How to Choose a Health Plan

A health insurance guide for federal employees.

Basic information

The Federal Employees Health Benefits Program (FEHBP) is available to eligible federal employees. The FEHBP enrolls more than 8 million people and is managed by the U.S. Office of Personnel Management (OPM).

Below are some features of the FEHBP:

• New employees have 60 days to elect to enroll in a plan or not to enroll.
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• The federal government pays up to 75 percent of the premium.
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• An employee must be covered under the FEHBP continuously for five years before retirement to be eligible for enrollment after retirement.

This is a brief description of the features of the Federal Employees Health Benefits Program. Before you make any final decisions about health plans, read the plan brochures.

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Web Account (online claims)

Yes

geha.com

800.821.6136

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Types of plans

Fee-for-Service (FFS) – Preferred Provider Organization (PPO)
A fee-for-service plan reimburses you or your provider according to a plan allowable cost. You may pay a deductible and coinsurance or copayment for some care. An FFS plan usually contracts with a preferred provider organization (PPO) for network discounts. You may choose any doctor or hospital, but may have lower out-of-pocket expenses with PPO providers.

Health Maintenance Organization (HMO)
An HMO plan provides care through a network of physicians, hospitals and other providers in a particular geographic area. Many HMOS require you to get authorization or a referral from your primary care physician (PCP) to see a specialist, find out what care you are likely to use. Office visits, hospital, but may have lower out-of-pocket expenses with PPO providers.

Point-of-Service (POS)
With a point-of-service plan, you may choose network providers or go out-of-network for care. If you use network providers, your out-of-pocket costs will be less. Some POS plans require you to get authorization or a referral from your primary care physician (PCP) to see other network providers.

High-Deductible Health Plan (HDHP) – HSA-qualified policy
An HDHP usually has a higher deductible than other plan types. An HDHP often covers preventive care with no deductible, for other care, you pay the deductible before the plan pays. An HDHP can be paired with a health savings account (HSA). Most plans provide a contribution to your HSA to help pay for your medical expenses before your deductible is met. You may pay medical expenses from your HSA until you meet your deductible and the plan pays. Deposits in an HSA are tax-free, as are withdrawals for qualified medical expenses. You own the funds in your HSA, and any interest earned. If you do not qualify for an HSA, you may have a health reimbursement arrangement (HRA).

Consumer Driven Health Plan (CDHP)
A CDHP is designed to involve you in making smart health care purchasing decisions. A high-deductible health plan is a type of CDHP. Typically, a CDHP has a high deductible and an HRA or HSA. Most plans provide a contribution to your HSA to help pay for your medical expenses before your deductible is met.

Coordination of benefits
When someone is covered by more than one group health plan or has automobile insurance that pays health care expenses without regard to fault, this is called double coverage. When you have double coverage, one plan normally pays its benefits in full as the primary payer and the covered expense is a condition you or a covered dependent may have prior to enrolling in a plan.

Pre-existing condition
A condition you or a covered dependent may have prior to enrolling in a plan will not receive coverage and will not be compensated if you or a dependent suffers injuries or becomes ill because of another person's act or omission, and you later receive compensation from that person.

Subrogation
When someone is covered by more than one group health plan or has automobile insurance that pays health care expenses without regard to fault, this is called double coverage. When you have double coverage, one plan normally pays its benefits in full as the primary payer and the covered expense is a condition you or a covered dependent may have prior to enrolling in a plan.
Choosing your health plan

What are your needs?
Are you generally healthy and do you make few visits to the doctor? Or do you have medical conditions that require attention from a specialist and several prescriptions? Is it important to have health care that goes with you when you travel? Do you have particular needs, such as coverage for chiropractic care? The answers to these questions can help lead you to the best plan.

Understand the plans
You'll want to understand the differences between a fee-for-service (FFS) plan, a health maintenance organization (HMO) plan and an HSA-qualified plan.

Customer service
Before joining a plan, find out if its members are satisfied with the customer service. Are claims paid quickly? Are questions answered promptly and satisfactorily? The Office of Personnel Management website (opm.gov) is a good source for information on different plans, as is the OPM plan comparison guide. Both include results of an annual OPM survey rating customer satisfaction.

Providers
For a PPO plan, you'll want a list of PPO doctors and hospitals. When looking at a new plan, find out if your current doctors are in the network. If not, are you willing to change to a new doctor? Will your doctor consider joining the network? Do you want to keep your current doctor and receive non-PPO benefits?
If you're considering an HMO, your choice of providers is more limited. If you need care from a specialist, find out what providers you will be allowed to see.

Evaluate cost
Look beyond the premium. How much are you likely to pay for deductibles, copays and membership dues? Consider what care you are likely to use. Office visits to a PPO provider? Emergency room care? Prescription drugs? Lab services? Take everything into consideration.
Enrolling in a plan

Once you have selected a plan, you must enroll in it. Your Human Resources, Health Benefits or Payroll office can advise you whether to enroll through an automated system or by completing the Standard Form (SF) 2809. You may also find information on how to enroll in an FEHB plan at opm.gov.

Automated system enrollment

Employee Express is an automated system that allows federal employees to complete a variety of benefit elections. You can access Employee Express by touch-tone phone, touch-screen kiosk or the Internet, 24 hours a day. Ask your Benefits or Payroll office if your agency uses Employee Express or go to opm.gov for a list of participating agencies. To learn more about the system, visit employeeexpress.gov.

Automated enrollment by agency

Visit opm.gov/healthcare-insurance/healthcare/plan-information/enroll to link to these systems:
- Department of Defense – DOD automated systems
- U.S. Postal Service – PostalBASE online and telephone system
- Department of Energy – DOE automated systems
- Health and Human Services and Environmental Protection – MyPay
- Employees of agencies payrolled by the National Finance Center – Employee Personal Page

Standard Form (SF) 2809 enrollments

Complete the Standard Form (SF) 2809 to enroll in an FEHB plan or change your current enrollment. This form is available at your Benefits or Payroll office. Visit opm.gov/healthcare-insurance/healthcare/plan-information/enroll to learn more about qualifying life events that permit changes to your health plan enrollment.

Ultimately, your enrollment is directed through the Office of Personnel Management (OPM) to your health plan. Your health plan will send your insurance identification cards and plan information to you within 15 business days of receiving your enrollment information.

This is a brief description of the FEHB enrollment process. Consult your Benefits or Payroll office for additional procedures.
With a point-of-service plan, you may choose network providers or go out-of-network. However, you may have to get authorization or a referral from your primary care physician (PCP) to be evaluated or treated by a different provider.

The answers to these questions can help lead you to the best plan. Evaluate cost, evaluate membership, evaluate customer service, evaluate features, and evaluate medical necessity.

### Types of plans

- **Fee-for-Service (FFS)** - Preferred Provider Organization (PPO)
- **Health Maintenance Organization (HMO)**
- **Point-of-Service (POS)**
- **Consumer Driven Health Plan (CDHP)**
- **High-Deductible Health Plan (HDHP) – HSA-qualified policy**
- **Health Reimbursement Arrangements (HRA)**

### Definitions

**Catastrophic limit**
This is the maximum coinsurance you pay for all family members before your health plan pays for all expenses.

**Coinsurance**
A percentage of the covered medical care that you pay. For example, if a plan pays 80 percent for a covered expense and the covered expense is $100, you pay a coinsurance of $20.

**Coordination of benefits**
When someone is covered by more than one group health plan or has automobile insurance that pays health care expenses without regard to fault, this is called double coverage. When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer.

**Copayment**
A fixed amount of money you pay for a covered service. For example, an office visit with a primary care or preferred provider might have a $15 copayment. This is the amount you pay for that covered service.

**Deductible**
A fixed amount of covered expenses you must incur before a plan starts paying benefits for those services.

**Medical necessity**
A plan may require that certain services, supplies or equipment meet specified criteria to be covered.

**Pre-certification**
A process used to evaluate the medical necessity of certain care, such as admission to a hospital, therapy treatment, certain medications, surgery and tests.

**Pre-existing condition**
A condition you or a covered dependent may have prior to enrolling in a federal health insurance plan. FEHB plans cover pre-existing conditions.

**Subrogation**
If you or a dependent suffers injuries or becomes ill because of another person’s act or omission, and you later receive compensation from that person or other insurance, you are required to refund benefits paid by your health plan.

### Insurance terms and definitions

- **Insurance terms and definitions**
- **Catastrophic limit**
- **Coinsurance**
- **Coordination of benefits**
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Dental and vision

The Federal Employees Dental and Vision Insurance Program (FEDVIP) offers dental and vision coverage to eligible federal employees, retirees and dependents on an enrollee-pay-all basis.

Enrollment options:

• Self Only
• Self Plus One
• Self and Family

The benefits of FEDVIP:

• Competitive premiums
• Premiums paid with pre-tax salary withholdings for active employees
• Eligibility includes enrollee’s spouse and unmarried, dependent children under age 22
• FEDVIP plans stand alone. You can choose a health plan from one insurance carrier and a dental plan from a different insurance carrier.

You can enroll in a FEDVIP plan during Open Season or following a qualifying life event. To enroll, visit BENEFEDS.com or call (877) 888-FEDS.

To learn more about the FEDVIP dental plans, visit opm.gov/healthcare-insurance/dental-vision.
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