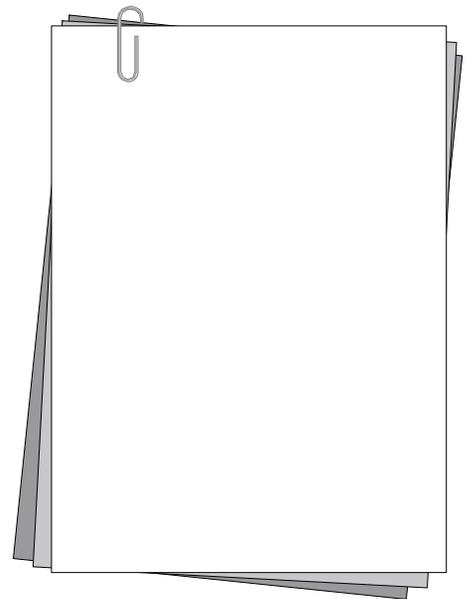

1997 FEHB Guide



Federal Civilian Employees

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Our Commitment to Our Customers

The U.S. Office of Personnel Management, Office of Insurance Programs, 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 your agency or retirement system so it can process your enrollment changes and deduct your premium. We also contract with and monitor your plan — and over 380 other health plans — that pay claims or provide care to covered members.

In 1995, we combined mail and telephone surveys with face-to-face focus group discussions to get feedback from our customers about the services we provide. You told us what you wanted, what you liked and disliked, and we listened. The standards we established reflect our commitment to you. We continuously strive to satisfy your expectations and will be surveying more of you again in the near future.

- ❖ 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 OPM's Office of Insurance Programs 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 OPM's Office of Insurance Programs about other matters, we will respond within 30 days after we get your letter. If we need more time to give you a complete response, we will let you know.



**More Information
Better Choices**

What the FEHB Program Can Offer You

The Federal Employees Health Benefits Program offers a practical way to help meet your health care needs. FEHB provides:



Immediate coverage from the effective date of enrollment in your new plan without a medical examination or restrictions because of age or physical condition.



A choice of 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. All plans available under the FEHB Program are listed in this booklet. We divided the Guide into three sections: managed fee-for-service; plans with a point of service product; and health maintenance organizations. See page 3 for a description of each.



A Government contribution toward the total cost of your premium. In 1997 the Government will pay up to \$1633.58 for each self only enrollment and \$3508.44 for each family enrollment.

The maximum Government contribution if you're paid every two weeks is \$62.83 self only and \$134.94 self and family. The monthly rates are \$136.13 self and \$292.37 family. Some plans get less than the maximum because the Government cannot contribute more than 75% of a plan's total premium.



Salary deduction for your share. You pay your share of the premium through a payroll deduction. Each plan's premium is the amount that will be deducted from your salary beginning in January 1997. Amounts for part-time employees may be different; see your personnel office to get the exact amount.



Annual opportunity to enroll or change plans. The 1996 Open Season is from **November 11 through December 9**. You may make one or more of the following changes: enroll if you are eligible and not now enrolled; change plans or options; or change from self only to family.



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



Continued group coverage. For these life events, the FEHB Program offers the opportunity to continue FEHB coverage:

- for you and your family when you retire from Federal service. (Normally you need to be continuously enrolled in FEHB for the last five years before you retire.)
- for your former spouse if you divorce. (Contact your personnel office to find out about the requirements.)
- for your family if you die.
- for you when you 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. It is your responsibility to understand when a family member loses FEHB eligibility. Your personnel office can help you. For the following life events, the FEHB Program offers an opportunity either to **temporarily** continue FEHB coverage or to convert to non-group (private) coverage: if you leave Federal service (including when you can't carry FEHB into retirement); when your covered dependent child marries or turns age 22; and if your spouse loses FEHB family member status and cannot indefinitely continue FEHB.

Using the Plan Information and Report Card

For 1997 we are introducing some new features that we think you will find helpful.

- We expanded the number of customer satisfaction survey responses to give you more detail about what others think of their health plans.
- We combined the plan information and report cards to make comparing plans easier.
- We added two new columns. "NCQA status" highlights the assessment of plans' operations by an independent reviewer. "Top rated plans" are the plans that were rated significantly higher by their enrollees.

National Committee for Quality Assurance (NCQA) accreditation. NCQA is a nationally-recognized leader in evaluating managed care plans such as 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 by employers, regulators, and consumers to assess the quality of operations of managed care plans.

You deserve to have as much information as possible in order to make an informed choice about health plans. Therefore, we have listed the accreditation status of the FEHB plans who took the initiative to seek an NCQA review. The following symbols appear in the NCQA status column to designate the accreditation status of the plans NCQA had reviewed when we went to print.

★ **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.** Plans that 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: a plan chose not to be reviewed; not all of its FEHB rating area was reviewed; it might have merged with another plan and that plan was not reviewed; it is too new to be reviewed; or a review decision is pending. You may call a plan for more information. You may also visit NCQA's Web site at <http://www.ncqa.org> for more information on health plan ratings.

Customers' Top Rated Plans. Plans scoring significantly higher than the average on the FEHB customer satisfaction survey are denoted by a ★ in the new Top rated plans column.



The FEHB Guide and many FEHB brochures are on our electronic bulletin board. **OPM Mainstreet** is open to anyone who has a personal computer, a modem, a phone line, and communications software. By dialing (202) 606-4800, callers may access the FEHB Guides, brochures, and other Open Season information.

Using the Plan Information and Report Card



Definitions

The following definitions are provided to help you understand the terms used in the FEHB Guide.

Brochure — A plan's description of benefits, limitations, exclusions, and definitions under the FEHB Program.

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

Coinsurance — The ratio you and your FEHB plan share for the cost of covered medical expenses.

Copayment — A fixed dollar amount you pay as your share of a service or benefit.

Covered charges — The charges for medical care or supplies your plan is responsible for before deductibles, coinsurance, and copayments are applied.

Deductible — The amount of covered expenses you must pay before benefits become payable by your plan.

Health Maintenance Organization (HMO) — A prepaid health plan that provides a comprehensive array of medical services, emphasizing prevention and early detection, through contracted physicians, hospitals, and other providers. Care received from a non-Plan provider, other than emergency care, is not covered. See pages 22-57 for a list of participating HMOs.

Managed Fee-for-Service — These plans pay for covered services after services are received. Managed fee-for-service plans use precertification and utilization review in managing patient care. See pages 8-11 for managed fee-for-service plans.

Preferred Provider Organization (PPO) — A fee-for-service product where patients use plan selected health care professionals who discount their fees to plan members. If you enroll in a plan with a PPO feature, you will pay less money out-of-pocket for medical services by visiting a PPO provider instead of a non-PPO provider. See pages 8-9 for the PPO options.

Point of Service (POS) — A managed care product that provides members with the option of using a selected network of providers. By using in-network providers, your out-of-pocket expenses are minimal, or the same as an HMO. If you use out-of-network providers, you are subject to substantial out-of-pocket costs in the form of deductibles, coinsurance, and copayments. See pages 12-20 for POS choices.

Using the Plan Information and Report Card

You can help get the right kind and quality of care for you and your family at the right price by taking a careful look at your choice of FEHB plans. The FEHB Program offers a variety of health plans and products to enhance your choices and make your health care dollar go further.

Managed care is an important part of the FEHB Program. It is a system of health care that integrates the financing, delivery, and prospective review of health services. Common features of managed care are pre-admission certification, the use of primary care physicians as gatekeepers to coordinate your medical care, and physicians and other providers working in organized networks.

In deciding which plan to choose, you should consider the cost of each plan, you and your family's medical needs, and the type of delivery system you prefer.

If you are eligible for FEHB coverage, you may enroll in any "open" fee-for-service plan. Some open plans require you to become a full or associate member in the organization that sponsors the plan. "Limited" employee organization plans only allow employees in certain specific occupational groups or agencies to enroll. *Membership requirements and/or limitations also apply to any POS product a plan may be offering.*

Important: Prepaid plans have been redesignated as either HMOs or POS products. If you do not find your plan in the HMO section, check the POS listings.



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

*The information in the **FEHB Guide** is intended to give you an overview of the Federal Employees Health Benefits Program and its participating plans. Before making any final decisions about health plans, please check the particular plan's brochure.*

Using the Plan Information and Report Card

1996 Customer Satisfaction Survey Results

Again in 1996, Federal employees have the opportunity to see how other enrollees in the FEHB Program rate their health plan. The information provided in this FEHB Guide may help you choose the health plan that is right for you. The Guide gives you ratings for 293 health plan choices available through the FEHB Program.

In June and July 1996, a random sample of plan enrollees was sent a questionnaire by the Gallup Organization, the Gallup Poll people. In August 1996, non-responding enrollees in plans with low response rates were given the opportunity to complete the survey over the telephone if they had not already returned the mailed survey.

Plan enrollees in all health plans surveyed were asked to rate various aspects of their health plan on a five-point scale of *poor*, *fair*, *good*, *very good*, and *excellent*. Results are shown for the percentage of enrollees in each plan who responded *good*, *very good* or *excellent* to an overall rating of their plan in the following categories:

- Access to medical care (arranging for and getting care)
- Quality of care (from doctors and other medical professionals)
- Doctors available through the plan's coverage (being able to find doctors you are satisfied with)
- Coverage (range of services covered) and
- Information provided by the plan, customer service, and simplicity of paperwork.

We also asked enrollees in all plans surveyed about the following areas of their health plan's performance.

- Thoroughness and competence of doctors and medical professionals
- Results of care - how much you were helped
- Explanation of what is wrong, being done, and what to expect
- Getting appointments when sick.

Enrollees in HMO plans and plans with a POS product reported their views on the following.

- Convenience of doctor's hours
- Choice of specialists
- Access to medical care in an emergency
- Ability to see the same doctor on most visits, and
- Choice of primary care doctors.

Enrollees in managed FFS plans reported on the following.

- The part of the premium you have to pay
- How quickly claims are processed
- How well the plan handles your questions, requests, or problems.

In addition, bar graphs inside the Guide show enrollees' **overall** satisfaction level 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	64	86
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The dark shading represents those who are *somewhat* satisfied with their health plan (19 in the example). The light shading adds the plan enrollees who said *very* satisfied to those who said *somewhat* satisfied. Finally, the white portion is the combination of *somewhat* satisfied, *very* satisfied, and *extremely* satisfied. The remaining enrollees of the plan indicated they were either *somewhat*, *very*, or *extremely dissatisfied* or *were neutral*.

Using the Plan Information and Report Card

1996 Customer Satisfaction Survey Results

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

Using the Information

Keep in mind that the results in the Guide are the opinions of current plan enrollees. This information may be very useful to you in identifying plans to consider. In addition, this booklet lists premiums for all FEHB health plans. You should review this information with the specific plan brochures that interest you. All of this information will help you select the health plan best suited to your needs.

Understanding the Survey Results

The error range for overall satisfaction with the listed plans is less than 7% at the 95% level of confidence. In other words, if the survey was conducted 100 times with 100 different samples of members, 95% of the time you could expect results in the same range.

Although the survey was based on a random sample of plan enrollees, enrollees' opinions may vary depending on their age, education level, state of health, and other characteristics. The results shown in this Guide have been adjusted 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 it has very few FEHB members, the plan is new to the FEHB Program, or the plan failed to provide membership data. In some cases the number of survey respondents was too small for us to reliably include their opinions in this Guide.