HOW TO CHOOSE A HEALTH PLAN

A health insurance guide for federal and postal employees.

GEHA®

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 copay 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 be evaluated or treated by a different provider.

High Deductible Health Plan (HDHP) – HSA-qualified plan

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, which helps pay for a portion of your out-of-pocket medical expenses, including before your deductible is met. 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).

Learn more about the triple tax advantages of an HSA at **geha.com/HSA**

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, which helps pay for a portion of your out-of-pocket medical expenses, including before your deductible is met.

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.

Choosing your health plan

Determine 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 for your needs.

Understand the plans

You'll want to understand the difference 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 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.

Learn more at **opm.gov/Healthcare-Insurance**

Providers

For a PPO plan, use the carrier's provider search tool on its website for the most up-to-date 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, membership dues and other out-of-pocket costs? 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 FEHBP 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

To link to these systems, visit **opm.gov/Healthcare-Insurance/Healthcare/Plan-Information/Enroll**

- Department of Defense – DOD automated systems
- U.S. Postal Service – PostalEASE 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 FEHBP plan or change your current enrollment. This form is available at your Benefits or Payroll office. To learn more learn more about qualifying life events that permit changes to your health plan enrollment, visit **opm.gov/Healthcare-Insurance/Healthcare/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 FEHBP enrollment process. Consult your Benefits or Payroll office for additional procedures.

Insurance terms and definitions

Coinsurance

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

Copay

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** copay.

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.

Out-of-pocket maximum (catastrophic limit)

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

Precertification

A process used to evaluate the medical necessity of certain care, such as admission to a hospital, therapy treatment, certain medications, surgery or tests.

Pre-existing condition

A condition you or a covered dependent may have prior to enrolling in a federal health insurance plan. FEHBP 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.

Basic information

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

- Employees may choose from PPO, HMO or HSA-qualified plans. More than 200 plans are available.
- The federal government pays up to **75%** of the premium.
- New employees have 60 days to enroll in a plan or not to enroll.
- Employees who miss the initial enrollment period and those who would like to change plans can do so during the annual federal Open Season.
- Employees can change plans or options throughout the year when a qualifying event occurs (marriage, birth of a child, geographical relocation, etc.).
- Employees may choose Self Only, Self Plus One or Self and Family enrollment. Self and Family enrollment covers immediate family including children up to age 26. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.
- The FEHBP plans cover all pre-existing conditions.
- There are no waiting periods. Benefits can be used as soon as coverage becomes effective.
- 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 final decisions about health plans, read the plan brochures.

Online resources

opm.gov/Healthcare-Insurance – OPM's site includes more information on the FEHBP as well as a plan comparison tool.

narfe.org – NARFE's site provides help with benefits and news that affects federal employees and retirees.

geha.com – Government Employees Health Association offers five unique medical plans and is the largest carrier devoted exclusively to federal and postal employees.

gehadental.com – GEHA Connection Dental Federal® is a dental plan offered under the Federal Employees Dental and Vision Insurance Program (FEDVIP).

Dental and vision

Enrollment options

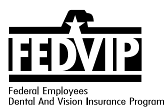
- Self Only, Self Plus One, Self and Family

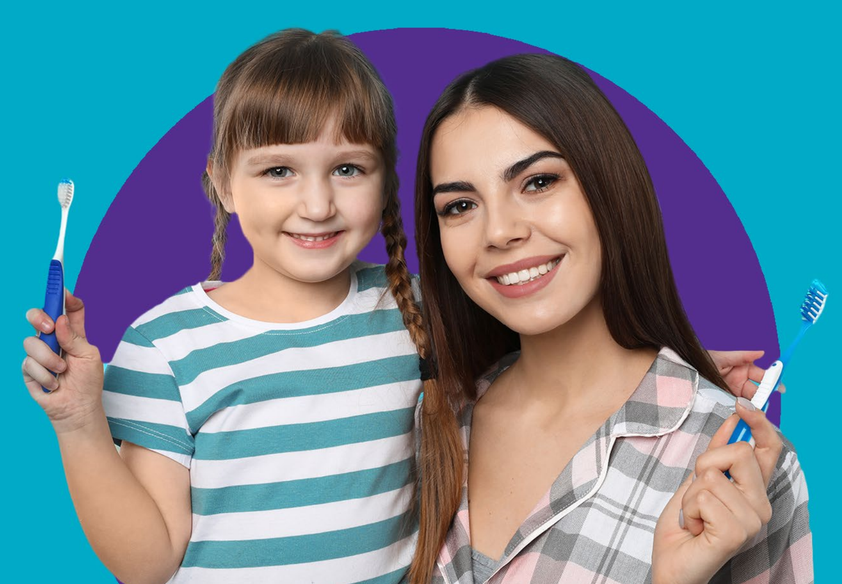
The benefits of FEDVIP

- Competitive premiums
- Premiums paid with pre-tax salary withholdings for active employees.
- Eligibility for FEDVIP has expanded to include certain retired uniformed service members, family members and survivors. If you are eligible to enroll in FEDVIP, you can choose from seven nationwide FEDVIP dental carriers and five vision carriers.
- FEDVIP plans stand alone. You can choose a health plan from one insurance carrier and a dental or vision plan from another.

You can enroll in a FEDVIP plan as a new employee during your initial 60-day enrollment period, at Open Season or following a qualifying life event. To enroll, visit **BENEFEDS.com** or call **877.888.FEDS**.

To learn more about FEDVIP dental plans, visit **opm.gov/Healthcare-Insurance/Dental-Vision**





Choosing a health plan should be simple

Use this worksheet to assist with your research of plans offered to federal employees or visit **opm.gov** to learn more.

Benefit	Your current plan	New plan
Self Only Biweekly premium	$	$
Self Plus One Biweekly premium	$	$
Self and Family Biweekly premium	$	$
Wellness incentives Annual amount	$	$
Doctors office visits	$	$
Urgent care copay	$	$
Prescription drugs	$	$
Lab fees	$	$
HSA/HRA contribution	$	$
Eye exam	$	$

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