	#N/A
MN	550-555	2	3	3	4	4	3	#N/A	#N/A	#N/A
MN	rest of state	3	2	2	2	2	2	#N/A	#N/A	#N/A
MO	630-633	2	2	2	1	1	1	1	#N/A	#N/A
MO	640-641	1	2	2	1	1	2	1	#N/A	#N/A
MO	rest of state	3	1	1	1	1	1	1	#N/A	#N/A
MS	entire state	2	1	1	1	1	1	5	#N/A	#N/A
MT	entire state	4	2	2	1	1	1	#N/A	#N/A	#N/A
NC	entire state	4	2	2	1	1	1	5	#N/A	#N/A
ND	entire state	3	1	1	1	1	2	#N/A	#N/A	#N/A
NE	entire state	1	1	1	1	1	2	#N/A	#N/A	#N/A
NH	entire state	5	4	4	5	5	5	#N/A	#N/A	#N/A
NJ	080-084	2	3	3	3	3	2	#N/A	#N/A	#N/A
NJ	rest of state	3	5	5	5	5	5	#N/A	1	#N/A
NM	entire state	3	3	3	1	1	1	#N/A	#N/A	#N/A
NV	897	4	4	4	4	4	4	#N/A	#N/A	#N/A
NV	rest of state	2	3	3	2	2	2	#N/A	#N/A	#N/A
NY	004, 005	3	5	5	5	5	5	#N/A	1	#N/A
NY	100-119, 124-126	3	5	5	5	5	5	#N/A	1	#N/A
NY	rest of state	4	2	2	2	2	3	#N/A	1	#N/A
OH	430-432	2	2	2	1	1	2	3	#N/A	#N/A
OH	440-443	2	2	2	1	1	3	1	#N/A	#N/A
OH	450-452	2	2	2	1	1	1	1	#N/A	#N/A
OH	453-455	2	2	2	1	1	2	1	#N/A	#N/A
OH	rest of state	3	1	1	1	1	1	1	#N/A	#N/A
OK	entire state	2	2	2	1	1	1	3	#N/A	#N/A
OR	970-973	4	3	3	4	4	5	#N/A	#N/A	#N/A
OR	rest of state	5	3	3	3	3	4	#N/A	#N/A	#N/A

Appendix J
Federal Employees Dental and Vision Insurance Program (FEDVIP)
Dental Rating Regional Chart

Rating Areas

State	State/ZIP (first 3)	Aetna	GEHA Std	GEHA High	MetLife Std	MetLife High	United Concordia	Humana/Comp Benefits	GHI	Triple-S Salud
PA	150-154, 156, 160	1	1	1	1	1	1	#N/A	#N/A	#N/A
PA	183	3	5	5	5	5	5	#N/A	1	#N/A
PA	189-194	2	3	3	3	3	2	#N/A	#N/A	#N/A
PA	rest of state	3	1	1	1	1	1	#N/A	#N/A	#N/A
PR	entire state	3	1	1	1	1	1	#N/A	#N/A	1
RI	entire state	5	4	4	5	5	5	#N/A	#N/A	#N/A
SC	entire state	4	2	2	1	1	1	5	#N/A	#N/A
SD	entire state	3	1	1	1	1	2	#N/A	#N/A	#N/A
TN	entire state	1	2	2	1	1	1	1	#N/A	#N/A
TX	750-753, 760-762	2	3	3	1	1	1	3	#N/A	#N/A
TX	770-775	2	3	3	1	1	1	3	#N/A	#N/A
TX	rest of state	2	2	2	1	1	1	3	#N/A	#N/A
UT	entire state	2	1	1	1	1	2	1	#N/A	#N/A
VA	201, 220-226	2	4	4	4	4	4	2	#N/A	#N/A
VA	230-232, 238	3	2	2	1	1	2	5	#N/A	#N/A
VA	rest of state	3	2	2	1	1	1	4	#N/A	#N/A
VI	entire state	overseas	1	1	5	5	5	#N/A	#N/A	#N/A
VT	entire state	5	2	2	2	2	3	#N/A	#N/A	#N/A
WA	980-985	5	5	5	5	5	5	#N/A	#N/A	#N/A
WA	986	4	3	3	4	4	5	#N/A	#N/A	#N/A
WA	rest of state	5	4	4	4	4	4	#N/A	#N/A	#N/A
WI	530-534	3	2	2	2	2	3	#N/A	#N/A	#N/A
WI	540	2	3	3	4	4	3	#N/A	#N/A	#N/A
WI	rest of state	3	2	2	2	2	2	#N/A	#N/A	#N/A
WV	entire state	4	2	2	1	1	1	3	#N/A	#N/A
WY	entire state	4	1	1	1	1	2	#N/A	#N/A	#N/A

Appendix K
Federal Employees Dental and Vision Insurance Program (FEDVIP) Premium Rate Charts

Nationwide Dental Rates

Please note: Rating areas for each carrier are not the same for all plans. Please refer to Appendix K to determine your specific region.

			Biweekly Premium			Monthly Premium		
Plan Name	**Option**	**Rating Region**	**Self Only**	**Self Plus One**	**Self & Family**	**Self Only**	**Self Plus One**	**Self & Family**
Aetna PPO	High (In and Out-of-Network benefits)	1	$13.45	$26.90	$40.35	$29.14	$58.28	$87.43
		2	$14.79	$29.59	$44.38	$32.05	$64.11	$96.16
		3	$15.73	$31.47	$47.20	$34.08	$68.19	$102.27
		4	$17.35	$34.69	$52.03	$37.59	$75.16	$112.73
		5	$18.82	$37.65	$56.47	$40.78	$81.58	$122.35
GEHA PPO	Standard (In and Out-of-Network benefits)	1	$9.24	$18.49	$27.73	$20.02	$40.06	$60.08
		2	$10.14	$20.27	$30.41	$21.97	$43.92	$65.89
		3	$11.49	$22.97	$34.46	$24.90	$49.77	$74.66
		4	$12.39	$24.78	$37.17	$26.85	$53.69	$80.54
		5	$13.74	$27.49	$41.22	$29.77	$59.56	$89.31
GEHA PPO	High (In and Out-of-Network benefits)	1	$14.66	$29.33	$44.02	$31.76	$63.55	$95.38
		2	$16.12	$32.23	$48.37	$34.93	$69.83	$104.80
		3	$18.26	$36.54	$54.81	$39.56	$79.17	$118.76
		4	$19.71	$39.43	$59.16	$42.71	$85.43	$128.18
		5	$21.87	$43.77	$65.66	$47.39	$94.84	$142.26
MetLife PPO	Standard (In and Out-of-Network benefits)	1	$8.56	$17.15	$25.72	$18.55	$37.16	$55.73
		2	$9.26	$18.52	$27.77	$20.06	$40.13	$60.17
		3	$10.24	$20.47	$30.70	$22.19	$44.35	$66.52
		4	$11.36	$22.72	$34.08	$24.61	$49.23	$73.84
		5	$12.46	$24.93	$37.40	$27.00	$54.02	$81.03
MetLife PPO	High (In and Out-of-Network benefits)	1	$15.32	$30.64	$45.92	$33.19	$66.39	$99.49
		2	$17.13	$34.27	$51.40	$37.12	$74.25	$111.37
		3	$18.65	$37.27	$55.92	$40.41	$80.75	$121.16
		4	$20.17	$40.32	$60.48	$43.70	$87.36	$131.04
		5	$22.57	$45.14	$67.70	$48.90	$97.80	$146.68
United Concordia PPO	High (In and Out-of-Network benefits)	1	$13.77	$27.53	$41.30	$29.84	$59.65	$89.48
		2	$15.78	$31.55	$47.33	$34.19	$68.36	$102.55
		3	$17.14	$34.23	$51.36	$37.14	$74.17	$111.28
		4	$18.47	$36.91	$55.39	$40.02	$79.97	$120.01
		5	$19.90	$39.81	$59.70	$43.12	$86.26	$129.35

Appendix K
Federal Employees Dental and Vision Insurance Program (FEDVIP) Premium Rate Charts

Regional Dental Rates

Please note: Rating areas for each carrier are not the same for all plans. Please refer to Appendix K to determine your specific region.

Plan Name	Option	Rating Region	Biweekly Premium			Monthly Premium		
			Self Only	Self Plus One	Self & Family	Self Only	Self Plus One	Self & Family
Humana/CompBenefits	High (In-Network Benefits only except for emergency services)	1	$9.88	$19.75	$29.63	$21.41	$42.79	$64.20
		2	$10.13	$20.26	$30.39	$21.95	$43.90	$65.85
		3	$10.69	$21.39	$32.08	$23.16	$46.35	$69.51
		4	$13.89	$27.77	$41.66	$30.10	$60.17	$90.26
		5	$14.63	$29.26	$43.89	$31.70	$63.40	$95.10
GHI PPO	High (In-and Out-of-Network Benefits)	1	$17.53	$35.04	$52.57	$37.98	$75.92	$113.90
Triple-S Salud PPO	High (In-Network Benefits only except for services rendered by orthodontists)	1	$4.50	$9.00	$11.85	$9.75	$19.50	$25.68

International Dental Rates

Please note: International premium rates are not regionally based.

Plan Name	Biweekly Premium			Monthly Premium		
	Self Only	Self Plus One	Self & Family	Self Only	Self Plus One	Self & Family
Aetna	$20.11	$40.22	$60.33	$43.57	$87.14	$130.72
GEHA Standard	$9.24	$18.49	$27.73	$20.02	$40.06	$60.08
GEHA High	$14.66	$29.33	$44.02	$31.76	$63.55	$95.38
MetLife Standard	$12.46	$24.93	$37.40	$27.00	$54.02	$81.03
MetLife High	$22.57	$45.14	$67.70	$48.90	$97.80	$146.68
United Concordia	$19.90	$39.81	$59.70	$43.12	$86.26	$129.35

Appendix K
Federal Employees Dental and Vision Insurance Program (FEDVIP)
Premium Rate Charts

Nationwide Vision Rates

Plan Name	Telephone & Website	Plan Option	Biweekly Premium			Monthly Premium		
			Self Only	Self Plus One	Self & Family	Self Only	Self Plus One	Self & Family
FEP BlueVision	1-888-550-2583 www.fepblue.org	Standard High	$3.91 $4.91	$7.82 $9.82	$11.73 $14.73	$8.47 $10.64	$16.94 $21.28	$25.42 $31.92
UnitedHealthcare Vision Plan	1-866-249-1999 TTY: 800-524-3157 www.myuhcvision.com/fedvip	Standard High	$3.13 $4.38	$6.12 $8.54	$9.11 $12.73	$6.78 $9.49	$13.27 $18.51	$19.74 $27.58
VSP (Vision Service Plan)	1-800-807-0764 www.choosevsp.com	Standard High	$4.28 $6.06	$8.55 $12.12	$12.83 $18.19	$9.27 $13.13	$18.53 $26.26	$27.80 $39.41

International Vision Rates

Plan Name	Telephone & Website	Plan Option	Biweekly Premium			Monthly Premium		
			Self Only	Self Plus One	Self & Family	Self Only	Self Plus One	Self & Family
FEP BlueVision	1-888-550-2583 www.fepblue.org	Standard High	$3.91 $4.91	$7.82 $9.82	$11.73 $14.73	$8.47 $10.64	$16.94 $21.28	$25.42 $31.92
UnitedHealthcare Vision Plan	1-866-249-1999 TTY: 800-524-3157 www.myuhcvision.com/fedvip	Standard High	$3.13 $4.38	$6.12 $8.54	$9.11 $12.73	$6.78 $9.49	$13.27 $18.51	$19.74 $27.58
VSP (Vision Service Plan)	1-800-807-0764 www.choosevsp.com	Standard High	$4.28 $6.06	$8.55 $12.12	$12.83 $18.19	$9.27 $13.13	$18.53 $26.26	$27.80 $39.41

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

- If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.
- If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.
- Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of April 16, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-800-362-1504

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants/default.aspx
Phone: 1-877-764-5437

ARKANSAS – CHIP
Website: http://www.arkidsfirst.com/
Phone: 1-888-474-8275

CALIFORNIA – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-866-298-8443

COLORADO – Medicaid and CHIP
Medicaid Website: http://www.colorado.gov/
Medicaid Phone: 1-800-866-3513
CHIP Website: http:// www.CHPplus.org
CHIP Phone: 303-866-3243

FLORIDA – Medicaid
Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml
Phone: 1-866-762-2237

GEORGIA – Medicaid
Website: http://dch.georgia.gov/ (Programs, then Medicaid)
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid
Website: http://www.in.gov/fssa/2408.htm
Phone: 1-877-438-4479

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.khpa.ks.gov
Phone: 800-766-9012

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://www.la.hipp.dhh.louisiana.gov
Phone: 1-888-342-6207

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/oms/
Phone: 1-800-321-5557

MASSACHUSETTS – Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth
Medicaid & CHIP Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/ (Health Care, then Medical Assistance)
Phone: 800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm
Phone: 573-751-6944

MONTANA – Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.dhhs.ne.gov/med/medindex.htm
Phone: 1-877-255-3092

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

NEVADA – Medicaid and CHIP
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900
CHIP Website: http://www.nevadacheckup.nv.org/
CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.state.nh.us/DHHS/MedicaidProgram/default.htm
Phone: 1-800-852-3345 x 5254

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW MEXICO – Medicaid and CHIP
Medicaid Website: http://www.hsd.state.nm.us/mad/index.html
Medicaid Phone: 1-888-997-2583
CHIP Website: http://www.hsd.state.nm.us/mad/index.html (Insure New Mexico)
CHIP Phone: 1-888-997-2583

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.nc.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov
Medicaid & CHIP Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm
Phone: 1-800-644-7730

RHODE ISLAND – Medicaid
Website: www.dhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov/
Phone: 1-888-549-0820

TEXAS – Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid
Website: http://health.utah.gov/medicaid/
Phone: 1-866-435-7414

VERMONT– Medicaid
Website: http://ovha.vermont.gov/
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-877-543-7669

WEST VIRGINIA – Medicaid
Website: http://www.wvrecovery.com/hipp.htm
Phone: 304-342-1604

WISCONSIN – Medicaid
Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: http://www.health.wyo.gov/healthcarefin/index.html
Telephone: 307-777-7531

To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

RETURN ADDRESS

NAME _____

STREET _____

CITY _____ STATE _____ ZIP CODE _____

Place postage stamp here

OWCP/DOL
DFEC Central Mail Room
P.O. Box 8300
London, KY 40742

Request for Registration Form or Brochures

OWCP/DOL
DFEC Central Mail Room
P.O. Box 8300
London, KY 40742

Official Business
Penalty for Private Use $300

Forwarding and Address Correction Requested

Detach

Request For Registration Form Or Brochures

This special postcard has been prepared to speed the return of health benefits open season information to you. Do not use it for any other purpose.

☐ I want to make a change during open season and know what plan or option I wish to enroll in. I have the brochure of that plan and don't need brochures. Please send me a registration form (SF 2809) only.

☐ I am considering making a change during open season but would like more information. Please send me a registration form (SF 2809) and a brochure for each of the plans I have listed below.

List enrollment codes of the plans for the brochures you want. Codes for each FEHB plan appear in the plan comparison chart.	CODE ☐☐ CODE ☐☐ CODE ☐☐ CODE ☐☐ CODE ☐☐ CODE ☐☐
Print or type your full name , OWCP claim number, and mailing address here. Address the other side and add a stamp. Then drop card in mail box.	Name OWCP claim number Street address
Check here if we need to change your mailing (home) address in our records. ☐	City, state, and ZIP code Signature Date

IMPORTANT

HMOs, Plans with a Point-of-Service product, High Deductible Health Plans, and Consumer-Driven Health Plans are open to compensationers in the plan's area.

Fee-for-Service plans sponsored by employee organizations have specific membership requirements. Some are restricted and open only to compensationers who are already members of the sponsoring organization.

Do not send this card to OPM.

Keep a record of the date you mail this.