
The **1999** Guide to
Federal
Employees
Health Benefits Plans

for
Federal Civilian
Employees



United States
Office of
Personnel
Management

Retirement and
Insurance
Service

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Our Commitment to Our Customers

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 almost 300 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

Table of Contents

	Page
FEHB and You	1
Program Features	4
Patient Bill of Rights and Responsibilities	5
Definitions and Explanations	6
Your Links to Information	
1999 FEHB Web Site	8
Employee Express	8
Quality Indicators	
Accreditation	9
1998 Customer Satisfaction Survey Results	10
A Word About Medicare	11
Plan Report Cards	
Nationwide Managed Fee-for-Service Plans	13
Plans Offering a Point of Service Product	17
Health Maintenance Organization Plans	27

Things to Remember

- A number of plans withdrew from the FEHB Program.
 Make sure your plan will be offered in 1999
 - Be aware of 1999 benefit changes
 - Check the 1999 premium

The information in the 1999 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 plans' brochure.

FEHB and You

The Federal Employees Health Benefits (FEHB) Program can help you meet your health care needs. Federal employees, retirees and their survivors enjoy the widest selection of health plans in the country. You can choose from among Managed Fee-for-Service (FFS) plans, regardless of where you live, or Plans offering a Point of Service (POS) Product and Health Maintenance Organizations (HMO) if you live (or sometimes if you work) within the area serviced by the plan. (See page 6 for definitions.)

Some FFS plans are open to all enrollees, but others require that you join the organization that sponsors the plan. Some plans limit enrollment to certain employee groups. Membership requirements and/or limitations also apply to any POS product the FFS plan may be offering.

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-approval of hospital stays, the use of primary care providers as “gatekeepers” to coordinate your medical care, and networks of physicians and other providers.

You are fortunate to be able to choose from among many different health plans competing for your business. Use this Guide to compare the costs, benefits, and features of different plans. The plan brochures tell you what services and supplies are covered and the level of coverage. Look over the brochures carefully, especially the Changes page of your current plan to see how benefits have changed from last year. You can get brochures from the health plans or your human resource office. They are also available on our

web site at www.opm.gov/insure. When it comes to your health care, the best surprise is no surprise.

Choosing a plan

Cost — certainly the premium you pay is an important consideration, but there are some other things you should consider. When thinking about premiums, what can you afford biweekly or monthly? Should you enroll in a High Option – and pay High Option premiums – if a Standard Option would do?

If you need to go to the hospital, how much will you have to pay? Do you know how much you will pay for an emergency room visit? If you have children, what will it cost you for a well-child care visit?

Do you have to pay a deductible for the services you might use? Your share of medical expenses is either a coinsurance (a percentage of the bill) or a copayment (a fixed dollar amount). Which option do you prefer and what does the plan require? Does the plan limit the dollar amount it will pay for certain services?

Coverage — check to see if the plan offers the services you think you might need. If you’re 65 or over, how does the plan coordinate coverage with Medicare? If you regularly see an allergist, do you pay extra for the allergy serum? Does the plan offer a pre-natal program? Given the trend toward reducing hospital stays, will your plan pay for home health care? Because health care is expensive, pay attention to the plan’s catastrophic coverage to see how you are protected. See if there are limits on the number of visits for the services you need.

FEHB and You

Choosing a plan *(continued)*

How the plan works — if predictable cost, comprehensive benefits, no paperwork, and a coordinated approach to health care are high priorities, consider a Health Maintenance Organization (HMO). Most HMOs require you to select a doctor to act as your primary care physician, or PCP, who refers you to specialists. If you don't use a plan doctor, the plan usually will not pay for services, unless it is an emergency.

A Plan offering a Point of Service (POS) Product also has rules about doctor choice and access to specialists, but you can choose any doctor you like and see specialists without referrals if you agree to pay more.

If you are willing to pay a little more in total costs for the widest choice of doctors, a Fee-for-Service (FFS) plan might be for you. FFS plans let you choose your own doctor and allow you to see specialists without a referral. Most FFS plans have Preferred Provider Organizations (PPO) that save you money if you use these providers.

Some plans offer 24-hour medical advice lines to help you make health decisions. These programs try to keep you healthy and avoid unnecessary – and potentially costly and time consuming – medical treatment.

Satisfaction — the experience of FEHB members form the satisfaction ratings in this Guide. If you're considering joining a FFS plan, chances are you'll file a claim. How quickly does the plan process claims? Will the plan be responsive to your questions? As an HMO enrollee, you might be most interested in how the plan is rated in access to care and choice of doctors. Ask the plan for its satisfaction ratings for the past few years. Have the ratings changed much? Ask your doctor's office about experiences with different health plans.

Accreditations — HMO accreditations reflect the independent evaluations of nationally-recognized organizations. Plans willing to go through an accreditation review show a commitment to continuous quality improvement and accountability.

FEHB and You

Getting the most from a plan

Within any plan, there are things you can do to minimize your out-of-pocket costs and make the plan work best for you.

Cost — an easy way to save money is to use your plan’s mail order drug program, if it has one. Request generic drugs instead of brand name drugs. Almost all FFS Plans have Preferred Provider Organizations (PPO, see definitions). Using a PPO will reduce your out-of-pocket expenses. If you do not use a PPO provider, your plan will base its payment on a “usual and customary” allowance which may be less than the actual billed charge. This means you might have to pay the difference. You can reduce the chance of this happening by discussing fees in advance with your provider. Remember that plans set their own allowances.

It is also important to note that all of the services provided in a PPO hospital may not be covered by PPO arrangements. Room and board will be covered, but

the anesthesia and radiology services may not be. The only way to find out is to ask ahead of time.

Quality — talk openly with your health plan and providers about the kind of quality you want. Is your HMO rated by a national accrediting organization? Ask your surgeon how frequently (s)he performs the procedure you’re considering and how the patients are doing. If you’re pregnant, ask your obstetrician the percentage of cases in which (s)he performs a cesarian section. Is your doctor proposing a radical approach to treatment when a more conservative one is just as effective? Does your doctor tell you about possible drug interactions with you when prescribing a new medication?

No one has a greater stake in your health than you. Understand how your plan works and don’t be shy about asking questions. An informed consumer is a better decision maker.



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

Program Features

Some of our important Program features are:

No waiting periods. Your human resource office or retirement system sets the effective date of your coverage. You can use your FEHB benefits as soon as your coverage is effective — there are no waiting periods, required medical examinations 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 1999, the Government will pay up to \$1873.56 for each self only enrollment and \$4170.14 for each self and family enrollment, but not more than 75% of the total premium for any plan. The Government contribution for part-time employees may be different. See your human resource 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 1998 Open Season is from November 9 through December 14, during which you may enroll if you are eligible and not now enrolled, change plans or

options, or change from self only to self and family. (You may change from self and family to self only or disenroll 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 the FEHB Program for the five years before you retire),
- for your former spouse if you divorce and he or she has a qualifying court order (see your human resource 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 resource office).

Coverage after FEHB ends. The FEHB Program offers either temporary continuation of FEHB coverage (TCC) 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 he or she does not have a qualifying court order (see your human resource 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

Patient Bill of Rights and Responsibilities

The Patient Bill of Rights and Responsibilities spells out recommendations made by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. These recommendations promote and ensure health care quality and protect health care consumers. The President signed an Executive memorandum directing us (the Office of Personnel Management) to take steps to bring the FEHB Program into contractual compliance with these recommendations.

We are pleased to report that most FEHB plans already comply with the Commission's Patient Bill of Rights and Responsibilities. For 1999, you can expect all of the following from your FEHB plan:

- Direct access to women's health care providers for routine and preventative women's health care services.
- Coverage of emergency department services for screening and stabilization without authorization if you have reason to believe your life is endangered or you would be seriously injured or disabled.

- Direct access to a qualified specialist within your network of providers if you have complex or serious medical conditions that need frequent specialty care. Authorizations, when required by a plan, will be for an adequate number of direct access visits under an approved treatment plan.
- Extensive information about plan characteristics and performance, provider network characteristics, and care management.
- The elimination of "gag rules" in provider contracts that could limit communication about medically necessary treatment.

The health care system works best when enrollees take the time to become informed. As responsible consumers, you should:

- Read and understand your health benefits coverage, limitations, and exclusions, health plan processes, and procedures to follow when seeking care.
- Work with your physician in developing and carrying out a treatment plan.
- Practice healthy habits.

Definitions and Explanations

request. This certificate may be important to qualify for benefits if you join a non-FEHB plan.

Brochure — A plan’s description of benefits, limitations, exclusions, and definitions under the FEHB Program. You can get brochures from the health plans. They are also available on our web site at www.opm.gov/insure.

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 in particular geographic or service areas. HMOs coordinate the health care services you receive. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work. Some HMOs have agreements with providers in other service areas for non-emergency care if you travel or are away from home for extended periods.

- The HMO provides a comprehensive set of 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 medical group to be your primary care provider (PCP). Your PCP takes care of most of your medical needs. In many HMOs, generally 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 generally not covered.

Definitions and Explanations

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 help control costs by managing some aspects of patient care. Most also provide access to PPOs.

Preferred Provider Organization (PPO) — A FFS option where you can choose plan-selected providers who have agreements with the plan. When you use a PPO provider, you pay less money out-of-pocket for medical service than when you use a non-PPO provider.

Plans offering a Point of Service (POS) Product — A product offered by an HMO or FFS plan that has features of both. In an HMO, the POS product lets you use providers who are not part of the HMO network. However, there is a greater cost associated with choosing these non-network providers. You usually

pay deductibles and coinsurances that are substantially higher than the payments when you use a plan provider. You will also need to file a claim for reimbursement, like in an FFS plan. The HMO plan wants you to use its network of providers, but recognizes that sometimes enrollees want to choose their own provider.

In an FFS plan, the plan's regular benefits include deductibles and coinsurance. But in some locations, the plan has set up a POS network of providers similar to what you would find in an HMO. The plan encourages you to use these providers, usually by waiving the deductibles and applying a copayment that is smaller than the normal coinsurance. Generally, there is no paperwork when you use a network provider.

Provider — As used in this Guide and plan brochures, a provider means an individual or institution that provides medical or health services, such as doctors, hospitals, nurse-midwives, or therapists. "Covered" providers are those the plan will reimburse.

Your Links to Information

1999 FEHB Web Site — www.opm.gov/insure

Our 1999 FEHB web site gives current and valuable information to help you choose a health plan. Visit us at www.opm.gov/insure.

You will find even more information on our site this year. The new Health Plan Profiler (HPP) lets you view and print summary information about health plans. Enrollees in some states can use a new interactive decision tool to narrow the health plan search.

You can download and print plan brochures and other materials, access definitions by clicking hyperlinks, and use automated links to navigate to other sites. When you visit www.opm.gov/insure you will see these choices and more:

- **1999 Plan Information** – gives you access to general information about plans, plan quality indicators (including detailed survey results which are not printed in this Guide), plan brochures, and information about how to choose a plan. You can link to other web sites with valuable information about health plans, including those plans participating in the FEHB Program. You also can view, download and print the **Guides to Federal Employees Health Benefits Plans**.

The **Health Plan Profiler** is an easy-to-use web tool that lets you create plan profiles and summaries. You also can link to FEHB plan web sites from the Health Plan Profiler. Plans that have a  in the column labeled “Web site” in this Guide have their own web site.

- **Annuitant Information** – gives you general information about Open Season for annuitants as well as new features available to retirees, including how to make Open Season changes through the Internet. You can also link to the Medicare web site.
- **Patient Bill of Rights** – gives you information about the three objectives of the Patient Bill of Rights and the eight principle areas of rights and responsibilities. You can also link to the full text of the Patient Bill of Rights and related background information.
- **Frequently Asked Questions** – gives you answers to questions about premiums, Employee Express, enrollment, family members, temporary continuation of coverage (TCC), switching plans, retirement and other topics of interest.

Employee Express



Employee Express is a user-friendly automated system that allows some Federal employees to make changes to their health insurance, as well as Thrift Savings Plan, financial allotments, deposit of net pay, home address, and state and Federal taxes. Employees can access Employee Express using a touch-tone telephone, a personal computer or computer kiosk and avoid the need to submit forms. Employee Express saves time and is accessible 24-hours a day, 7 days a week. If you are unsure whether you can use Employee Express, contact your human resource or payroll office. You may visit Employee Express at www.employeeexpress.gov or link to it from our web site.

Quality Indicators

Accreditation

We encourage all FEHB plans to get accreditation from national accrediting organizations. These organizations evaluate health plans and health care organizations and confer accreditation, much like educational accrediting organizations confer accreditation on schools. We have listed the accreditation status of the FEHB plans that requested review from two large, nationally-recognized accrediting organizations — NCQA and JCAHO.

National Committee for Quality Assurance (NCQA)

The NCQA accreditation process evaluates how well an HMO 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.

- ★ **Full Accreditation** 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** 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 their accreditation status should be changed.
- ◐ **Provisional Accreditation** 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** indicates that a plan was reviewed but did not qualify for any of the above categories.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The JCAHO accreditation process evaluates an HMO's level of performance in key functional areas, such as care and treatment of patients, patient rights, improving organizational performance, and organizational ethics. JCAHO standards set performance expectations about the quality of patient care.

- ★ **Accreditation With Commendation** is granted to those plans that have demonstrated exemplary performance in complying with JCAHO standards.
- **Accreditation** is granted when a plan has demonstrated acceptable compliance with JCAHO standards.
- ◐ **Accreditation With Recommendations For Improvement** is granted when a plan receives at least one recommendation addressing insufficient or unsatisfactory compliance in a specific performance area.
- ⊗ **Not Accredited** indicates a plan has been denied accreditation because of significant noncompliance with JCAHO standards, or a plan's accreditation is withdrawn by JCAHO, or the plan voluntarily withdrew from the accreditation process.

Note: This Guide does not show an accreditation status for every plan. There may be various reasons why you won't find an accreditation symbol for a plan; check with the plan for specific information.

You may call a plan for more information about their accreditation status or call NCQA toll free at (888) 275-7585 or JCAHO at (630) 792-5800. You may also visit NCQA's web site at www.ncqa.org or JCAHO's web site at www.jcaho.org. You can link to either site from our web site at www.opm.gov/insure.

Quality Indicators

1998 Customer Satisfaction Survey Results

Each year we ask a sample of Federal enrollees to rate their satisfaction with their plans. We know this is an important consideration for most people when choosing between plans. Ratings are included in this Guide for most FEHB plans.

If a plan is not rated, 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.

The Ratings. We survey enrollees and ask them to rate various aspects of their health plan on a five point scale of *poor*, *fair*, *good*, *very good*, and *excellent*. Plans that enrollees rated significantly better than average in any category have a ●, average ratings get a ◐, and significantly below average get a ○. The average rating for all plans of the same type is shown in the column heading.

For more detailed information about ratings, visit our web site at www.opm.gov/insure.

The categories shown in this Guide were chosen because of their importance to most people in selecting a plan (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,
- Getting claims processed quickly (FFS only),
- Quality of care (from doctors and other medical professionals), and
- Results of care.

Overall Satisfaction. We also asked enrollees about their **overall** satisfaction with their health plan.

A bar graph for each plan shows the percentage of plan enrollees who indicated they were *extremely satisfied*, *very satisfied* or *satisfied*.

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*. The numbers in the bar add to 86, meaning 86% of respondents were at least satisfied with the plan. The remainder were less than satisfied with the plan overall.

Plans with an overall satisfaction score that is significantly higher than the average overall score are identified with a ✓ in the column labeled “Top rated plans”.

A Word About Medicare

Most Federal employees aren't yet eligible for Medicare, but many of us have friends or relatives who are. The Balanced Budget Act of 1997 (P.L. 105-33) expanded Medicare's health plan options with the creation of Medicare+Choice. Beginning in 1999, Medicare beneficiaries can remain in the original Medicare plan or choose to get their Medicare benefits from an array of other Medicare+Choice options. These options include managed care plans such as HMOs and PPOs, as well as Private FFS plans and Medical Savings Accounts (MSAs). Medicare benefi-

ciaries will receive information about these new choices this fall, or can check Medicare's web site at www.medicare.gov. If a friend or relative asks you about these new choices, they need to know that they don't have to make any change. If they want to change and have an employer-sponsored health care policy, they should first talk with their former employing office. Former Federal employees should call their retirement system before making any change, especially if they are considering suspending their FEHB coverage.

Choosing a Health Plan?

DID YOU KNOW?

About 58,000 Americans are waiting for organ transplants, and about 4,000 die each year while waiting.

There is *no* cost to your family when you become an organ donor.

Your decision to become an organ and tissue donor *will not* affect your medical care because every effort is made to save your life before donation occurs.

A national system is in place to ensure fair distribution of organs without regard to race, gender, age, income or celebrity status.

All major religious groups in the U.S. approve of and support organ and tissue donation.

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

Organ & Tissue DONATION



©Coalition on Donation

Share Your Life.

SIGN YOUR DONOR CARD.

Share Your Decision.SM

TELL YOUR FAMILY.

For a free brochure and donor card, call the
Coalition on Donation at 1-888-90-SHARE
(1-888-907-4273) or visit the
U.S. Department of Health & Human Services web site:
www.organdonor.gov