2024 FEHB

Open Season Guide

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Getting the Most from Your Federal Health Insurance

Updated for the 2024 Plan Year

The Federal Employees Health Benefits program is one of the most valuable of federal benefits. If you have any doubt about that, ask a private sector employee whose company doesn't offer health insurance, or maybe ask a private sector retiree who had insurance and then lost it when leaving the job.

If you still have doubts, consider that FEHB for years has been held up as a model program of employer-sponsored insurance—good coverage at a competitive cost, a wide range of plan choices, no limits or waiting periods to enroll, and a continued government contribution toward premiums for retirees at the same rate as for active employees.

And if you even then still have doubts, consider the experience of recent years as the Coronavirus pandemic put new strains on health care programs including the FEHB, yet the program not only pivoted quickly to meet those demands but did so with only relatively moderate premium increases.

It's no wonder that federal employees by and large like their program. In the most recent survey of federal employee views of their benefits, the FEHB was ranked as important or extremely important by 93 percent. Among those who didn't rank it that highly, the main reason was that they had health insurance elsewhere, such as through a spouse's employment or through the military Tricare program.

Further, 95 percent said the FEHB meets their needs to a moderate extent or more, nearly as many said that they considered it important or very important to them, and 73 percent rated it a good or excellent value.

One especially telling result is that while 72 percent said the availability of health coverage influenced their decision to go to work for the government, once they experienced being in the FEHB, their opinion rose: 79 percent said it influences their decision to stay.

Almost all eligible persons who are not enrolled said the reason was not dissatisfaction with the FEHB in general, or with its features or cost, but rather that they had health coverage from another source, such as a spouse's employment or Tricare.

That's not to say the program is perfect. While the government pays 70 percent of the total premium cost (for both active employees and retirees), some private sector employers pay more, at least for certain categories of enrollees. Also, FEHB does have some gaps in coverage, and average premiums do increase yearly like clockwork.

The average enrollee premium in the FEHB rose 7.7 percent for 2024 over 2023, 1 percentage point less than the increase over 2022-2023—which had been the largest in more than a decade. Out-of-pocket costs such as deductibles and copays—which also must be considered along with premium costs when deciding on a plan—remained about the same.

"Major cost drivers of the program generally align with those in the commercial market," the Office of Personnel Management said. That means increases in health care costs generally, and for prescription drugs—and especially for new and specialty drugs—which account for more than a quarter of total costs in the FEHB. Other drivers of premium increases include overall higher rates of use, the impact of providers using new and more expensive technology, and general medical inflation.

Premium rates are at www.opm.gov/healthcare-insurance/healthcare/plan-information/premiums.

(Premiums in the separate Federal Dental and Vision Insurance Program meanwhile remained about flat for 2024, with premiums for vision decreasing by 1.1 percent on average and premiums for dental plans increasing by 1.4 percent. That program offers similar choices during the open season to those available in the FEHB, except that retirees may also newly enroll in the FEDVIP program. See www.opm.gov/healthcare-insurance/dental-vision.)

However, with about 160 total plans, including about a dozen available nationally, there were some decreases within that average (along with larger increases, of course). And while the program sometimes is described as "vanilla" because all plans must comply with certain general requirements, there is much variation among them.

But it's up to you to take the initiative to get informed and choose wisely to get the most from it. This publication is designed to help you do just that.

The first step is to shore up your understanding of FEHB. While that may seem unnecessary—especially for someone who has been in the program for many years—there could well be important features of the program that would benefit you, but which you simply have not paid sufficient attention to.

The reality is, many FEHB-eligible persons treat their health insurance as a file it and forget it benefit. Many have been with the same plan much or even all of their time in FEHB and pay little attention during open season beyond a look at the new premium rates and at any major changes in coverage in their current plan. Only about 5 percent switch plans in any given year, even though all are eligible to change during annual open seasons.

Also, it's important to understand how FEHB evolves over time, both due to new laws and decisions by the Office of Personnel Management, which oversees the program. Don't make the mistake of thinking that your coverage next year will be just like this year.

In recent years the OPM has emphasized controls over prescription drug costs; expansion of telehealth services; incentives for retirees eligible for Medicare to enroll in that program as well even though it means paying a separate premium; and incentives for covered persons to participate in wellness programs and to better manage

chronic conditions. Just for 2024, the program expanded coverage for anti-obesity medication, mental health and substance abuse disorder services, prenatal and postpartum care, assisted reproductive technology and gender affirming care.

Don't even assume that your current plan will be available next year; each year, some drop out. For 2024, the major development was the dropout of Humana and its network of regional plans, which reduced the total number of available plans by about 100. That was attributed to that company's decision to exit the employer-sponsored health insurance market.

Enrollees in plans that drop out must make a new election for the upcoming year during an open season; if they don't, there are procedures for automatically enrolling them in another plan to protect against losing coverage.

Meanwhile, some plans newly join or existing ones expand their offerings, opening up new possibilities.

Beyond comparing premium and coverage terms in the plans available to you, don't neglect to consider your enrollment type. The program offers self-only, self and family and self plus one coverage (the "one" must be someone eligible for coverage as a family member). While there can be exceptions, as explained below, self plus one generally is less expensive than family coverage within a plan. However, there still are many thousands of family coverage enrollments covering only two people, years after the introduction of self plus one, simply because they haven't paid enough attention.

Then, you need to know what choices you can make and have a strategy for making them. This applies not only during open season but also potentially outside it when certain life events occur such as marriage or the birth of a child, when you could benefit from reexamining your health coverage

Staying with what you already have is a decision too, and it may well be the best for you. But whatever you do, make sure your decision is made in a thoughtful way, with all the facts in hand.

Understanding the FEHB

A hallmark of FEHB is its range of choice, which provides eligible persons with the opportunity (and responsibility) to make informed decisions to put the program to its best use for their personal situations.

Of the 159 plans for 2024, only 10 carriers provide plans that are nationally available (18, if you count as separate plans the high-deductible and consumer-driven options—see below for how they work—offered by some of them) and even some of those restrict who can enroll in them. Most of the rest are localized health maintenance organization plans, at least one of which is available in every state. Some plans offer a choice of two levels with differing cost and coverage terms, and/or a high-deductible or consumer-driven design.

FEHB provides health insurance coverage to some 8.2 million people, a number about evenly split between enrollees and covered family members. Almost all federal employees are eligible to participate, and most retirees also remain eligible, so long as they were covered by FEHB for the five consecutive years before retiring on an immediate annuity (there are limited exceptions to that requirement). Premiums for retirees are the same as for active employees, although charged on a monthly rather than biweekly basis. The government contributes on average about 70 percent of the total premium.

Active employees can pay premiums with pre-tax payroll money. Retirees cannot pay through this "premium conversion" arrangement, making the insurance effectively more expensive for them even though the premium rates are the same as for active employees.

The annual open season gives all eligible persons have an opportunity to join the program or make enrollment changes, which also are allowed at other times due to certain life events, as described below.

There are three types of enrollment in each FEHB plan: self only, which provides benefits only to you; and self and family, providing benefits to you and all eligible family members, and self plus one, which covers you and only one eligible family member.

Eligible family members include spouses and children up to age 26 (with no age limit if they were disabled before that age). Foster children can be covered under more limited circumstances: the child must live with you as the sponsor in a parent-child relationship, you must be the primary source of support for the child and you must expect to raise the child to adulthood. You must sign a certification that the foster child meets those requirements.

Note: An employing office may require an enrollee to verify eligibility of family members during initial enrollment and when family members are being added to an existing enrollment due to a qualifying life event such as marriage (in the latter case, for retirees OPM may issue such a requirement). FEHB carriers similarly can impose such requirements in situations in which premiums do not change such as adding a family member to an existing family enrollment. Enrollees may be required to produce documents such as a marriage license and proof of common residency for a marriage; a government-issued birth certificate for a child; an adoption certificate or decree for an adopted child; and a medical certificate of disability for a child age 26 or older who is incapable of self-support because of a condition arising before that age. If the documentation is not considered sufficient, enrollees are to be given a chance to produce sufficient documents, and a reconsideration procedure is available in the case of a decision of ineligibility.

Generally, premiums for self-only are the least expensive and for family coverage are the most expensive, with self plus one in between. However, in some cases the enrollee share of premiums for self plus one is higher than that for family coverage. The

reason is that a high percentage of self plus one enrollees are married older employees or retirees with no children eligible for coverage—and in the term used in the insurance industry, older people on average "consume" more health care. Be sure to pay close attention to premiums if choosing between self plus one and family coverage within a plan.

You can choose self plus one even if you have more than one family member who would be eligible, but remember that doing so means that the other family member or members would need to get their health coverage elsewhere. You can change the designation of which family member is covered during an open season, or due to certain life events. The change must be consistent with that event, such as adding a spouse as the second person when a covered child ages out of eligibility.

Under certain circumstances voluntary removal from coverage of an eligible family member is allowed, most commonly for the family member to enroll in health insurance sponsored by his or her own employer. With the consent of both spouses, an enrollee may drop a covered spouse. Similarly, an enrollee may drop an eligible child who is past the age of majority in the jurisdiction of the child's residence by providing proof that the child is no longer a dependent; the child also can request to be dropped on providing such proof. Minor children may be dropped only under a court order.

A family member with other health insurance coverage who is also covered under an FEHB self plus one or self and family enrollment can still carry both coverages and doesn't need to be removed from the FEHB enrollment. That's because FEHB program coverage can be coordinated with non-FEHB coverage.

On an enrollee's death, eligible family members can continue coverage so long they are eligible for survivors' benefits due to death in service or upon death of a retiree.

In addition, there is variation in plan designs. 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.

- FFS plans reimburse you or your physician or hospital for covered services rather than provide or arrange for services as prepaid plans do. FFS plans allow you to choose your own physicians, hospitals and other health care providers without a referral. Some 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.
- A plan offering a point of service product 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. Membership requirements and/or limitations also apply to any POS product the FFS plan may be offering.

- In prepaid plans, your covered health services are pre-funded by your premium and the government's contribution toward the cost of your health insurance. Generally you must use specified plan physicians, hospitals and other providers at designated locations, although care elsewhere may be available after a referral.

An "indemnity benefit plan" is a variant of a fee-for-service plan in which an enrollee may choose any health care provider but may have to pay a portion of the charge and, if it exceeds "usual and customary" rates, the difference.

There are two other major variants. In "consumer-driven" options, enrollees get a sum of money to pay toward health costs, then pay a deductible, and then have standard fee-for-service or HMO coverage. In "high-deductible health plans," enrollees have a tax-favored account—typically, a health savings account for those not eligible to draw Medicare benefits, and a health reimbursement arrangement for those who are—that can be used to pay the deductible and certain other qualifying health expenses.

Although there is no precise standard benefit package in the FEHB, all plans have certain aspects in common. By law, all of them cover basic hospital, surgical, physician, and emergency care. Within those requirements, OPM sets certain minimums under standards prevailing in the health insurance industry.

Further, OPM sets standards for providing benefits including prescription drugs (which may have separate deductibles and coinsurance); mental health care with parity of coverage for mental health and general medical care coverage; child immunizations; coverage of certain treatments; and limits on an enrollee's total out-of-pocket costs for a year, called the catastrophic limit (generally, once an enrollee's covered out-of-pocket expenditures reach the catastrophic limit, the plan pays all covered medical expenses). Certain program-wide requirements are added nearly every year, as described below.

Changes in FEHB

Although the FEHB is seen as a generally stable program, it does change over time; eligible persons must keep such changes in mind when deciding how to put the program to their best use.

Changes come in two main forms. First, in the spring of each year OPM sets the terms of the program for the following calendar year, the beginning of a process of negotiations between that agency and health insurance carriers over the specifics of coverage and premiums. Those changes often are in response to trends and developments in health care. In addition, changes to health insurance law in general can affect the program.

Details of changes in coverage and premiums, which become effective with a new plan (calendar) year, typically are announced about a month in advance of the annual open season that begins in early November.

Effective in 2022 were new protections against "surprise billing": out-of-pocket costs that can arise for example in emergency and other urgent care settings when enrollees don't have time to check whether facilities are in-network, or when they unknowingly receive care at an in-network facility from providers who are out of network. Also effective in 2022 were new price and quality transparency requirements and expanded coverage for medically recommended foods and for fertility treatments, among other benefits.

For the 2023 plan year, carriers were told to continue the increased levels of telehealth and other services related to the pandemic, including required coverage over-the-counter tests, booster doses, therapeutics, and pharmacy access to therapeutics. OPM emphasized a focus on comprehensive mental health and substance use disorder benefits including ensuring parity with medical and surgical benefits; expanding coverage for infertility diagnosis and treatment including assistive reproductive technology such as in vitro fertilization; and expanded coverage of anti-obesity medication and medical foods for metabolic disorders. OPM meanwhile encouraged, but did not require, carriers to expand coverage for prenatal and postpartum care, fertility treatment and gender affirming care.

For 2024, OPM required carriers to expand coverage for anti-obesity coverage including wellness activities, nutrition counseling and medications; mental health and substance abuse disorder services; prenatal and postpartum care; assisted reproductive technology; and gender affirming care. It also encouraged them to enhance coordination of benefits with the Medicare Part D program—prescription drug coverage that most retirees don't enroll in because FEHB provides similar coverage—in light of changes to that program including a cap on enrollees' out of pocket spending under Part D starting in 2025.

Also notably in 2024, Humana withdrew from the program, resulting in the number of regional plans reducing by about 100. That affected some 25,000 enrollees, requiring them to choose a different plan for 2024 or else be enrolled by default in the lowest-cost nationwide plan, the GEHA "Elevate" option.

In recent years, OPM has emphasized policies including cost-containment steps for costly "specialty" and "compound" prescription drugs; restricting prescriptions for opioids; encouraging enrollees to participate in wellness programs; and encouraging greater use of telehealth services when feasible as an alternative to more expensive personal appointments.

Another initiative has been to create financial incentives for retirees to enroll in Medicare Part B (physicians' services), which comes with an added premium but which takes over as the first payer for those who have both. A number of plans offer some type of Medicare Part B incentive – either through copay, coinsurance or deductible waivers or Part B premium reimbursement.

Note: A "Postal Service Health Benefits Program" created by the wide-ranging Postal Service reform law enacted in 2022

will not take effect until 2025. That program will replace FEHB coverage for postal employees, annuitants and eligible family members but they may continue to participate in the FEHB program through the 2024 plan year. The PSHB is to generally make the same plans available and on the same coverage terms as in the FEHB but with their premiums determined separately. One major difference will be that future postal retirees would have to enroll in Medicare Part B when they become eligible, typically at age 65. Those already retired would retain the option of not enrolling, as would current employees at their retirement who reach age 64 or older before 2025.

Making Health Coverage Decisions

FEHB offers eligible persons regular opportunities to change coverage, as part of the annual benefits open season that runs from early November through early December (exact dates vary by year—in 2023 for 2024, November 13-December 11). Changes outside of open season also are allowed if an enrollee experiences certain "qualifying life events" as described below.

Newly hired employees may enroll within 60 days of hiring; otherwise they must wait until the next open season unless they experience a qualifying life event.

Note: Most years, a few plans drop out of the FEHB, restrict their coverage area or eliminate an option. In almost all cases, this is announced in the fall ahead of the open season. If an enrollee makes no new election, agencies (or OPM, in the case of retirees) are to automatically enroll them in the lowest cost nationwide plan available if the plan has dropped out or restricted its coverage area to exclude them, or in the lowest cost remaining plan option provided by the same carrier that is not a high deductible health plan, if only their option is being dropped.

During Open Season—The benefits open season is an annual opportunity to review your health needs. Open season applies to the FEHB and also to the Federal Employees Dental and Vision Insurance Program (FEDVIP) for both active employees and retirees—as well as to the flexible spending account program (FSAFEDS), which is only for active employees. There aren't any waiting periods or pre-existing condition limitations if you are either a new enrollee or an existing enrollee making a change.

Note: Enrollment, or lack of it, in one of these programs does not affect eligibility to be enrolled in any of the others. Also, it is not necessary to enroll for the same type of coverage—an enrollee could have self only coverage under FEDVIP while having self and family coverage under FEHB, for example.

Even enrollees satisfied with their FEHB and FEDVIP coverage can benefit from examining their options in the open season. Plans revise their covered services year to year. Similarly, while premiums on average increase each year, there is wide variation among plans, potentially making a current plan less affordable, or making more affordable a plan an individual previously ruled out as too expensive. Also, in addition to dropouts or coverage restrictions,

sometimes plans newly join or broaden existing geographic coverage areas.

FEDVIP plans are more stable but their terms and premiums change somewhat each year too. It's also important to check how a FEDVIP plan's benefits would dovetail with any vision and dental benefits offered through an FEHB plan, especially if you are changing one or the other. FEDVIP always pays benefits secondary to your FEHB coverage, to the extent that it includes dental and vision benefits.

Individual FEHB health plans provide benefit brochures to their existing enrollees online and/or in paper form, which includes and explanation of benefit changes for the next year and new premium rates. OPM posts those brochures at www.opm.gov/healthcare-insurance/healthcare/plan-information/guides along with plan comparison features, contact information, and other information.

During an open season:

- If you aren't already enrolled in an FEHB plan and/or a FEDVIP plan, you can enroll.
- If you are already enrolled in FEHB and/or FEDVIP and are happy with your current coverage, you don't have to do anything. Your enrollment(s) will continue automatically. However, at least be sure your plan is still participating in the program and review its benefits and premiums for the upcoming year.
- If you are already enrolled, but want to make a change, you can change to another plan, change levels of coverage within a plan (for those offering more than one level), or alter your coverage among self only, self plus one or self and family.

If you wish to participate in FSAFEDS in the following year you must enroll even if you currently are enrolled—enrollments don't continue one year to the next as they do under FEHB and FEDVIP. You can choose a dependent care account and/or a health care account (note: for FEHB enrollees in certain plans offering similar tax breaks, only a "limited expense" FSA is available). Further, to take advantage of the allowable carryovers beyond the end of a plan year allowed in each, you must be enrolled in that type of account for the following year. As an enrollee in FSAFEDS, you'll be able enjoy the lower taxable income benefits and pay for your FEHB and FEDVIP co-pays and deductibles.

Outside Open Season—Outside of open season, you can enroll in the FEHB, change your plan enrollment, change among the coverage options or cancel coverage in certain circumstances. The most common of these are in connection with what are called qualifying life events: a change in family status; a change in employment status; or if you or a family member lose FEHB or other health coverage. (In addition, there are some specialized situations in which enrollees may make changes, such as moving to an area in which their current plan is not available.)

A change in family status is: marriage, birth or adoption of a child, acquisition of a foster child, legal separation, divorce, or death of a spouse or dependent.

A change in employment status is: you are reemployed after a break in service of more than three days; you return to pay status after your coverage terminated during leave without pay status or because you were in leave without pay status for more than 365 days; your pay increases enough for premiums to be withheld; you are restored to a civilian position after serving in the uniformed services; you change from a temporary appointment to an appointment that entitles you to a government contribution; or you change to or from part-time career employment.

A qualifying loss of coverage is: under another FEHB enrollment because the covering enrollment was terminated, canceled, or changed to self only; when enrolled in a prepaid health maintenance organization and you or a covered family member move or change worksite outside of the HMO's enrollment area; under another federally-sponsored health benefits program; under Medicaid or similar State-sponsored program for the needy; under CHAMPVA, TRICARE, or TRICARE-for-Life; when you had previously suspended your FEHB coverage to participate in one of these programs; or when your membership in the employee organization sponsoring the FEHB plan terminates under a non-federal health plan.

When one of these events occurs, you may, depending on the circumstances:

- enroll;
- change your enrollment among the coverage levels;
- change your enrollment to another plan or another option within the plan, for plans that have more than one; or
- cancel your enrollment.

A change to self only may be made only if the event causes the enrollee to be the last eligible family member under the FEHB enrollment. A cancellation may be made only if the enrollee can show that as a result of the event, he or she and all eligible family members now have other health insurance coverage.

If you have self plus one coverage and have more than one family member who would be eligible, you can change the designation of which is covered during an open season, or due to certain specified life events, so long as the choice is consistent with the event.

If you have family coverage and a life event occurs that causes you to have only one eligible family member remaining—for example, a child aging out of eligibility—a switch from family coverage to self plus one is not automatic. You must change your enrollment.

Similar policies apply under FEDVIP.

Details regarding FEHB choices are on the election form, SF-2809, available at www.opm.gov/forms (for FEDVIP at www.benefeds.com – search for “qualifying life events”).

Note: Entering “phased” retirement is not a qualifying life event for either FEHB or

FEDVIP, nor is switching from phased retirement to full retirement (or from phased retirement back to full-time work, if allowed). However, the period of phased retirement does count toward the requirement to have been covered by FEHB for the five years before retirement in order to be eligible to carry that coverage into retirement.

Issues to Consider—Within the general structure of FEHB, there is wide variation among how plans operate and exactly what they cover, under what terms. Failure to consider your health plan choices—whether during an open season or if you have the opportunity due to a qualifying life event—could leave you without the health care services or supplies you need or paying higher premiums than are necessary. Dental and/or vision coverage can fill in the gaps of any coverage you now have, or pay for services you now don't get.

One question is what type of plan would work best for you. Each type of plan has several important general aspects that may be especially positive or negative for you:

A fee for service plan without a preferred provider feature is a traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse you after you have filed an insurance claim for each covered medical expense. When you need medical attention, you visit the doctor or hospital of your choice. This approach may be more expensive for you and require extra paperwork.

A fee for service plan with a preferred provider option (PPO) allows you to see medical providers who reduce their charges to the plan; you pay less money out-of-pocket when you use a PPO provider. When you visit a PPO you usually won't have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. Also, the network may not have all the doctors or hospitals you want. If you don’t use the network, you will generally pay more when you get care; fewer preventive health care services may be covered; and you will have to file claims for services yourself.

In "PPO-only" options, you must use PPO providers to get benefits. You will generally pay copayments, but will have no deductibles, and will have little, if any, paperwork.

Health maintenance organization plans charge a copayment for primary physician and specialist visits and generally have no deductible or coinsurance for in-hospital care. More preventive health care services may be covered than under a fee for service plan, and you will have little, if any, paperwork. You will have limitations on the doctors and other providers you can use, however, and care received from a provider not in the plan's network is not covered unless it's emergency care or the plan has a reciprocity arrangement.

In HMO plans with a point of service (network) feature, if you use the network you will get full network benefits and coverage with little paperwork. Such plans let you use providers who are not part of

their network but you would pay more and usually pay higher deductibles and coinsurances than you pay with a network provider. Also, some services may not be covered and you will need to file a claim for reimbursement.

In a consumer-driven health plan, 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 assume significantly higher cost sharing expenses after you have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

In a high deductible health plan, the enrollee pays a deductible and other out-of-pocket costs up to certain limits. They can have first dollar coverage (no deductible) for preventive care and higher out-of-pocket copayments and coinsurance for services received from non-network providers.

In addition, consider these personal questions when comparing types of plans, or different plans within a category:

While your exact need for health care is unpredictable, you can act on what you reasonably can foresee. Then examine whether your existing plan is best for such considerations, or whether a change would better fit your needs.

Do you expect to have any medical costs in the coming year that you didn't have in the current year? For example, are you expecting upcoming surgery? Or can you reasonably expect different types of care or procedures than you currently experience, such as chiropractic care, laser eye surgery or extensive dental work? If you have family members on your plan, don't forget to think through those same issues regarding them.

What would be your share of the cost of prescription drugs you reasonably expect to be taking? Could your medication needs foreseeably change, and what would be your cost for them?

What deductibles, copays, and coinsurances would you pay under your various options? Can you (if an active employee) make them effectively more affordable by paying for more of them through a health care flexible spending account?

One valuable feature of FEHB is that you can change your coverage each year. That is, you could switch plans to capture the benefits of an attractive feature that you may need in only one year—related to the upcoming birth of a child, for example—and then switch back again the following year.

Finally, there are circumstances in which a married couple without eligible children may wish to choose to have two self-only plans. It's not uncommon for both in a couple to work for the federal government and have an entitlement to enroll in the FEHB program on their own. One attraction of having separate coverage is that it allows each of them to tailor their plan selection to their specific needs.

However, keep in mind that each enrollee will have to meet the co-insurance and deductible requirement plus the catastrophic limit on his or her own. This may or may not make a difference in the decision. Also,

remember that one of the enrollees would have to elect self plus one to obtain coverage for a new child. In that case, it likely would make more sense to switch to one family enrollment.