

# 1998 Guide to Federal Employees Health Benefits Plans



for  
Federal Civilian  
Employees



**United States  
Office of  
Personnel  
Management**

Retirement and  
Insurance  
Service

RI 70-1  
Revised November 1997

# Our Commitment to Our Customers

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The U.S. Office of Personnel Management (OPM) administers the Federal Employees Health Benefits (FEHB) Program, the largest employer-sponsored health insurance program in the world. We interpret the health insurance laws and write regulations for the FEHB Program. We give advice and help to agencies and retirement systems so they can process your enrollment changes and deduct your premium. We also contract with and monitor your plan — and over 350 other health plans — that pay claims or provide care to covered members.

## This is our commitment to you:

- Your choice of health benefits plans will compare favorably for value and selection with the private sector.
- When you use the FEHB Guide and plan benefit brochures, you will find they are clear, factual and give you the information you need.
- When you change plans or options, your new plan will issue your identification card within 15 days after it gets your enrollment form from your agency or retirement system.
- Your fee-for-service plan should pay your claims within 20 work days; if more information is needed, it should pay within 60 days.
- If you ask us to review a claim dispute with your plan, our decision will be fair and easy to understand, and we'll send it to you within 60 days. If you need to do more before we can review a claim dispute, we will tell you within 14 work days what you still need to do.
- When you write to us about other matters, we will respond within 30 days after we get your letter. If we need time to give you a complete response, we will let you know.



Better Information  
Better Choices  
Better Health



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 Things to Remember

- Make sure your plan will be offered in 1998
- Be aware of benefit changes for 1998
- Check the premium for 1998

*The information in the 1998 Guide to Federal Employees Health Benefits (FEHB) Plans gives you an overview of the FEHB Program and its participating plans. Before making any final decisions about health plans, be sure to check the plan's brochure.*



**Call the FEHB Fraud Hot Line  
202/418-3300  
if a provider has billed you for services  
you did not receive.**

# FEHB and You

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The Federal Employees Health Benefits (FEHB) Program can help you meet your health-care needs. Federal employees enjoy the widest selection of health plans in the country. They can choose among managed fee-for-service (FFS) plans, plans offering a point of service (POS) product and health maintenance organizations (HMO) (see page 3 for definitions).

Managed care is an important part of the FEHB Program. You will find managed care features in all the plans described in this Guide. Common features of managed care are pre-admission certification, the use of primary care providers as “gatekeepers” to coordinate your medical care, and a network of physicians and other providers.

If you are eligible for FEHB coverage, you may enroll in a managed FFS plan. Some of these plans are open to all enrollees, but some of these plans require that you join the organization that sponsors the plan. Other managed FFS plans limit enrollment to certain employee groups.

You may also enroll in a POS or an HMO if you live (or sometimes if you work) in the specific geographic area where the plan provides services. Membership requirements and/or limitations that apply to a managed FFS plan also apply to any POS product the plan may be offering (see above).

In deciding which plan to choose, you should consider your and your family’s medical needs, the cost of each plan, and the type of health benefits plan (FFS, POS, HMO) you prefer. You can help get the right kind and quality of care at the right price by carefully comparing the plan information in this Guide and carefully reviewing the plan’s brochure before making any final decisions. You can get copies of brochures from your personnel office, by contacting the plans directly at the numbers shown in this Guide, or on the World Wide Web.

Plans that have a  in the column labeled “Website” have their own website.

The 1998 Guide to Federal Employees Health Benefits Plans for Federal Civilian Employees, plan brochures, and other information, including links to plan Websites, are available on the World Wide Web. Visit our website at <http://www.opm.gov/insure>. The Guide and brochures are also available on OPM ONLINE. Anyone who has a personal computer, modem, phone line and communications software can access OPM ONLINE by dialing 202/606-4800.



## Employee Express

Employee Express is an automated system that allows some Federal employees to make changes using a touch-tone telephone, a personal computer or computer kiosk instead of a form. If you are not sure whether you can use Employee Express, call your personnel office.

# Program Features

Some of our important Program features are:

**No waiting periods.** Your coverage starts right away, without a waiting period, medical examination or restrictions because of age or physical condition.



**A choice of coverage.** You can choose self only coverage just for you, or self and family coverage for you, your spouse, and unmarried dependent children under age 22. Under certain circumstances, your FEHB enrollment may cover your disabled child 22 years old or older who is incapable of self-support.



**A choice of plans and options.**

- Managed fee-for-service plans
- Plans offering a point of service product
- Health maintenance organizations



**A Government contribution.** The Government contributes toward the total cost of your premium. In 1998, the Government will pay up to \$1714.96 for each self only enrollment and \$3699.02 for each family enrollment.

The Government usually pays 75% of the total premium. The maximum dollar contribution, if you're paid every two weeks, is \$65.96 self only and \$142.27 self and family. The monthly rates are \$142.91 self and \$308.25 family. However, some plans get less than the maximum because the Government contribution cannot exceed 75% of a plan's total premium. The Government contribution for part-time employees may be different. See your personnel office to get the exact amount.

**Salary deduction.** You pay your share of the premium through a payroll deduction.

**Annual enrollment opportunities.** Each year you have the opportunity to enroll or change plans. The 1997 Open Season is from November 10 through December 8, during which you may enroll if you are eligible and not now enrolled, change plans or options, or change from self only to family. (You may change from family to self only at any time.)



**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 in FEHB for the five years before you retire),
- for your former spouse if you divorce and you have a qualifying court order (see your personnel 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 personnel office).

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

- for you and your family if you leave Federal service (including when you can't carry FEHB into retirement),
- for your covered dependent child if he or she marries or turns age 22, or
- for your former spouse if you divorce and you do not have a qualifying court order (see your personnel office for more information).

# Definitions and Explanations

**Brochure** – A plan’s description of benefits, limitations, exclusions, and definitions under the FEHB Program.

**Catastrophic limit** – The maximum amount of certain covered charges you have to pay out of your own pocket during the year.

**Coinsurance** – How you and your FEHB plan split the cost of covered medical expenses. For example, a 20% coinsurance means you pay 20% of most covered charges. The plan pays 80%.

**Copayment** – A fixed dollar amount you pay as your share of a service or benefit (sometimes called a copay).

**Covered charges** – What the plan pays for. You’ll find information about covered benefits, expenses and services in each plan’s brochure.

**Deductible** – The amount of covered charges you must pay before the plan begins to pay.

**Health Maintenance Organization (HMO)** – A health plan that provides care through a network of physicians and hospitals located in particular geographic or service areas. HMOs emphasize prevention and early detections. Your eligibility to enroll in an HMO is determined by where you live or, in some plans, where you work. Some HMOs have agreements with providers in other service areas for non-emergency care if you travel and are away from home for extended periods.

- The HMO pays for all covered services — as long as you use the doctors and providers in the HMO network. You may have to pay something when you get care, for example, a \$10 copayment per office visit.
- Most HMOs ask you to choose a doctor or clinic to be your primary care provider, or PCP. Your PCP takes care of most of your medical needs. In many HMOs, you must get permission or a “referral” from your PCP in order to see other providers in the network.
- Care received from a non-network provider, other than emergency care, is not covered.

**Managed Fee-for-Service (FFS) Plan** – A traditional type of insurance that lets you use any doctor or hospital, but you usually must pay a deductible and coinsurance. These plans are called FFS because doctors and other providers are paid for each service, such as an office visit, or test. They control costs by managing patient care. They also provide access to PPOs.

**Plans Offering a Point of Service (POS) Product** – A product offered by an HMO or FFS plan that gives you the choice of using a selected network of providers, like an HMO, or using non-network providers at an additional cost. If you don’t use the network, you must pay substantial deductibles, coinsurance, and copayments.

**Preferred Provider Organization (PPO)** – A managed fee-for-service product where you can choose plan-selected providers who discount their fees. By visiting a PPO provider, you will pay less money out-of-pocket for medical service than you would by visiting a non-PPO provider.

# Quality Indicators

## National Committee for Quality Assurance (NCQA)

**National Committee for Quality Assurance (NCQA)** is a nationally-recognized leader in evaluating HMOs. The NCQA accreditation process evaluates how well a health plan manages all parts of its delivery system including physicians, hospitals, other providers, and administrative services. NCQA evaluations are used to assess the quality of a plan's operations.

We have listed the accreditation status of the FEHB plans who requested an NCQA review. The following symbols appear in the NCQA status column to designate the accreditation status.

★ **Full Accreditation.** This status is granted for a period of three years to those plans that have excellent programs for continuous quality improvement and meet NCQA's rigorous standards.

● **One-Year Accreditation.** This status is granted to plans that have well-established quality improvement programs and meet most NCQA standards. NCQA reviews the plans again after a year to determine if they have progressed enough to move up to Full Accreditation.

◐ **Provisional Accreditation.** This status is granted for one year to plans that have adequate quality improvement programs and meet some NCQA standards. When these plans demonstrate progress, they can qualify for a higher level of accreditation.

⊗ **Denial.** This status indicates plans were reviewed but did not qualify for any of the above categories.

*Note:* The absence of an NCQA status symbol next to a plan's name could be because:

- the plan is too new to be reviewed,
- not all of the plan's FEHB rating area was reviewed,
- the plan might have merged with another plan and that plan was not reviewed,
- a plan's review decision is pending, or
- a plan chose not to be reviewed.

You may call a plan for more information or call NCQA toll free at 888/275-7585 to check on the accreditation status of a health plan 24 hours a day, 7 days a week. You may also visit NCQA's website at <http://www.ncqa.org> or link to the NCQA site after visiting our website at <http://www.opm.gov/insure>.

# Quality Indicators

## 1997 Customer Satisfaction Survey Results

This Guide shows you how other enrollees in the FEHB Program rate their health plan. The Guide gives you ratings for the health plan choices available through the FEHB Program.

**The Ratings.** We surveyed enrollees and asked them to rate various aspects of their health plan on a five-point scale of *poor*, *fair*, *good*, *very good*, and *excellent*. Selected results are shown for the percentage of enrollees in each plan who rated their plan *good*, *very good* or *excellent* in the following categories (Some categories apply only to POS and HMO plans or only to FFS plans):

- Ability to see the same doctor on most visits,
- Access to medical care (arranging for and getting care),
- Access to medical care in an emergency (POS and HMO only),
- Choice of doctors available through the plan (being able to find doctors you are satisfied with),
- Costs you personally have to pay (FFS only),
- Coverage (range of services covered),
- Explanation of care (what is wrong, what is being done, and what to expect),
- Getting appointments when sick,
- How quickly claims are processed (FFS only),
- Quality of care (from doctors and other medical professionals), and
- Results of care.

**Overall Satisfaction.** Bar graphs show enrollees' overall satisfaction with their health plan by graphing responses to the following question:

*All things considered, how satisfied are you with your current health plan?*

A bar graph for each plan shows the percentage of plan enrollees who indicated one of three levels of satisfaction.

Example: 

19	45	22
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In the example, 19% of respondents are *extremely satisfied*, 45% are *very satisfied*, and 22% are *satisfied*.

Plans with an overall satisfaction score that is significantly higher than the average overall score are identified with a ★ the column labeled "Top rated plans". Scores that are significantly higher than the average for any of the rating elements are printed in **magenta**; scores that are significantly lower than the average are underlined.

**Understanding the Survey Results.** The error range for overall satisfaction is less than 6% at the 95% level of confidence. In other words, if we repeated the survey, we would expect similar results 95% of the time.

Although the survey was based on a random sample of plan enrollees, enrollees' opinions may vary depending on age, education level, state of health, and other characteristics. We have adjusted the results shown in this Guide for these differences. Generally, adjusted results are not much different from the unadjusted results.

If your plan is not rated in this Guide, it is because the plan is new to the FEHB Program or the number of respondents was too small for us to reliably include their opinions.

# Choosing a Health Plan?

## How About Choosing Organ and Tissue Donation?

### *Did you know?*

*More than 54,000 Americans are waiting for organ transplants, and each year about 4,000 die waiting.*

*As an organ and tissue donor, you could save and improve the lives of more than 50 people!*

*To be an organ and tissue donor, even if you've signed something, you must tell your family members now so they can carry out your decision later.*

*The federal government will provide you with time off if you want to help someone now by donating bone marrow or by being a living organ (e.g., kidney) donor. As a living donor, you are entitled to up to 7 days of paid leave not charged to your sick or annual leave.*

© Coalition on Donation

For a free brochure and donor card, call  
800/355-SHARE (800/355-7427)  
or visit the website at: <http://www.organdonor.gov>

Say **YES** to organ and tissue donation on your donor card or driver's license and **DISCUSS** your wishes with your family.

# Plan Report Cards

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## Nationwide Managed Fee-for-Service Plans

(Pages 8 through 10)

**Important:** Some FFS plans also offer a POS product.  
Check the POS section.

# Plan Report Cards

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## Plans Offering a Point of Service Product

(Pages 12 through 20)

**Important:** Some plans have been redesignated as HMOs.  
If you do not find your plan in the section,  
check the HMO section.

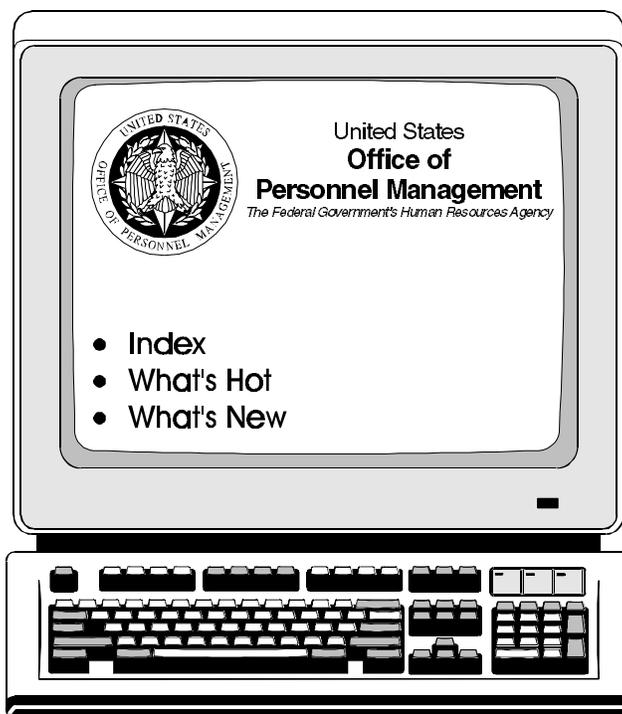
# Plan Report Cards

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## Health Maintenance Organization Plans

(Pages 22 through 53)

**Important:** Some plans have been redesignated as POS products. If you do not find your plan in this section, check the POS section.



Visit our website at  
<http://www.opm.gov/insure>