Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

Table of Contents

Things to Remember

- The plan you choose can make a difference in your health.
- Be aware of benefit changes for 2006.
- Check the premium for 2006.
- Look for new choices.

The information in this Guide gives you an overview of the FEHB Program and its participating plans. Read the plan brochures before you make any final decisions about health plans.

U.S. Office of Personnel Management 1900 E Street NW, Washington, DC 20415 | (202) 606-1800 | TTY (202) 606-2532

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

Changing Enrollment During Open Season

Each year, in early November, your current health benefits plan sends you a brochure, and your retirement office sends you instructions for ordering brochures and making Open Season changes. It is very important that you keep your address up to date to ensure that you receive your Open Season materials each year. If you move, please be sure to let your retirement office know your new address. Any address request sent to OPM must have your CSA or CSF claim number so that we can identify you

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, do not respond to the Open Season material. Your coverage under your current health plan continues automatically.

Cancellation - You may voluntarily cancel your enrollment at any time. If you cancel, 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 a temporary continuation of coverage (TCC). Once your cancellation takes effect, you will not be able to enroll again as a retiree unless you have been continuously covered as a family member under another enrollment in the FEHB since the date of your cancellation, and you lose the coverage because the enrollment ends or the enrolle changes from self and family to self only.

Suspension - You may suspend your FEHB enrollment for any of the following reasons:

- because you are eligible under Medicaid or a similar state-sponsored program of medical assistance for the needy; or
- because you have coverage under Peace Corps, TRICARE, TRICARE For Life, or CHAMPVA military program

For more information on how to suspend your FEHB enrollment, contact your retirement office. Time limitations and other restrictions apply. For instance, you must submit eligibility documentation that you are suspending FEHB to enroll in one of the other programs listed in case you wish to reenroll in the FEHB Program at a later time.

If you have suspended FEHB coverage for one of the eligible programs (and 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 plan's service area, or you involuntarily lose coverage under one of the eligible programs. If you cancel your coverage for any reason, you cannot reenroll.

Coordination of FEHB benefits with Medicare or other coverage - If the original Medicare Plan is your primary payer, which is generally the case if you have Medicare and are not working, check the plan brochure to see if the plan waives some of its FEHB cost-sharing (e.g., deductibles, coinsurance, or copayments.)

If you are interested in an HMO plan, some FEHB HMOs also offer Medicare Advantage plans. Information on coordinating benefits with other

- to enroll in a Medicare Advantage plan (these are Health Maintenance Organizations of Fee-for-Service plans approved by the Centers for Medicare and Medicaid Services):

coverage, original Medicare or Medicare Advantage is available in Section 9 of the plan brochures

Table of Contents

U.S. Office of Personnel Management 1900 E Street NW, Washington, DC 20415 | (202) 606-1800 | TTY (202) 606-2532

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

Picking a Health Plan

Step 1: 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	You must use the plan's network for full benefits. Not using PPO providers means only some or none of your benefits 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 network.	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 network for full benefits. You may go outside the network but it will cost you more.	Referral generally required to get full 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. Not using the network will cost you more.	Referral not required to get full 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/HSA or HRA	Some plans are network only, others pay something even if you do not use a	Referral not required to get full benefits from PPOs.	You will pay an annual deductible and cost-sharing. You pay less if you use the	If you have an HSA account, you may have to file a claim to obtain reimbursement.

network provider.	network.

See Definitions for a more detailed description of each type of plan.

Step 2: Medical care services. Are preventive care services important to you? What about the freedom to choose your own doctors? Do you prefer to pay a higher deductible in return for a lower premium? Estimate what you might spend on your health care for deductibles, coinsurance/copayments, and services that are not covered. What is the maximum you will have to pay out-of-pocket each year?

An easy-to-use tool allowing you to compare plans is available on the web at www.opm.gov/insure/06/spmt/plansearch.aspx. If you do not have Internet access, use the chart below by consulting the health plans' brochures to review your costs, including premiums, and estimate what you might spend on health care next year. Plan brochures can be obtained from your Human Resources office or on the OPM web site at www.opm.gov/insure/health.

	Health Plan_____	**Health Plan_____**	**Health Plan_____**
Annual premium			
Annual deductible			
Office visit to primary care doctor			
Office visit to specialist			
Hospital inpatient deductible/copayment/coinsurance			
Hospital room & board charges			
Prescription Drugs			
Catastrophic protection limit			
Home health care visits			
Durable medical equipment			
Maternity care			
Well-child care			
Routine physicals			
Accreditation			
The following information can be found in the Member Survey Results section in the benefit charts.			
Overall plan satisfaction			
Getting needed care			
Getting care quickly			
How well doctors communicate			
Customer service			
Claims processing			

Step 3: Think quality. How well do health plans keep their members healthy? How well do health plans treat members when they are sick? Good quality health care means doing the right thing at the right time, in the right way, for a person to achieve the best possible results. Good quality doesn't always mean receiving more care. We provide two types of quality information: accreditation (independent evaluations from private organizations) and member survey opinions (by enrollees).

HMO Accreditation. The evaluations shown in this Guide are performed by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and URAC. The following are the accreditation levels used by each organization. Check your health plan's brochure for its accreditation level.

National Committee	**Excellent** – Levels of service and	**Commendable** –	**Accredited** – Meets	**Provisional** – Meets	**New Health Plan**

for Quality Assurance (www.ncqa.org)	clinical quality that meet or exceed NCQA's requirements for consumer protection and quality improvement AND achieve health plan performance results that are in the highest range of national or regional performance.	Meets or exceeds NCQA's requirements for consumer protection and quality improvement.	most of NCQA's requirements for consumer protection and quality improvement.	some but not all of NCQA's requirements for consumer protection and quality improvement.	–Applies to health plans that are less than two years old.
Joint Commission on Accreditation of Healthcare Organizations (www.jcaho.org)	**Accreditation with Full Compliance** – Demonstrates satisfactory compliance with JCAHO standards in all performance areas.	**Accreditation with Requirements for Improvement** – Demonstrates satisfactory compliance with JCAHO standards in most performance areas.	**Provisional** – Demonstrates a previously unaccredited plan's satisfactory compliance with a subset of standards.	**Conditional** – Demonstrates failure to meet standard(s) or specific policy requirement(s) but is believed capable to do so in a specified time period.	
URAC (www.urac.org)	**Full Accreditation** – Demonstrates full compliance with standards.	**Conditional** – Meets most of the standards but needs some improvement before achieving full compliance.	**Provisional** – A plan that has otherwise complied with all standards but has been in operation for less than 6 months.		

Note: This chart shows the accreditation levels available under each accrediting organization listed. It is not intended to draw comparisons among the different accrediting organizations.

Member Survey Results. Each year Federal Employees Health Benefits (FEHB) plans with 500 or more subscribers mail the Consumers Assessment of Health Plan Survey (CAHPS)' to a random sample of plan members. For Health Maintenance Organizations (HMO)/Point-of-Service (POS) plans, 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 consists of a set of standardized health plan performance measures that evaluate members' satisfaction with their health p lans. Independent vendors certified by the National Committee for Quality assurance (NCQA) administer the surveys.

Previously, OPM used symbols to indicate whether a plan's ratings on each of the CAHPS measures were: Average, Above Average, or Below Average compared to a national average. This year , OPM is reporting each plan's scores on the various survey measures. We now show the percentage of satisfied members on a scale of 0 to 100. Also, we list the national average for each measures. Since we offer both HMO plans Free-for-Service/PPO 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

- Were you satisfied with the choices your health plan gave you to select a personal doctor?
- Were you satisfied with the time it takes to get a referral to a specialist?

Getting Care Quickly

- Did you get the advice or help you needed when you called your doctor during regular office hours?
- Could you get an appointment for regular or routine care when you wanted?

How Well Doctors Communicate

- Did your doctor listen carefully to you and explain things in a way you could understand?
- Did your doctor spend enough time with you?

Customer Service

- Was your plan helpful when you called its customer service department?
- Did you have paperwork problems?
- Were the plan's written materials understandable?

Claims Processing

- Did your plan pay your claims correctly and in a reasonable time?

In evaluating plan scores, you can compare individual plan scores against other plans and against the national average for each plan type. 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.

Fee-for-Service (FFS) plans and their Preferred Provider Organizations (PPO) are organized much differently and perform different functions than Health Maintenance Organizations (HMO) and Point-of-Service (POS) plans. Consequently, the accreditation of these plans is different from HMOs and POS plans.The following chart shows activities common to FFS/PPO plans and the X indicates that your FFS/PPO plan (or a vendor with which it contracts has achieved accreditation in these areas.

	Behavioral Health	Care Management	Disease Management	Health Utilization Management	Health Network Accreditation	Health Plan Accreditation
APWU Health Plan	X	X	X	X	X	
Blue Cross and Blue Shield		X				
GEHA		X	X	X	X	
Mail Handlers				X		
NALC	X		X	X		
PBP Health Plan		X	X	X	X	
Association				X	X	
Foreign Service	X		X	X	X	
Rural Carrier				X	X	
SAMBA		X		X		

Behavioral Health – a utilization management program that specializes in mental health and substance abuse or chemical dependency services.

Case Management – identifying plan members with special healthcare needs, developing a strategy that meets those needs, and coordinating and monitoring the ongoing care.

Disease Management – intensively managing a particular disease. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. Similar to care management but more focused on a defined set of diseases.

Health Utilization Management – managing the use of medical services so that a patient receives necessary, appropriate, high-quality care in a cost-effective manner. It requires plans to use clinical personnel to make decisions.

Health Network Accreditation – this standard includes key quality benchmarks for network management, provider credentialing, utilization management, quality management and improvement and consumer protection.

Health Plan Accreditation – a comprehensive assessment of a plan's performance in key areas including network management, provider credentialing, utilization management, quality management and improvement, and consumer protection.

Table of Contents

U.S. Office of Personnel Management 1900 E Street NW, Washington, DC 20415 | (202) 606-1800 | TTY (202) 606-2532

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems, such as permanent disabilities, extended hospital stays, longer recoveries, and additional treatments. By asking questions, learning more, and understanding your risks, you can improve the safety of your health care, and that of your family. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**
   - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
   - Tell them about any drug allergies you have.
   - Ask about side effects and what to avoid while taking the medicine.
   - Read the label when you get your medicine, including all warnings.
   - Make sure your medicine is what the doctor ordered and know how to use it.
   - Ask the pharmacist about your medicine if it looks different than you expected.

3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures.
   - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.**
    - Ask your doctor which hospital has the best care and results for your condition if you have more than one hospital from which to choose
    - Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. **Make sure you understand what will happen if you need surgery.**
    - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
    - Ask your doctor, "Who will manage my care when I am in the hospital?"

    - Ask your surgeon:

        Exactly what will you be doing?
        About how long will it take?
        What will happen after surgery?
        How can I expect to feel during recovery?

6. Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.HospitalCompare.hhs.gov A tool to provide you with information on how well the hospital in your area care for their adult patients suffering from heart attack, heart failure, and pneumonia
- www.ahrq.gov/consumer/pathqpack.htm The Agency for Healthcare Research and Quality make available a wide-ranging list of topics from patient safety to choosing quality healthcare providers to improving the quality of care you receive.
- www.QualityCheck.org A source for finding and comparing accredited healthcare organizations, including hospitals, assisted living facilities, nursing homes, and settings for addictions, children and youth services, and community ,mental health facilities.
- www.leapfroggroup.org The Leapfrog Group is active in promoting safe practices in hospital care.

Table of Contents

U.S. Office of Personnel Management 1900 E Street NW, Washington, DC 20415 | (202) 606-1800 | TTY (202) 606-2532

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

FEHB Web Resources

Use the FEHB web site for additional help in choosing the health plan that is right for you.

The FEHB web site at www.opm.gov/insure/health can help you to choose your health plan and enroll. In addition to the information found in this Guide you will find:

- An interactive tool that allows you to make side-by-side comparisons of the costs, benefits, and quality indicators of the plans in your area.
- All health plan brochures.
- A comparison of how FEHB plans perform in important medical areas under the Health Plan Employer Data and Information Set (HEDIS). HEDIS is a set of standardized performance measures that allows users to reliably compare managed care health plan performance across specific clinical areas. The performance measures are related to many significant diseases such as cancer, heart disease, asthma, and diabetes. Compare plan results at www.opm.gov/insure/health/hedis2006.
- Information on enrolling, including online enrollment for employees of selected agencies.
- Information on how plans in the FEHB Program coordinate benefit payments with Medicare.
- A comprehensive set of Frequently Asked Questions and answers on all aspects of the Program.
- An online version of the FEHB Handbook for more information on FEHB policies and procedures.

Table of Contents

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

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.** Choose between Self Only or Self and Family.
- **A Choice of Plans and Options.** Select from Fee-for-Service (with the option of a Preferred Provider Organization), Health Maintenance Organization, Point-of-Service plans, Consumer-Driven plans, or High Deductible Health Plans.
- **A Government Contribution.** The Government pays 72 percent of the average premium toward the total cost of your premium, up to a maximum of 75 percent of the total premium for any plan.
- **Annual Enrollment Opportunity.** Each year you can change your health plan enrollment. This year the Open Season runs from November 14, 2005, through December 12, 2005. Other events allow for certain types of changes throughout the year. See your Retirement System office for details.
- **Continued Group Coverage.** Eligible participants can continue coverage following retirement, divorce, death, or changes in employment status. See your Retirement System office for more information.
- **Coverage after FEHB Ends.** You or your family members may be eligible for temporary continuation of FEHB coverage or for conversion to non-group (private) coverage when FEHB coverage ends. See your Retirement System office for more information.
- **Consumer Protections.** Go to www.opm.gov/insure/health/consumers to: see your appeal rights to OPM if you and your plan have a dispute over a claim; read the Patients' Bill of Rights and the FEHB Program and; learn about your privacy protections when it comes to your medical information.

If the original Medicare Plan is your primary payer, which is generally the case if you have Medicare and are not working, check the plan brochure to see if the plan waives some of its FEHB cost-sharing (i.e., deductibles, coinsurance or copayments).

If you are interested in an HMO plan, some FEHB HMOs also offer Medicare Advantage plans. Information on coordinating benefits with other coverage, original Medicare Advantage is available in Section 9 of the plan brochures.

Table of Contents

U.S. Office of Personnel Management 1900 E Street NW, Washington, DC 20415 | (202) 606-1800 | TTY (202) 606-2532

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

Definitions

Accreditation - The status granted to a health care organization following a rigorous, comprehensive, and independent evaluation. The evaluation includes an assessment of the care and service being delivered in important areas of public concern, such as immunization rates, mammography rates, and member satisfaction.

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 cost of the service (you pay 20%, for example).

Consumer-Driven Health Plans (CDHP)- Describes a wide range of approaches to give you more incentive to control the cost of either your health benefits or health care. You have greater freedom in spending health care dollars up to a designated amount, and you receive full coverage for in-network preventive care. In return, you have a higher annual deductible than standard medical plans after you have used up the designated amount. The catastrophic limit is usually higher than those in other plans.

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).

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 tax-free 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. To open an HSA you must be covered under a High Deductible Health Plan and cannot be eligible for Medicare or covered by another plan that is not a High Deductible Health Plan or a general purpose HCFSA or a dependent on another person's tax return. HSAs 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.

High Deductible Health Plan (HDHP) - A High Deductible Health Plan is a health insurance plan in which the enrollee pays a deductible of at least $1,100(self-only coverage) or $2,200 (family coverage). The annual out-of-pocket amount (including deductibles and copayments) the enrollee pays cannot exceed $5,000 (self-only coverage) or $10,000 (family coverage). HDHPs can have first dollar coverage (no deductible)for preventive care and higher out-of-pocket copayments and coinsurance for services received from nonnetwork providers. HDHPs offered by the FEHB Program establish and partially fund HSAs for all eligible enrollees and provide a comparable HRA for enrollees who are ineligible for an HSA. The HSA premium funding or HRA credit amounts vary by plan.

In-Network – You receive treatment from the doctors, clinics, health centers, hospitals, medical practices, and other providers with whom

Fee-for-Service (FFS) - Health coverage in which doctors and other providers receive a fee for each service such as an office visit, test, or procedure. The health plan will either pay the medical provider directly or reimburse you for covered services after you have paid the bill and filed an insurance claim. When you need medical attention, you visit the doctor or hospital of your choice.

Formulary – A list of both generic and brand name drugs that are preferred by your health plan. Health plans choose formulary drugs that are medically safe and cost effective. A team including pharmacists and physicians meet to review the formulary and make changes as necessary.

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 its brand name counterpart, but it must have the same active ingredients, strength, and dosage form (pill, liquid, or injection).

Health Maintenance Organization (HMO) – A health plan that provides care through contracted or employed physicians and hospitals located in particular geographic or service areas. HMOs emphasize prevention and early detection of illness. Your eligibility to enroll in an HMO is determined by where you live or, in some plans, where you work.

Health Reimbursement Arrangements (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 ineligible foran 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.

your plan has an agreement to care for its members.

Out-of-Network – You receive treatment from doctors, hospitals, and medical practitioners other than those with whom the plan has an agreement, at additional cost. Members in a PPO-only option who receive services outside the PPO network generally pay all charges.

Point-of-Service (POS) – A product offered by a health plan that has both in-network and out-of-network features. In a POS you don't have to use the plan's network of providers for every service but you generally pay more out of network.

Preferred Provider Organization (PPO) – FFS Plans and many HDHPs use PPOs which are a network of providers. PPOs give you the choice of using doctors and other providers in the network or using non-network providers. You don't have to use the PPO, but there are advantages if you do. (Be aware, however, that some of the services provided in a PPO hospital may not be covered by PPO arrangements. Room and board will be covered, but anesthesia and radiology, for instance, may be covered under non-PPO benefits.) Note that some FFS plans may offer an enrollment option that is "PPO--only." You **must** use network providers to receive benefits from a PPO--only plan.

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

Table of Contents

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

The Federal Long Term Care Insurance Program

It's important protection.

Here's why you should consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself–or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and 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 lifetime premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

To find out more and to request an application. Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Table of Contents

U.S. Office of Personnel Management 1900 E Street NW, Washington, DC 20415 | (202) 606-1800 | TTY (202) 606-2532

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

Stop Health Care Fraud

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium. OPM's Office of the Inspector General investigates allegations of fraud, waste, and abuse in the FEHB Program, regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your health plan identification number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid health care providers who say that an item or service is not usually covered, but they know how to bill your health plan to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from your health plan.
- Do not ask your doctor to make false entries on certificates, bills, or records to get your health plan to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call your health plan and explain the situation.
  - If they do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300
OR WRITE TO:

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400

Washington, DC 20415

- Remember, FEHB-covered family members may not include:
  - your former spouse after a divorce decree or annulment is final (even if a court orders it); or
  - your child over age 22 unless he/she became incapable of self support before age 22.
- If you have any questions about the eligibility of a dependent, check with your Human Resources office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Table of Contents

U.S. Office of Personnel Management 1900 E Street NW, Washington, DC 20415 | (202) 606-1800 | TTY (202) 606-2532

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

Nationwide Fee-For-Service Plans Open to All

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 a contract with the health plan to offer discounted charges. You can also choose medical providers who are not contracted 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) offer discounted charges. You usually pay a copayment or a coinsurance charge 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. Lab work and radiology services from independent practitioners within the hospital are frequently not covered by a 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 and coinsurance. You pay a greater amount of the out-of-pocket cost.

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

See the tables

Table of Contents

U.S. Office of Personnel Management 1900 E Street NW, Washington, DC 20415 | (202) 606-1800 | TTY (202) 606-2532

Federal Employee Health Benefit Program

RI 70-9 For Federal Retirees and Their Survivors

Nationwide Fee-for-Service Plans Open Only to Specific Groups

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 a contract with the health plan to offer discounted charges. You can also choose medical providers who are not contracted 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) offer discounted charges. You usually pay a copayment or a coinsurance charge 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. Lab work and radiology services from independent practitioners within the hospital are frequently not covered by a PPO agreement. If you receive treatment from medical providers who do not contract 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 the remaining charges directly. You pay a greater amount of the out-of-pocket cost.

See the tables

Table of Contents

Federal Employee Health Benefit Program

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Health Maintenance Organization Plans and Plans Offering a Point-of-Service Product

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 most 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 a 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 a 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 and coinsurance. Your out-of-pocket costs are higher and you file your own claims for reimbursement.

See the tables

Table of Contents

U.S. Office of Personnel Management 1900 E Street NW, Washington, DC 20415 | (202) 606-1800 | TTY (202) 606-2532

Federal Employee Health Benefit Program

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High Deductible and Consumer-Driven Health Plans

Nationwide and Regional High Deductible Health Plans with a Health Savings Account or Health Reimbursement Arrangement and Consumer-Driven Plans

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 $1,050 for Self and $2,100 for Family coverage) and annual out-of-pocket limits (not to exceed $5,000 for Self and $10,000 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)

Health Savings Accounts are available to members who do not have Medicare or another health plan. The amount of the "premium pass through" is based on whether you have a Self Only or Self and Family enrollment. You have the option to make tax-free contributions to your account, provided the total contributions do not exceed the limits established by law, which are typically not more than the plan deductible. 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. However, if you enroll in a HDHP with a HSA, you are not eligible to participate in a Health Care Flexible Spending account.

Features of an HSA include:

- Tax-deductible deposits you make to the HSA.
- 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.

Health Reimbursement Arrangement (HRA)

For members who are not eligible for an HSA, have Medicare or another non-High Deductible Health Plan, the HDHP will provide and administer a Health Reimbursement Arrangement.

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.		
	Health Savings Account (HSA)	**Health Reimbursement Arrangement (HRA)**
ELIGIBILITY	You must enroll in a High Deductible Health Plan. No other general medical insurance coverage permitted.	You must enroll in a High Deductible Health Plan or Comsumer-Driven Health Plan.
FUNDING	You cannot be enrolled in Medicare Part A or Part B. The plan deposits a monthly "premium pass through" into your account. The plan will send you forms to complete to establish your account.	The plan deposits the credit amount directly into your HRA. The plan will send you forms to complete to establish your account.
CONTRIBUTIONS	The maximum allowed is a combination of the health plan "premium pass through?and the member contribution up to the amount of the plan deductible.	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, 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 health plan, or to pay the plan's deductible. See IRS Publication 502 for a complete list of eligible expenses. Over-
	Over-the-counter drugs, for instance, are eligible expenses but health benefit premiums are not.	the-counter drugs, for instance, are eligible expenses but health benefit premiums are not.
PORTABLE	Yes, you can take this account with you when you terminate employment or retire.	If you retire and remain in your health plan 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 health plan 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.

Consumer-Driven Plans - A Consumer-Driven plan provides you with greater freedom in spending health care dollars the way you want. The typical plan has common components: 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 members receive full coverage for in-network preventive care.

- See table1

- See table2

Table of Contents

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