Alphabet Soup of Health Plans

A NARFE Federal Benefits Institute Webinar

Presented by Tammy Flanagan
Navigating the Acronyms

FFS  
HMO  
HDHP  
CDHP  
FSA  
HSA  
FEDVIP  
FEHBP
Paradox of Choice

FEHBP
90 different plans
250 plan options

Private Sector
Take It or Leave It
Three things to consider this Open Season (11/14 - 12/12):

**FEHBP**
- Federal Employees Health Benefit Program

**FEDVIP**
- Federal Employees Dental and Vision Insurance Program

**FSAFEDS**
- Federal Flexible Spending Account Program
All plans have in common:

- Cover spouse, dependent children
- Government contribution of premium
- No pre-existing condition exclusion
- Self Only; Self Plus One; and Self and Family
- Preventative care (within plan network)
- Prescription drug coverage
- Catastrophic maximum
Some plans don’t cover:

- Cosmetic surgery
- Routine eye and dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the United States
- Routine foot care
- Weight loss programs
- Chiropractic care
Some (most) plans cover:

• Acupuncture
• Bariatric Surgery
• Chiropractic Care
• Infertility Treatment
• Applied Behavior Analysis (ABA) for Autism Disorders
Test Your Knowledge

Which statement is **true** about Self Plus One FEHBP enrollment?

A. You are automatically enrolled in this coverage
B. Always less expensive than Self and Family
C. Covers you and one family member
D. You may not switch to self and family once enrolled
Test Your Knowledge

Which statement is **true** about Self Plus One FEHBP enrollment?

A. You were automatically enrolled in this coverage
B. Always less expensive than Self and Family
C. **Covers you and one family member**
D. You may not switch to self and family once enrolled
FEHBP: FFS

Fee For Service

• Nationwide Plans
• Lower deductible
• Preferred Provider Organization (PPO) Networks
  – BC/BS Basic / Standard
  – SAMBA Standard / High
  – GEHA Standard / High
  – MHBP Value / Standard
  – United Healthcare Choice / Choice Plus
  – NALC Value / High
  – APWU High
FEHBP: HMO

Health Maintenance Organization

- Regional Plans
- Large metropolitan areas (typically)
- Some states have none (i.e., South Carolina, Alaska)
- Open Access (some) (i.e., Aetna Open Access)
- May not cover out of network (some)
- No deductible
- One-stop shopping under one roof (i.e., Kaiser)
FEHBP: CDHP

Consumer Driven Health Plan

• Health Fund, Medical Fund, Personal Care Account or “benefit allowance”
• Higher deductible (use “funds” first, then deductible)
• Carry over balance of health fund / remain in plan
• In a “good” year, spend $0 out of pocket
High Deductible Health Plan

- HSA: Health Savings Account
- HRA: Health Reimbursement Arrangement
- Premium “Pass-Through” (rebate)
- Higher deductible (use “funds” first, then deductible)
- Carry over balance of HSA or HRA
- Manage HSA or HRA as investment
- Tax-free into HSA and tax-free out of HSA for qualified expenses
Deductible: Plans A, B, C and D

- CDHP: $800
- FFS (High): $350
- HDHP: $1,500
- FFS (Low): $350
Compare Plans A, B, C and D

Annual Premium (Self)

<table>
<thead>
<tr>
<th>Plan</th>
<th>CDHP</th>
<th>HDHP</th>
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<tbody>
<tr>
<td></td>
<td>$2,840</td>
<td>$1,474</td>
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<tr>
<td></td>
<td>$2,755</td>
<td>$1,851</td>
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</tbody>
</table>

Health Fund or Pass Through

<table>
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<th>Plan</th>
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<th>HDHP</th>
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<tbody>
<tr>
<td></td>
<td>$1,200</td>
<td>$750</td>
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<tr>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>
Brand Name Drug: Plans A, B, C and D

Mail Order

- Caremark Plan A: $320
- Caremark Plan B: $223
- Aetna Plan C: $608
- Aetna Plan D: $2,027

Retail

- Caremark Plan A: $1,244
- Caremark Plan B: $861
- Caremark Plan C: $912
- Caremark Plan D: $2,203

National Active and Retired Federal Employees Association

Sponsored by GEHA
Test Your Knowledge

What is the most important factor when choosing a health plan?

A. Coverage for gym membership
B. Low premium
C. Worst case (catastrophic)
D. Tax savings
Test Your Knowledge

What is the most important factor when choosing a health plan?

A. Coverage for gym membership
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Catastrophic Protection

Annual Maximum Out of Pocket:

Yearly amount the federal government sets as the most each individual or family is required to pay in cost sharing (e.g., co-payments, deductibles and coinsurance) during the plan year for covered, in-network services.

This amount may be higher than the out-of-pocket limits the plan sets.
You Are Responsible:

For example:

• Non-member facility charges $60,000
• We pay $1,625
• You would owe $58,375

➤ $60,000 - $1,625 = $58,375

➤ This example assumes your calendar-year deductible has been met.
Plan A: These expenses do not count toward your catastrophic protection out-of-pocket maximum:

• The difference between plan allowance and billed amount;
• Expenses in excess of our maximum limitations;
• 35% coinsurance for inpatient in a non-member hospital;
• 35% coinsurance for outpatient by a non-member facility;
• The $500 penalty for failing to obtain precertification.
Not covered: (Plan A)

- Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency;
- Ambulette service;
- **Air ambulance without prior approval**;
- Ambulance transportation for member convenience or for reasons that are not medically necessary.

Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the plan.
Annual Out-of-Pocket (Self)

In-Network
- CDHP
  - $6,600
- HDHP
  - $4,000
- FFS High
  - $5,000
- FFS Low
  - $6,000

Out of Network
- CDHP
  - $12,000
- HDHP
  - $5,000
- FFS High
  - $7,000
- FFS Low
  - $8,000
Welcome to the New FSAFEDS.com
Please register to access your account.

Check Out Your Online Account
Introducing the FSAFEDS App
Choose Reimbursement or Payment Options

Home  Explore Your Options  Enroll in a Plan  File a Claim  Support & FAQ Center  Benefit Officers Toolbox

NEED HELP?
Forgot Username or Password?

New to the site?

Sponsored by National Active and Retired Federal Employees Association

The Benefits of Better Health
Health Care FSA: $2,600
- Medical
- Dental
- Vision

Limited Expense FSA: $2,600
- Compatible with Health Savings Account

Dependent Care FSA: $5,000
- Child or adult daycare expenses
- Children under 13
- Adult disabled child or relative
Education & Support

Learn more about Dental and Vision (FEDVIP), Long Term Care (FLTCIP), Flexible Spending Accounts (FSAFEDS) and how BENEFEDS relates to them all.

What would you like to learn about?

- Dental & Vision
- Long Term Care
- Flexible Spending
- What is BENEFEDS?
- Plan Tools
- FAQs
Use Tools to Compare

3 Clicks!

www.opm.gov
“Insurance”
“Healthcare”
“Plan Information”

Choose a Plan & Enroll
FEHBP Plan Information for 2017
New for 2017: Summary of Benefits

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters</th>
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<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For Network providers: $600/person; $1,200/family. For Non-Network providers: $900/person; $1,800/family. Does not apply to preventive care, office visits, or outpatient surgery you receive from a Network provider, or prescription drugs.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for certain covered services you use. <strong>Copayments</strong> do not count toward your <strong>deductible</strong>, which generally starts over January 1st. When a covered service or supply is subject to a <strong>deductible</strong>, only the Plan allowance for the service or supply counts toward the <strong>deductible</strong>. See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong> and for which services are subject to the <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet <strong>deductibles</strong> for specific services, but see the chart beginning on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For Network providers/facilities and pharmacies: $6,750/person; $13,500/family. For Non-Network providers/facilities: $10,000/person; $20,000/family.</td>
<td>The <strong>out-of-pocket limit</strong>, or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, penalties for failure to obtain precertification or preauthorization, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
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</table>
Compare Summary

• Look at examples of out-of-pocket expenses
• Participating and non-participating
• Specific services covered
• 10 pages instead of 100!
Use Tools to Compare FEHBP Plan Brochures

Search online using “Alt key” “F key” to find keywords
Use Tools to Compare narfe Magazine October - December
Did you know?

To continue health benefits into retirement, you must:

(1) Retire on an **immediate** annuity; and

(2) Have been continuously enrolled for the **five years** of service immediately preceding retirement (or if less than five years, for all service since your first opportunity to enroll).
To Do List

1. Consider Self Plus One (for family of two)
2. Compare and consider all available FEHBP plans and narrow your choices to 3 or 4
3. Attend a local health fair if available
4. Consider future health care costs
5. Review your out-of-pocket expenses for 2016
6. After choosing your health plan, consider FSA, HSA and FEDVIP!
Open Season
November 14 through December 12
Find the health plan that fits.

deha.com/switch