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**IMPORTANT: This booklet contains significant new information for you if you are or will be covered by the health insurance program. Please read it carefully.**



# 1992 Enrollment Information Guide and Plan Comparison Chart

(1991 Open Season)

*For Federal Civilian Employees*

This booklet contains information about enrollment in the Federal Employees Health Benefits Program during the Open Season that begins on November 12 and continues through December 9, 1991. It will help you select the health care protection best suited to your needs. However, before you make a final choice, you should review carefully the official brochures for those plans that interest you. While this booklet provides a general overview of the health benefits offered by each plan, the official brochures provide the contractual description of coverage that determines how claims for payment or for service are paid or provided.

#### **ATTENTION ALL ENROLLEES**

All fee-for-service plans in the FEHB Program require precertification of each hospital admission and reduce benefits by \$500 if you fail to obtain it. See page 2 for details.

#### **SPECIAL NOTICE**

Important information on how plans pay for or provide services is on pages 4, 5, 6 and 8.



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## You Can Help

You know that health care costs are increasing each year because those increases are reflected in your premiums. The Federal Employees Health Benefits (FEHB) Program, like the majority of employer provided health insurance programs throughout the country, asks members to make special efforts to be responsible consumers of health care services.

All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages, preadmission certification and large case management. Preadmission certification ensures that a proposed hospitalization is medically necessary and that you are admitted only for the number of hospital days required to treat your condition. Large case management gives your plan the flexibility to determine, in consultation with you and your physician, the most cost effective way to provide services.

The preadmission certification provision makes you responsible for ensuring that the requirement is met. **You must check, or confirm that your doctor has checked, with your plan before being admitted to the hospital.** If that doesn't happen, your plan will reduce benefits by \$500. Be a responsible consumer. Be aware of your plan's cost containment provisions. Avoid penalties and help keep premiums under control by following the procedures specified in your plan's brochure. This requirement does not apply if Medicare is the primary payer for the hospital confinement or if you are confined in a hospital in certain overseas locations (see the Plan's FEHB brochure).

If you believe that a provider of medical services has filed a fraudulent claim, please call OPM at (703) 908-8662. An example would be when services have been billed but not rendered.

## Introduction

The Federal Employees Health Benefits Program offers you a practical way to help meet the costs of health care. The Program provides:

- a choice of plans and options;
- a Government contribution up to 75% toward the cost of your premium;
- payments for your share of the premium through payroll deductions;
- immediate coverage from the date of enrollment without a medical examination or restrictions because of your age or physical condition;
- under certain circumstances, the opportunity for temporary continuation of group coverage or conversion to nongroup coverage if your enrollment ends or a covered family member loses eligibility for coverage; and
- if certain conditions are met, continued protection for you and eligible family members after your retirement and for eligible family members after your death.

### How To Be a Good Health Benefits Consumer

There are some things you can do to help assure that you and your family receive the right kind and quality of care at the right price.

**The first thing you can do is to choose the health benefits plan that best meets your needs.** The Federal Employees Health Benefits Program includes a variety of health benefits plans that take very different approaches to health care coverage. You may choose one of the fee-for-service health benefits plans. In these plans, you are free to go to virtually any doctor or hospital of your choice and the provider will either bill the plan directly or give you the bill to forward to the plan for payment of covered services. Or you may choose one of the prepaid plans that operate through affiliated doctors and hospitals in designated locations. In these plans, most of your covered services are prepaid by your premium and are available only from the affiliated providers.

In deciding which type of plan to choose, you should consider the following:

- the coverage offered by each type of plan;
- the cost of each plan, *i.e.*, your premium and out-of-pocket costs for services covered only in part or not at all; and
- the accessibility of health care services.

Before you make a final decision, be sure to review the official brochures for those plans that interest you.

**The next thing you can do is to see that you and your covered family members use health care services wisely.** Always include the subject of costs in any discussion with the

providers of service. Remember that in most instances you must pay any amounts charged by a provider that your plan does not pay. For instance, you are responsible for deductibles, coinsurance and copayments, as well as the amount a provider may charge above the reasonable and customary charge or scheduled allowance for a particular service (see "Definitions" in this booklet for an explanation of these terms). (Sometimes provider charges are limited by law; if you are enrolled in a fee-for-service plan, see your brochure for details.) Also, keep in mind that approximately one-third of the claim disputes in the FEHB Program concern the amount paid by the plans. You can avoid this type of claim dispute by (1) checking with the provider of service to be sure the plan was billed correctly, *e.g.*, that the proper procedure code(s) was used, complications were correctly indicated on the billing or operative report, etc.; and (2) being mindful that the plan determines the reasonable and customary charges based on available information.

**Another very important thing you can do to assure quality care at the right price for you and your family is to observe the cost containment provisions your plan has established.** These provisions are explained in the plan brochure and two of them -- preadmission certification and large case management -- are highlighted in this booklet (see "You Can Help" on page 2). Be sure to note that if you fail to obtain preadmission certification your benefits will be reduced by \$500.

With the introduction of utilization control features in all of the fee-for-service plans and the continued implementation of controls in the prepaid plans, we expect positive results in our cooperative effort with you to control premium increases.

### About Open Season November 12 - December 9, 1991

Each year, the Office of Personnel Management reviews the benefits and premiums of the plans in the Federal Employees Health Benefits Program and negotiates adjustments in benefits and premiums to be effective the following January. Also, some new plans are accepted for participation in the Program and some plans cease to participate.

Open Season is your annual opportunity to join the Federal Employees Health Benefits Program if you are not already enrolled. If you are enrolled, it is your opportunity to change your health plan coverage to become effective the following January.

If you are already enrolled and do not wish to make a change, your current enrollment will continue without any additional action on your part. **However, you should check the Comparison Chart beginning on page 10 to be sure that your current plan (and option) will be participating in the Federal Employees Health Benefits Program in 1992.**

If you want to enroll in the Federal Employees Health Benefits Program or change your current health plan enrollment during Open Season, you must file a Health Benefits Registration Form (Standard Form [SF] 2809) in time for it to be received by your employing office by December 9, 1991. Your employing

office can give you the specific day in January 1992 on which your enrollment or enrollment change will take effect. Your certified copy of the SF 2809 may be used as proof of coverage until your new plan sends you an identification card.

## Your Health Insurance Premium

You and the Government share the cost of your premium. For 1992, the maximum biweekly Government contribution is \$60.50 for a self only enrollment and \$130.58 for a family enrollment. The maximum monthly Government contribution is \$131.08 for self only and \$282.92 for family. The exact amount of the Government contribution for your plan is shown on the plan's brochure cover.

You pay the remainder of premium costs. The premium costs on the Comparison Chart in this booklet show your share only -- the amount you must pay, that will be withheld from your salary. (If you are not a full-time employee, your share of the premium may be different. Your employing office can tell you the specific amount.)

## Who Is Covered Under Your Enrollment

- **Self only enrollment** -- A self only enrollment provides benefits just for you -- the enrolled employee.
- **Self and family enrollment** -- A self and family enrollment provides benefits for you, your spouse, and your unmarried dependent children under 22 years old. In some cases, a disabled child who is 22 years old or older is eligible for coverage if you have adequate medical certification of a mental or physical handicap that existed before his or her 22nd birthday. In such cases, you should ask your employing office about the documentation required.

Children covered by your enrollment include your legally adopted children and recognized children born out of wedlock; and stepchildren or foster children, if they live with you in a regular parent-child relationship and you meet certain other requirements. Ask your employing office for details about these requirements. Children whose marriage ends before they reach age 22 again become eligible for coverage from the date the marriage ends until they reach age 22.

Other relatives -- for example, your grandchildren (unless the foster parent-child relationship described above exists) or your parents -- are not eligible for coverage even though they live with you and are dependent upon you.

To provide coverage for a new eligible family member, you must have, elect or change to a self and family enrollment.

## Using Your Health Plan Comparison Chart and Picking a Health Plan

The **Plan Comparison Chart** beginning on page 10 provides general information about many of the major features of each plan in the FEHB Program. It can help you to compare

benefits, premiums, and other factors that may influence your decision about which plan to select for the coming year. For example, you can determine each plan's relative cost by comparing your premium and your out-of-pocket expenses as reflected by deductibles, copayments, coinsurance, and catastrophic limits.

**You should not rely on the Chart alone.** Detailed information about plan benefits and the contractual features appear only in the individual plan brochures. All benefits are subject to the definitions, limitations and exclusions set forth there. You should review carefully the official brochure for each plan that interests you before you pick your health plan.

**Picking your health plan.** To assist you in making the best possible choice of health plans we expanded and clarified the description of plans available to you under the FEHB Program. We hope this information will help you this Open Season.

There are two basic types of health benefits plans available to you under the FEHB Program, prepaid plans and fee-for-service (FFS) plans. Many people decide on the type of plan they want before selecting the specific plan and option that best suits their medical needs and their budget.

In **prepaid plans**, your covered health services are prefunded by your premium and the Government's contribution toward the cost of your health insurance. Prepaid plans, also called Comprehensive Medical Plans or Health Maintenance Organizations (CMPs or HMOs), meet your health care needs through specified plan physicians, hospitals and other providers at designated locations. Prepaid plans pay providers for most of your health care services through salaries or other arrangements. Your premiums cover most of the cost of services. Every prepaid plan has some form of cost sharing through copayments for certain services, such as doctors' office visits, hospital admissions and prescription drugs. You can read about these details in each brochure. Because prepaid plans provide services through specified providers you must live within that plan's service/enrollment area to join. The first thing you should do when you are interested in a prepaid plan is to make sure you live within the service/enrollment area. Prepaid plans provide many routine medical services that are not always provided by FFS plans; but the prepaid plans differ as to the exact services provided and the providers you can use. Therefore, you should consult both the plan brochure and plan provider directory before selecting a prepaid plan.

Your decision may also be affected by the way the prepaid plan operates. Group practice plans provide care through a group of doctors who practice at medical centers operated by or under contract to the plans. Individual practice plans provide care through participating doctors who practice in their own offices. Mixed model plans include doctors who practice in their own offices as well as doctors in medical groups. Prepaid plans arrange hospital and other care not available in plan centers and offices when necessary.

This year some prepaid plans are offering "opt-out" benefits which allow you to obtain certain non-emergency benefits outside the prepaid plan provider system on a fee-for-service basis.

**Fee-for-service (FFS) plans** reimburse you or your provider 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. However, the amount of reimbursement paid by each FFS plan varies, as do their deductibles, methods for applying deductibles to families and the amount of coinsurance you are required to pay for any given covered service. The type and extent of covered services also vary.

Many FFS plans use "preferred provider organization" (PPO) arrangements to improve your fee-for-service benefits. These arrangements with health care providers allow FFS plans to provide enhanced benefits or to limit the out-of-pocket expenses usually associated with fee-for-service reimbursement arrangements. Each brochure specifies how the plan's arrangements with providers work. If you choose a FFS plan which includes a PPO, it will be to your advantage to learn about and use the plan's provider arrangements to limit your expenses and to maximize your benefits.

There are several types of FFS plans:

- The Government-wide Service Benefit Plan is administered by the Blue Cross and Blue Shield Association through 69 local plans and is open to all Federal employees. The Service Benefit Plan provides reimbursement for covered services in two ways. First, benefits may be paid to physicians who participate with the local plans and generally agree to accept the local plan's determination of reasonable and customary charges, less any coinsurance or deductibles you are responsible for, as payment in full. Similarly, local plans have member hospital agreements which require the hospitals to accept as payment in full the Service Benefit Plan's payment, less the deductible that you are responsible for. In most areas of the country, local plans have preferred providers. In most cases, by using participating or preferred physicians and member or preferred hospitals you can limit your costs for covered expenses to your deductibles and coinsurance. Second, if you do not use a participating physician the local plan will limit its reimbursement to a set percentage of the locally determined reasonable and customary calculation. Generally, the plan's reimbursement to the nonparticipating physician will not limit your out-of-pocket expenses to the brochure deductible and coinsurance and you will be responsible for any portion of the bill above the plan's allowance. If you use a nonmember hospital your reimbursement will be significantly less than the hospital charge. Therefore, if you enroll in the Service Benefit Plan it will be to your advantage to receive your care from preferred providers or participating physicians and from member hospitals.
- The remaining FFS plans are sponsored by unions and other employee organizations. Some plans open their membership to all Federal employees and may charge a membership fee or annual dues while some plans limit their membership to certain groups of Federal employees.

Most of these FFS plans base their payments for covered services on reasonable and customary charges as determined by the plans. There are several methods these plans use to determine their reasonable and customary charges; the details are discussed in the next section. In cases where plans use the same basis to determine reasonable

and customary reimbursements you can compare directly what your out-of-pocket expenses will be. When you take advantage of a plan's preferred provider arrangement you can effectively limit your out-of-pocket expenses for covered services to deductibles and coinsurance. If you do not take advantage of a preferred provider arrangement (or if one is not offered in your area), your plan's reimbursement probably will not cover all of your provider's bill. In those cases you will be responsible for any amount applied toward a deductible, your coinsurance, and any charges due above your plan's reasonable and customary limit.

One FFS plan, the Mail Handlers Benefit Plan, reimburses its members for covered services in two ways. Payments for outpatient diagnostic services are made under a reasonable and customary charge system. All other provider services are reimbursed on a fee schedule basis where the plan pays a fixed amount for each service. These payments probably will not cover your medical bills and you are responsible for the balance of your provider's charges.

As noted above, if you choose a FFS plan it will be to your advantage to use affiliated providers whenever possible. This is especially true if your plan makes a preferred provider organization available to you. The Service Benefit Plan and most of the employee organization plans have made arrangements with certain providers to reduce your out-of-pocket expenses and in some cases to provide enhanced benefits. By using preferred providers or participating providers you will be sure that the plan's determination of reasonable and customary charges will be accepted as the basis for your out-of-pocket expenses. Therefore, you should consider the availability of affiliated providers when choosing a FFS plan.

## How Fee-for-Service Plans Determine Their Claims Payments

As noted above, the basis for many plans' claim payments, subject to deductibles and coinsurance, begins with determining the *reasonable and customary* charge appropriate for the procedure covered by your claim. Claims data is gathered for a given period by the plan and/or an independent organization and updated periodically. By analyzing the claims data, your plan knows how much other providers in your area charge for the procedure. Some charges may be higher than your provider's and some may be lower. The plan then sets a benchmark or "percentile" at the highest dollar amount it considers reasonable and customary for the procedure. A 90th percentile factor means that 90 percent of the claims that your plan analyzed were at or below the benchmark charge. (For example, if there were 20 charges for the procedure, when the 20 are listed in numeric order the dollar amount of the 18th charge becomes the benchmark --  $20 \times 90$  percent equals 18.)

Once the plan establishes its benchmark or percentile, it applies its coinsurance percentage to that amount or an amount adjusted for unusual circumstances, such as the complexity of a surgical procedure. For example, if the plan pays 80 percent of reasonable and customary charges, it will pay the lower of 80 percent of your claim or 80 percent of the benchmark amount. If your physician or other health care provider charges more than the reasonable and customary

amount, you will be responsible for paying any balance due in addition to the coinsurance.

Some other systems, such as *fee schedules*, are sometimes used to determine what your claim payment will be. The fee schedule approach sets a specific dollar allowance for any given procedure and pays your claim up to that amount.

All fee-for-service plans pay at least some types of claims according to a reasonable and customary allowance. Many of them use health care charge data collected by commercial industry sources. Among these are HIAA (Health Insurance Association of America), MDR (Medical Data Research) and the Prudential Insurance Company. HIAA and MDR charge data are updated twice a year and Prudential charge data are updated annually. Other plans use claims information compiled locally. In either case, the charge data allows a plan to establish a reasonable and customary charge for a given procedure or service by geographic area. Regardless of the source of the charge data, the plan is solely responsible for its interpretation and use. It is also responsible for determining specific allowances where sufficient data is not available or in unusual circumstances.

Alliance, BACE, NAPUS, NTEU and Secret Service Plans are underwritten by Blue Cross and Blue Shield of the National Capital Area which has established its reasonable and customary allowances in the Washington, DC, area on its data base, updated annually, of all physician claims paid in the prior year. Outside the Washington Metropolitan area the allowances are adjusted upward or downward based on local conditions. The allowances also vary by procedure but generally exceed the 90th percentile.

APWU, Foreign Service, GEHA and Rural Carriers have established their reasonable and customary allowances at the 90th percentile and use charge data collected by HIAA.

The Blue Cross and Blue Shield Service Benefit Plan bases its reasonable and customary allowances on claims information compiled locally and usually updated annually. The local plan allowances are generally based on the 80th percentile.

Mail Handlers has established its allowances for outpatient diagnostic services at the 90th percentile and uses charge data collected by HIAA. The plan uses nationwide scheduled allowances for all other claims.

NALC has established its allowances for surgical care at the 90th percentile and uses charge data collected by HIAA. The plan uses MDR charge data at the 90th percentile for other claims.

Postmasters uses MDR charge data at the 90th percentile for surgical care and other charges at actual costs unless the plan determines that the charge is unreasonable and limits the charge to the 90th percentile.

SAMBA uses the 80th percentile of the Prudential Insurance Company charge data base for surgical procedures and anesthesia and actual charges for all other care.

Panama Canal in the U.S. bases allowances on charge data collected by HIAA at the 85th percentile for surgical care; a fee schedule for other inpatient doctor services; and actual charges for other charges.

Check the comparison chart on page 10 and the brochures for more information about how plans pay claims.

## General Information About Enrollment and Coverage

### Dual Enrollment

Normally, you may not enroll or be enrolled as an employee if you are covered as a family member under someone else's enrollment in the Federal Employees Health Benefits Program. However, such dual enrollments may be permitted under certain circumstances in order to:

- Protect the interests of employees' children who otherwise would lose coverage as family members, or
- Enable an employee who is under age 22 and covered under a parent's enrollment and becomes the parent of a child to enroll for self and family coverage.

No person (employee or family member) is entitled to receive benefits under more than one enrollment in the Program.

### Continuation of Enrollment After Retirement

To continue your enrollment after you retire, you must retire:

- Under a retirement system specifically for Federal civilian employees, and
- On an immediate annuity.

In addition, you must be currently enrolled in a plan under the Federal Employees Health Benefits Program and must have been enrolled (or covered as a family member) in a plan under the Program for:

- The five years of service immediately before retirement, or
- If fewer than five years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 31 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

### Temporary Continuation of Coverage

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible for temporary continuation of your health benefits coverage under the Federal Employees Health Benefits Program after separation. Ask your employing office for RI 70-5, Enrollment Information Guide and Plan Comparison Chart for individuals eligible for Temporary Continuation of Coverage (TCC). TCC is available to you whether your separation is voluntary or involuntary (unless it is for gross misconduct), and you would not otherwise be eligible for continued coverage under the Program. (An example is separation for retirement when you do not meet the five-year enrollment requirement for continuation of enrollment into retirement described above).

Your TCC begins after your coverage as an employee (including any extension of coverage for conversion period) ends and continues for up to 18 months after your separation from service. You must pay the total premium (both the

Government and employee shares) plus a charge for administrative expenses of 2 percent of the total premium. When your TCC ends (except by cancellation or nonpayment of premiums), you are entitled to a 31-day extension of coverage for conversion to nongroup coverage.

In certain cases, a child who loses eligibility for coverage (such as when the child reaches age 22 or marries) and a former spouse who loses eligibility for coverage (and who is not eligible to enroll or continue enrollment in the FEHB Program under the Spouse Equity law or similar statutes) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC in these cases generally continues for up to 36 months after the qualifying event occurs, e.g., the date a child reaches age 22 or the date of the divorce. When their TCC ends (except by cancellation or nonpayment of premiums), child and former spouse enrollees are entitled to a 31-day extension of coverage for conversion to nongroup coverage.

#### Notification and Election Requirements under TCC:

- **Separating Employees** -- Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office will notify the employee of his or her opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

- **Children and Former Spouses** -- When a child or former spouse becomes eligible for TCC, the employing office or retirement system must be notified. For a child, the employing office must be notified within 60 days after the qualifying event occurs. For a former spouse, the employee or annuitant or former spouse must notify the employing office within 60 days after the former spouse's change in status, e.g., former spouse remarries before reaching age 55. The employing office or retirement system then notifies the child or the former spouse of his or her rights under TCC. If a child wants continued coverage, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must make the election within 60 days after any of the following events, whichever is later:

- The date of the qualifying event;
- The date he or she loses coverage as an enrolled former spouse because of remarriage or loss of qualifying court order; or
- The date he or she receives the notice.

**Important:** If the employing office or retirement system is not notified of a child or former spouse's eligibility for TCC within the 60-day time limit, the opportunity to elect TCC ends. The time limit is 60 days after the qualifying event, in the case of a child; and 60 days after the change in status, in the case of a former spouse.

#### Cancellation of Enrollment

You may voluntarily cancel your enrollment at any time. However, once your cancellation takes effect, you may not enroll again until an event occurs that permits enrollment, e.g., change in marital status or the next Open Season. In addition,

you will not be eligible to continue your enrollment after you retire unless you reenroll before you retire and meet all the requirements for continuation of enrollment after retirement, including the five-year enrollment requirement (see page 6).

Your employing office can give you details about the above enrollment and coverage information.

## Definitions

Insurance is a fairly complex subject and the technical terms and details about benefits may be difficult to understand. The following terms, which have special meaning in the health care field, have been defined, as much as possible, in everyday English to help you understand the benefits coverage and limitations of the various plans in the Federal Employees Health Benefits Program:

**Brochure** -- the booklet showing the complete details of a plan's benefits, limitations (or limited benefits), exclusions, and definitions. The brochure is a plan's contractual statement of benefits.

**Case Management (or Large Case Management)** -- the monitoring of a patient with a major illness to assure that the type of services provided is appropriate and cost effective.

**Catastrophic Limit** -- a benefit feature to limit the amount you have to pay in a calendar year if you or your family incur large and unusual medical bills. The catastrophic limit is the maximum amount of covered expenses you have to pay out of your own pocket during the year for yourself and your family. Generally, there are separate catastrophic limits for medical-surgical expenses and mental conditions expenses. The limits apply to your coinsurance payments. Depending on the plan, these limits may also include any copayments and the calendar year, inpatient and mental health deductibles you pay. Please refer to the brochures for the plans that interest you.

**Coinsurance** -- the stated percentage of covered charges you must pay after you have met any applicable deductible. For example, if a plan pays 80 percent of covered charges (after applying any deductible), you would be responsible for the deductible and the 20 percent balance.

**Copayment** -- a fixed dollar amount you must pay for a service or benefit provided by a plan.

**Covered Charges** -- those amounts of your expenses for medical care that are covered by a plan. An expense that is not a covered charge cannot be used to satisfy the plan's deductible or catastrophic limit. Often a plan includes as covered charges only an amount specified in a scheduled allowance or based on a reasonable and customary profile. See the plan brochures to find out how covered charges are determined. Covered charges do not include expenses for nonmedical items related to an illness or injury or for specific items excluded by the plan.

**Deductible** -- the amount of covered charges you must pay before the plan pays benefits, e.g., calendar year deductible and inpatient hospital deductible. Generally, no more than two or three family members must meet the calendar year deductible. However, some plans have a family calendar year deductible which can be met by any or all of those covered.

**Dental Care** -- any type of dental care beyond accidental dental injury benefits. The level of benefits may range from

diagnostic and preventive care for children to include for all family members restorative, endodontic and periodontal services.

**Enrollment Area** -- the geographic area within which a prepaid plan (CMP/HMO) enrolls members. To be eligible to enroll in a prepaid plan, you must live within this area. The plan brochure identifies the enrollment area.

**Exclusions** -- charges, services, or supplies that are not covered. A plan does not provide or pay benefits for excluded items, and charges for them do not count towards deductibles or catastrophic limits.

**Extended Care Facility** -- an institution that furnishes, in lieu of hospitalization, room and board and medically prescribed skilled nursing care 24 hours a day by an organized medical staff; and is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics or domiciliary care.

**Home Health Care** -- medically supervised care and treatment in the home of a patient whose physician certifies that without such care confinement in a hospital or extended care facility would be required. Typically, care and treatment are provided in accordance with an approved home health care plan and must begin within a specified period of time after discharge from a hospital.

**Home Nursing Care** -- skilled care in the home provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.). The care generally must be ordered by a physician; is usually limited to a specified number of hours per day and visits per year; and does not include homemaking services of any kind.

**Hospice Care** -- a coordinated program of home and/or inpatient palliative and supportive care for a terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a licensed or certified hospice care facility or agency.

**Inpatient Services** -- the care provided to you while you are a bedpatient in a covered facility.

**Limitations (or Limited Benefits)** -- statements in the brochure showing services or supplies that are not fully covered; only partially paid for by a plan; or covered only if the service or supply provided meets certain specified criteria, e.g., preadmission testing within 72 hours of surgery.

**Maternity Care** -- prenatal and postnatal care and delivery by a covered hospital, physician, or other covered practitioner, including nurse midwives. Plans generally pay for maternity care the same as for other covered inpatient and outpatient services.

**Mental Conditions/Substance Abuse** -- conditions and diseases listed in the most recent edition of International Classification of Diseases (ICD) as psychoses, neurotic disorders and personality disorders; other non-psychotic mental disorders listed in the ICD, to be determined by the Plan; also disorders listed in the ICD requiring treatment for abuse of or dependence upon substances, such as alcohol, narcotics, or hallucinogens.

**Opt-out** -- benefits offered for non-emergency care provided outside a prepaid plan's (CMP/HMO) regular health care delivery system, generally at a higher out-of-pocket expense to you than for care inside the plan's delivery system. If your plan has the Opt-out feature, it will be described in the plan brochure.

**Outpatient Services** -- the care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor's office.

**Preadmission Certification** -- a procedure whereby (1) you or your doctor is required to contact your plan before your admission to a hospital and (2) your plan determines the appropriateness of the admission and the length of stay.

**Preferred Provider Organization (PPO) Arrangement** -- agreements between a fee-for-service plan and physicians, hospitals, health care institutions, or other providers to provide services to you at a reduced cost.

**Premium** -- the biweekly or monthly fee you must pay for your enrollment in an FEHB plan, as shown on the Comparison Chart beginning on page 10 of this booklet.

**Prescription Drugs** -- outpatient drugs and medicines that, by United States law, cannot be obtained without a doctor's prescription.

**Reasonable and Customary Charge** -- one of two benefit maximums plans use as the amount of your medical or dental care expenses they will cover for a particular service. (The other is the Scheduled Allowance.) A Reasonable and Customary Charge is the amount a plan considers appropriate for the service or procedure in the geographic area. Health insurance industry-accepted methods are used by the plans to establish and periodically update reasonable and customary charges. The actual amount a provider charges for a particular service may be more than the reasonable and customary charge set by the plan for that service. You must pay any amount charged above the reasonable and customary charge unless the provider accepts a lesser amount because of plan-provider agreements or statutory limitations. See page 5 for more information.

**Scheduled Allowance or Fee Schedule** -- one of two benefit maximums plans use as the amount of your medical or dental care expenses they will cover for a particular service. (The other is the Reasonable and Customary Charge.) A Scheduled Allowance is the fixed dollar amount that has been assigned to a covered medical or dental service. You must pay any amount the provider charges above it. (Because a plan's Scheduled Allowance for a particular service applies nationwide and the amount providers charge for that service varies geographically, the Scheduled Allowance is likely to defray more of the provider's charge in some areas than in others.) See page 5 for more information.

**Service Area** -- the geographic area where prepaid plan providers and facilities are available to you. This area is the same as, or within, the plan's enrollment area.

1992

# Plan Comparison Chart

(1991 Open Season)

# FEHB Plan Comparison Chart - For Benefits Beginning in January 1992

## Fee-for-Service Plans

- The calendar year deductible shown is the per person amount. The calendar year deductible may not apply to every covered charge.
- The inpatient hospital deductible shown is a per person amount. It typically is a per-admission or per confinement deductible. However, for certain plans, it is a deductible that applies just to the first admission in a calendar year or a separate calendar year deductible that applies only to inpatient hospital expenses.
- These plans require you to share costs for covered charges. In addition to the calendar year and inpatient hospital deductibles, other cost-sharing amounts you pay may include coinsurance and/or copayments.
- The amounts of covered charges that plans pay for medical-surgical primary care shown on the next page are maximum amounts. Payments may be affected, however, by certain limitations and conditions, which are described in the plan brochures. The provider's total charge may not be paid because it exceeds the maximums used by the plan. See "Using Your Health Plan Comparison Chart and Picking a Health Plan" on page 4.

Fee-for-Service Plan Name and Option	Enrollment Code			Plan Telephone Number	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Medical-Surgical Primary Care			
	Plan Code	Self Only	Self & Family		Self Only	Self & Family	Self Only	Self & Family	You Pay			
									Calendar Year Deductible	Inpatient Hospital Deductible	Catastrophic Limit (max. covered out of pocket) person/family	
<b>Government-wide Plan</b>												
Blue Cross and Blue Shield Service Benefit Plan	High	10	1	2	See Local Phone Book	176.48	366.37	81.45	169.09	\$200	\$50	\$2,000/\$2,000
	Std	10	4	5		41.06	86.28	18.95	39.82	\$250	\$100	\$3,000/\$3,000
<b>Open Plans</b>												
Alliance	YA	1	2	(202) 939-6325	46.52	145.54	21.47	67.17	\$300	\$150	\$2,500/\$2,500	
APWU	47	1	2	(800) 222-2798	43.73	92.56	20.18	42.72	\$175	None	\$2,000/\$2,000	
GEHA	31	1	2	1-800-821-6136	51.22	100.84	23.64	46.54	\$250	None	\$2,500/\$3,000	
Mail Handlers	High	45	1	2	1-800-468-2958	34.94	77.87	16.12	35.94	NA	\$125	\$2,500/\$3,500
	Std	45	4	5		1-800-468-2958	26.67	57.89	12.31	26.72	NA	\$250
NALC	32	1	2	(703) 729-4677	57.85	113.26	26.70	52.27	\$200	\$100	\$1,750/\$3,500	
NTEU	YY	1	2	(202) 783-4444	92.48	222.13	42.68	102.52	\$275	\$225	\$2,250/\$2,250	
Postmasters	High	36	1	2	(703) 683-5585	188.03	405.56	86.78	187.18	\$250	\$150	\$2,000/\$2,500
	Std	36	4	5		(703) 683-5585	43.42	93.88	20.04	43.33	\$300	\$200
<b>Restricted Plans (open ONLY to specific groups)</b>												
BACE	Y2	1	2	(301) 881-0510	38.50	91.12	17.77	42.05	\$150	\$150	\$1,500/\$1,500	
Foreign Service	40	1	2	(202) 833-4910	47.09	150.28	21.73	69.36	\$200	\$175	\$2,000/\$2,000	
NAPUS	YP	1	2	(800) 451-4479	63.90	128.38	29.49	59.25	\$200	None	\$700/\$1,400	
Panama Canal Area	43	1	2	(504) 566-1300	34.46	74.73	15.90	34.49	NA	\$125	\$1,000‡	
Rural Carriers	38	1	2	(800) 638-8432	48.19	88.43	22.24	40.81	\$250	\$200	\$1,500/\$3,000	
SAMBA	44	1	2	(301) 984-1440	41.95	144.11	19.36	66.51	\$200	None	\$1,000/\$2,000	
Secret Service	Y7	1	2	(800) 424-7474	41.87	125.43	19.32	57.89	\$200	\$100	\$1,000/\$2,000	

‡ Per person

**ABBREVIATIONS:** ECF — Extended Care Facility  
 HHC — Home Health Care  
 NA — Not Applicable

PPO — Preferred Provider Organization Arrangement  
 R & C — Reasonable & Customary  
 SA — Scheduled Allowance

# Do Not Rely on This Chart Alone - See Plan Brochures for Details

- Most plans require that accidental injury care must be received within a specified number of hours of the injury for the amounts shown to apply.
- The mental conditions inpatient catastrophic limit is the maximum amount of covered out-of-pocket expenses you pay per person per year until the plan pays up to the lifetime maximum; you pay any expenses that exceed it. The lifetime maximum is the amount up to which plans pay per person for covered mental conditions inpatient services.
- A PPO may be available in your area. Please see plan brochures for details.
- While not shown on the Chart and you should see plan brochures for details, all or virtually all plans provide:
  - Prescription drug benefits, which may include a mail order program and you share costs.
  - Mental conditions outpatient care benefits, which usually have dollar and/or visit limits, and you share costs to these limits.
  - Inpatient and outpatient care benefits for alcoholism and drug abuse, which usually have dollar, day and/or visit limits, and you share costs to these limits.
  - Inpatient and outpatient hospice care benefits, which have a dollar maximum that varies by plan.

Medical - Surgical Primary Care								Mental Conditions		Other Benefit Features			Brochure Number RI
Plan Pays								Inpatient Care		ECF and/or HHC	Dental Care	PPO	
Inpatient Care				Outpatient Care				You Pay	Plan Pays				
Hospital Charges		Physician Charges		Physician Charges		Diagnostic Tests (R & C)	Accidental Injury Care (R & C)	Catastrophic Limit ‡	Lifetime Maximum ‡				
Room & Board	Other Hosp. Exp.	Surgeons (R & C)	Other Drs (R & C)	Surgeons (R & C)	Other Drs (R & C)								
<b>Government-wide Plan</b>													
100%	100%	80%	80%	80%	80%	80%	100%	\$4,000	\$75,000	HHC	No	Yes	71-5
100%	100%	75%	75%	75%	75%	75%	100%	\$8,000	\$50,000	No	Yes	Yes	71-5
<b>Open Plans</b>													
100%	100%	75%	75%	90%	75%	75%	100%	\$8,000	\$50,000	Both	Yes	No	71-3
100%	80%	85%	85%	100%	85%	85%	85%	\$8,000	\$50,000	HHC	Yes	Yes	71-4
100%	80%	80%	80%	80%	80%	80%	100%	\$8,000	\$50,000	HHC	Yes	Yes	71-6
100%	100%	SA	SA	SA	SA	75%	75%	\$5,000	\$50,000	No	Yes	Yes	71-7
100%	100%	SA	SA	SA	SA	70%	75%	\$5,000	\$50,000	No	No	Yes	71-7
100%	80%	85%	75%	85%	75%	75%	SA	\$8,000	\$50,000	HHC	Yes	Yes	71-9
100%	100%	75%	75%	100%	75%	75%	100%	None	None	Both	Yes	No	71-11
100%	85%	85%	80%	100%	80%	80%	80%	\$8,000	\$50,000	Both	Yes	Yes	71-13
100%	80%	75%	75%	75%	75%	75%	75%	\$8,000	\$50,000	Both	Yes	Yes	71-13
<b>Restricted Plans (open ONLY to specific groups)</b>													
100%	100%	80%	80%	100%	80%	80%	100%	\$8,000	\$50,000	Both	Yes	Yes	72-8
100%	80%	90%	80%	100%	80%	80%	100%	\$8,000	\$75,000	Both	Yes	No	72-1
100%	100%	75%	75%	100%	75%	75%	100%	\$4,200	\$50,000	Both	Yes	No	72-3
100%	80%	100%	SA	100%	SA	SA	100%	None	None	No	Yes	Yes	72-4
100%	80%	90%	75%	90%	75%	75%	SA	\$8,000	None	Both	Yes	No	72-5
100%	90%	100%	80%	100%	80%	80%	100%	\$6,500	\$50,000	Both	No	Yes	72-6
100%	100%	80%	80%	80%	80%	80%	100%	\$4,000	\$50,000	Both	Yes	No	72-11

The above benefits may be subject to dollar, day and/or visit limits; as well as preadmission approval, precertification, second opinion and/or other requirements. Read the plan brochures carefully.

## FEHB Plan Comparison Chart - For Benefits Beginning in January 1992

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- Some Prepaid plans require you to share costs for certain services.
- Many Prepaid plans provide chiropractic care benefits and most provide hospice care benefits.
- Many Prepaid plans provide "Opt-Out" benefits (see definition).

## Prepaid Plans (Commonly referred to as CMP/HMOs)

- Every Prepaid plan provides physicals, immunizations, and prescription drug benefits and all Prepaid plan benefit packages include catastrophic coverage, since these plans provide for necessary care during a year.
- Every Prepaid plan provides benefits for mental conditions/substance abuse inpatient and outpatient services. However, benefits are limited to short-term care, generally 30 to 45 days of inpatient care and 20 to 35 outpatient visits per calendar year. You typically share costs to benefit limits.

Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features		Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>Alabama</b>													
Complete Health of Alabama	NJ	1	2	Anniston, Huntsville & Montgomery areas	(800) 654-5507	MMP	60.82	183.98	28.07	84.91	Both	Yes	73-532
Complete Health of Alabama	NL	1	2	Mobile, Ozark & Other areas	(800) 654-5507	MMP	67.45	185.73	31.13	85.72	Both	Yes	73-532
Complete Health of Alabama	NY	1	2	Birmingham area	(800) 654-5507	MMP	66.35	183.13	30.62	84.52	Both	Yes	73-532
Humana Alabama	NS	1	2	Huntsville area	(205) 532-2050	IPP	50.57	177.54	23.34	81.94	Both	No	73-529
Humana Alabama	PY	1	2	Montgomery area	(205) 270-5544	IPP	41.70	184.13	19.24	84.98	Both	No	73-529
PARTNERS Health Plan of Alabama	DF	1	2	Birmingham area	(205) 942-5787	IPP	42.14	148.62	19.45	68.59	Both	No	73-349
Prime Health	AA	1	2	Mobile area	(205) 342-0022	GPP	81.10	132.21	37.43	61.02	Both	Yes	73-280
Principal Health Care of Florida	C2	1	2	Southwestern Alabama	(904) 484-4080	MMP	39.13	139.69	18.06	64.47	Both	No	73-355
<b>Arizona</b>													
CIGNA Phoenix	16	1	2	Phoenix area	(602) 371-2300	GPP	34.31	108.27	15.84	49.97	Both	Yes	73-28
CIGNA Tucson	B1	1	2	Tucson area	(602) 571-6596	MMP	36.88	109.51	17.02	50.54	Both	No	73-95
FHP/Arizona	A3	1	2	Phoenix and Tucson areas	(602) 966-6773	MMP	36.50	125.30	16.85	57.83	Both	Yes	73-18
Humana Phoenix	DY	1	2	Maricopa County	(602) 381-4300	IPP	39.35	167.01	18.16	77.08	Both	No	73-401
Intergroup of Arizona, Inc.	A7	1	2	Cochise/Phoenix/Santa Cruz/Tucson areas	(602) 326-4357	MMP	32.68	96.46	15.08	44.52	Both	No	73-283
PARTNERS Health Plan of Arizona	A1	1	2	Graham/Greenlee/SE Pinal/Yuma Cos.	(602) 750-8151	IPP	41.20	165.67	19.01	76.46	Both	No	73-556
PARTNERS Health Plan of Arizona	TD	1	2	Cochise/Pima/Santa Cruz Cos.	(602) 750-8151	IPP	34.04	92.67	15.71	42.77	Both	No	73-556
<b>Arkansas</b>													
American HMO - Arkansas	RB	1	2	Little Rock and Ft. Smith areas	1-800-333-3534	MMP	36.23	122.79	16.72	56.67	Both	No	73-565
<b>California</b>													
AETNA Health Plan of San Diego, Inc.	NI	1	2	San Diego County	(619) 497-0244	MMP	39.86	145.58	18.40	67.19	Both	No	73-569
AETNA Health Plans of So. CA	RG	1	2	Southern California	1-800-347-4343	IPP	37.86	121.40	17.47	56.03	Both	No	73-538
Bay Pacific Health Plan	BU	1	2	Greater San Francisco Bay area	(415) 952-2005	IPP	41.31	106.78	19.07	49.28	Both	No	73-111
Blue Cross CaliforniaCare	M5	1	2	Most of California	(800) 825-1030	MMP	37.46	99.24	17.29	45.80	Both	No	73-517
Blue Shield of California HMO	SJ	1	2	Most of California	1-800-541-6652	IPP	40.60	154.92	18.74	71.50	Both	No	73-574
Bridgeway Plan for Health	CC	1	2	San Francisco Bay area	(800) 554-3110	MMP	38.90	106.08	17.95	48.96	Both	No	73-115
CareAmerica-Southern CA	BG	1	2	Los Angeles area	1-800-827-2273	IPP	35.67	109.79	16.46	50.67	Both	No	73-290
CIGNA Healthplan of San Diego	SK	1	2	San Diego County	1-800-368-2471	IPP	65.50	200.64	30.23	92.60	Both	No	73-402
CIGNA Medical Group Healthplan	61	1	2	Los Angeles/Orange Counties	(800) 344-0557	GPP	51.22	165.73	23.64	76.49	Both	No	73-14
FHP/California	66	1	2	Southern California	(213) 809-5399	MMP	39.09	176.15	18.04	81.30	Both	Yes	73-18
Foundation Health of CA	C6	1	2	Northern/Central California	(800) 621-PLAN	IPP	49.86	159.82	23.01	73.76	Both	No	73-74

Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features ECF and/or HHC	Dental Care	Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family			
<b>California (cont.)</b>													
Health Net	LB	1	2	Most of California	1-800-640-2004	MMP	38.64	110.96	17.83	51.21	Both	No	73-159
Health Plan of America	BH	1	2	Most of California	(800) 427-2669	IPP	36.41	103.03	16.80	47.55	Both	No	73-220
Health Plan of the Redwoods	CW	1	2	Sonoma/Marin/Part of Mendocino/Lake Cos.	(707) 544-2273	MMP	53.35	178.15	24.62	82.22	Both	No	73-221
Kaiser (Northern CA)	59	1	2	Northern California	(415) 987-3190	GPP	39.37	91.63	18.17	42.29	Both	No	73-3
Kaiser (Southern CA)	62	1	2	Southern California	(213) 667-4102	GPP	42.03	134.25	19.40	61.96	Both	No	73-2
Kaiser (Southern CA)	RC	1	2	Bakersfield area	(805) 836-0123	GPP	40.27	116.44	18.58	53.74	Both	No	73-2
Lifeguard Health Plan	CD	1	2	Northern California/Bay area	(408) 943-9400	IPP	41.72	140.04	19.25	64.63	Both	No	73-188
Lincoln National Health Plan of CA	CY	1	2	Portions of California	1-800-999-8033	MMP	40.61	139.45	18.74	64.36	Both	Yes	73-260
Mexicare (Northern CA)	CX	1	2	Northern California	(415) 375-8600	MMP	32.28	77.66	14.90	35.84	Both	No	73-246
Mexicare (Southern CA)	CM	1	2	Southern California	(213) 765-2000	MMP	37.83	120.10	17.46	55.43	Both	No	73-43
National Med	MN	1	2	Stan./San Joaq./Merced/Tuolum. Cos.	1-800-468-8600	IPP	37.64	93.62	17.37	43.21	Both	No	73-512
PacificCare of California	CQ	1	2	Northern and Southern California	(800) 624-8822	MMP	36.17	106.28	16.69	49.05	Both	No	73-105
PCA Health Plans of California	CL	1	2	Sacramento area	(916) 921-0996	MMP	41.10	130.61	18.97	60.28	Both	No	73-561
Qual-Med California	CF	1	2	Northern California	(415) 465-1400	IPP	53.11	177.50	24.51	81.92	Both	No	73-176
St. Joseph's Omni Health Plan	HN	1	2	San Joaquin, Stanislaus and Tuolumne Cos.	(209) 466-6664	IPP	35.56	93.19	16.41	43.01	Both	No	73-406
Takecare	LC	1	2	Northern California/Los Angeles areas	1-800-635-2273	MMP	38.31	109.31	17.68	50.45	Both	No	73-144
United Health Plan	C4	1	2	Los Angeles/Orange Counties	(213) 671-3465	MMP	43.14	167.92	19.91	77.50	Both	No	73-269
ValuCare/Central Valley Health Plan	BE	1	2	Central Valley area	(209) 435-8366	IPP	41.53	145.21	19.17	67.02	Both	No	73-403
<b>Colorado</b>													
COMPREKARE (High)	D6	1	2	Denver/Col Springs/No. Colorado	(303) 750-6200	MMP	38.35	110.72	17.70	51.10	Both	Yes	73-49
COMPREKARE (Std)	D6	4	5	Denver/Col Springs/No. Colorado	(303) 750-6200	MMP	31.11	80.25	14.36	37.04	Both	Yes	73-49
HMO Colorado	L2	1	2	Front Range and San Luis Valley	(303) 831-4114	MMP	39.02	116.12	18.01	53.59	Both	Yes	73-147
Kaiser Colorado	65	1	2	Denver area	(303) 344-7500	GPP	32.34	82.13	14.92	37.90	Both	Yes	73-19
Lincoln National Health Plan of CO, Inc.	DD	1	2	Denver/Col Springs/No. CO/So. CO	1-800-255-1139	MMP	36.32	90.80	16.76	41.91	Both	Yes	73-78
Qual-Med Colorado	MT	1	2	Col Springs/Denver/South Central CO	(719) 598-0553	MMP	35.04	91.79	16.17	42.36	Both	No	73-514
Rocky Mountain HMO	88	1	2	Western Colorado	(303) 243-7050	IPP	46.26	138.28	21.35	63.82	Both	Yes	73-27
<b>Connecticut</b>													
CIGNA Healthplan of Connecticut	AL	1	2	Northern, Central and Southern CT	(203) 745-2288	IPP	116.31	311.83	53.68	143.92	Both	No	73-410
Community Health Care Plan	71	1	2	New Hvn/Middlesex/Htd/Ftd/Lcthd Cos.	1-800-237-2427	MMP	90.38	248.48	41.71	114.68	Both	No	73-24
Health New England	DJ	1	2	Northern Connecticut	(413) 787-4000	IPP	55.34	128.99	25.54	59.53	Both	No	73-437
HMO IPA Network	KH	1	2	Portions of Connecticut	(413) 499-4009	IPP	42.90	163.26	19.80	75.35	Both	No	73-194
Kaiser Connecticut	DM	1	2	Hartford and Stamford areas	(203) 678-5100	GPP	40.22	109.68	18.56	50.62	Both	No	73-114
Physicians Health Services/CT	DP	1	2	Eastern, Southern & Western CT	(800) 848-4747	IPP	60.43	217.41	27.89	100.34	Both	No	73-140
U.S. Healthcare Connecticut	H1	1	2	Frid/Htd/Lcthd/New Hvn Cos.	1-800-537-9384	IPP	47.52	202.37	21.93	93.40	Both	Yes	73-412

ABBREVIATIONS: ECF — Extended Care Facility  
 GPP — Group Practice Plan  
 HHC — Home Health Care  
 IPP — Individual Practice Plan  
 MMP — Mixed Model Plan

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Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features		Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>Delaware</b>													
Delaware Valley HMO	SP	1	2	State of Delaware	(302) 571-0822	IPP	45.50	175.03	21.00	80.78	Both	Yes	73-65
Healthcare Delaware	MR	1	2	New Castle County	(302) 421-4141	IPP	76.31	243.10	35.22	112.20	Both	No	73-513
Principal Health Care of Delaware	RV	1	2	State of Delaware	(302) 322-4700	IPP	72.28	266.18	33.36	122.85	Both	No	73-544
US Healthcare - Delaware	NK	1	2	State of Delaware	1-800-537-9384	IPP	43.65	205.79	20.15	94.98	Both	Yes	73-527
<b>District of Columbia</b>													
AETNA HEALTH PLAN	V8	1	2	Washington, DC	1-800-537-5096	IPP	37.50	104.46	17.31	48.21	Both	Yes	73-250
CareFirst	JQ	1	2	Washington, DC	(301) 528-7000	MMP	35.09	93.00	16.19	42.92	Both	Yes	73-268
George Washington Univ HP (High)	E5	1	2	Washington, DC	(202) 416-0400	MMP	60.91	128.79	28.11	59.44	Both	Yes	73-46
George Washington Univ HP (Std)	E5	4	5	Washington, DC	(202) 416-0400	MMP	35.84	76.88	16.54	35.48	Both	Yes	73-46
Group Health Association (High)	50	1	2	Washington, DC	(202) 966-4357	GPP	56.51	165.41	26.08	76.34	Both	Yes	73-8
Group Health Association (Std)	50	4	5	Washington, DC	(202) 966-4357	GPP	28.97	73.80	13.37	34.06	Both	Yes	73-8
HealthPlus (High)	JN	1	2	Washington, DC	(301) 441-1600	IPP	40.13	94.34	18.52	43.54	Both	Yes	73-67
HealthPlus (Std)	JN	4	5	Washington, DC	(301) 441-1600	IPP	29.68	68.25	13.70	31.50	Both	Yes	73-67
Kaiser/Mid-Atlantic	E3	1	2	Washington, DC	(202) 364-3400	GPP	35.67	96.25	16.46	44.42	Both	Yes	73-47
Lincoln National Health Plan	DS	1	2	Washington, DC	1-800-782-0622	IPP	43.38	142.20	20.02	65.63	Both	Yes	73-442
M.D. IPA	JP	1	2	Washington, DC	(301) 294-5100	IPP	31.03	87.66	14.32	40.46	Both	Yes	73-100
Physicians Care	X9	1	2	Washington, DC	1-800-542-7258	IPP	52.03	229.50	24.01	105.92	Both	Yes	73-331
Prudential Health Plan/Mid-Atlantic	HD	1	2	Washington, DC	1-800-888-5447	MMP	41.43	165.65	19.12	76.45	Both	Yes	73-413
<b>Florida</b>													
AV-MED/Gainesville	JF	1	2	Gainesville area	1-800-237-1255	IPP	39.16	150.26	18.07	69.35	Both	Yes	73-126
AV-MED/Jacksonville	HW	1	2	Jacksonville area	1-800-227-4184	IPP	43.61	199.29	20.13	91.98	Both	Yes	73-126
AV-MED/Orlando	GP	1	2	Orlando area	1-800-227-4848	IPP	41.00	170.56	18.92	78.72	Both	Yes	73-126
AV-MED/South Florida	EM	1	2	South Florida	1-800-432-6676	IPP	46.96	208.96	21.67	96.44	Both	Yes	73-126
AV-MED/Tampa	H5	1	2	Tampa area	1-800-257-2273	IPP	39.88	158.17	18.41	73.00	Both	Yes	73-126
Capital Health of Tallahassee	EA	1	2	Tallahassee area	(904) 386-3161	MMP	33.93	90.60	15.66	41.81	Both	No	73-197
CIGNA Healthplan of Florida	EJ	1	2	Tampa area	(813) 281-1000	GPP	42.05	182.57	19.41	84.26	Both	Yes	73-170
CIGNA Healthplan of Florida	EN	1	2	Orlando area	(407) 660-1344	MMP	48.86	215.52	22.55	99.47	Both	Yes	73-170
Family Health Plan, Inc.	FQ	1	2	Dade and Broward Counties	1-800-772-4347	IPP	32.31	83.39	14.91	38.49	Both	No	73-551
Health Options-Jacksonville/Gainesville	E8	1	2	Jacksonville and Gainesville areas	(904) 731-7967	MMP	39.90	148.10	18.41	68.35	Both	No	73-219
Health Options-Pensacola	D5	1	2	Escambia & Santa Rosa Counties	(904) 484-7550	IPP	39.93	151.84	18.43	70.08	Both	No	73-385

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	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family			
<b>Florida (cont.)</b>													
Health Options-South FL/Palm Beach	FN	1	2	Palm Beach area	1-800-955-3569	IPP	35.73	98.80	16.49	45.60	Both	No	73-82
Health Options-South Florida/Miami	FR	1	2	Dade and Broward Counties	1-800-955-3599	IPP	37.66	122.49	17.38	56.53	Both	No	73-82
Health Options-Tampa Bay	D7	1	2	Tampa Bay area	(813) 882-0632	MMIP	46.89	184.99	21.64	86.38	Both	No	73-384
HIP Network of Florida	K7	1	2	Broward/Dade/Palm Beach	(305) 491-9055	IPP	47.52	222.00	21.93	102.46	Both	No	73-421
Humana Medical Plan-Daytona	P7	1	2	Daytona area	(904) 676-1850	MMIP	35.58	115.57	16.42	53.34	Both	No	73-278
Humana Medical Plan-Orlando	P5	1	2	Orlando area	(407) 661-6001	MMIP	34.52	103.61	15.93	47.82	Both	No	73-278
Humana Medical Plan-South Florida	EE	1	2	South Florida	(800) 531-4773	MMIP	33.16	96.20	15.30	44.40	Both	No	73-278
Humana Medical Plan-Tampa	JH	1	2	Tampa area	(800) 544-7541	MMIP	29.67	84.79	13.69	39.13	Both	No	73-278
PCA Health Plans of Florida	PJ	1	2	Broward, Dade, Palm Beach Cos.	(305) 267-6633	IPP	38.42	116.72	17.73	53.87	Both	No	73-573
Principal Health Care of Florida	C2	1	2	Northwest Florida	(904) 484-4080	MMIP	39.13	139.69	18.06	64.47	Both	No	73-355
ProCare of Jacksonville	EC	1	2	Jacksonville area	(904) 396-5401	MMIP	36.01	113.23	16.62	52.26	Both	No	73-261
ProCare of South Florida	HE	1	2	South Florida	1-800-457-3885	IPP	38.70	150.46	17.86	69.44	Both	No	73-422
ProCare Orlando	EH	1	2	Orlando area	(407) 875-2171	GPP	30.18	84.52	13.93	39.01	Both	No	73-164
ProCare-Tampa Bay	FH	1	2	Tampa Bay area	1-800-284-4302	IPP	35.81	118.22	16.53	54.56	Both	No	73-343
<b>Georgia</b>													
HMO Georgia, Inc.	CR	1	2	Atlanta, Augusta & Macon areas	(404) 365-9673	IPP	43.33	156.48	20.00	72.22	Both	No	73-424
Kaiser-Georgia	F8	1	2	Atlanta area	(404) 261-2825	GPP	39.06	141.18	18.03	65.16	Both	Yes	73-321
Partners Health Plan of Georgia, Inc.	F3	1	2	Atlanta area	(404) 951-1255	MMIP	55.25	182.91	25.50	84.42	Both	Yes	73-304
ProCare of Atlanta	EZ	1	2	Atlanta area	(404) 955-7735	MMIP	35.01	109.16	16.16	50.38	Both	No	73-107
<b>Guam</b>													
FHP/Guam	JK	1	2	Guam	646-1984	GPP	33.15	110.53	15.30	51.01	Both	Yes	73-18
Guam Memorial Health Plan (High)	ZA	1	2	Guam and Belau (Palau)	(671) 472-4647	IPP	38.33	109.88	17.69	50.71	Both	Yes	73-213
Guam Memorial Health Plan (Std)	ZA	4	5	Guam and Belau (Palau)	(671) 472-4647	IPP	28.11	75.11	12.97	34.67	Both	No	73-213
Health Maintenance Life	28	1	2	Guam	646-7826	IPP	23.40	70.23	10.80	32.41	Both	Yes	73-36
<b>Hawaii</b>													
HMSA	87	1	2	Hawaii	(808) 944-2498	IPP	33.56	88.95	15.49	41.05	Both	Yes	73-10
HMSA's Community Health Program	F6	1	2	Hawaii	(808) 944-2372	GPP	34.75	94.08	16.04	43.42	Both	Yes	73-60
Island Care	F9	1	2	Hawaii	(808) 523-8686	IPP	42.42	140.58	19.58	64.88	Both	Yes	73-319
Kaiser Hawaii (High)	63	1	2	Hawaii	(808) 521-0803	GPP	39.56	98.46	18.26	45.44	Both	Yes	73-5
Kaiser Hawaii (Std)	63	4	5	Hawaii	(808) 521-0803	GPP	31.35	72.73	14.47	33.57	Both	Yes	73-5
<b>Idaho</b>													
Group Health Northwest	VR	1	2	Kootenai and Bonner Counties	(208) 664-5174	MMIP	39.55	120.41	18.25	55.57	Both	Yes	73-96
Lincoln National Health Plan	GM	1	2	Ada and Canyon Counties	1-800-255-1139	GPP	39.69	150.46	18.32	69.44	Both	No	73-426
Qual-Med Washington	TM	1	2	Northern Idaho	1-800-845-7881	IPP	39.18	127.64	18.08	58.91	Both	No	73-287

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GPP — Group Practice Plan    MMP — Mixed Model Plan

HHC — Home Health Care

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## Prepaid Plans (Commonly referred to as CMP/HMOs)

- Every Prepaid plan provides physicals, immunizations, and prescription drug benefits and all Prepaid plan benefit packages include catastrophic coverage, since these plans provide for necessary care during a year.
- Every Prepaid plan provides benefits for mental conditions/substance abuse inpatient and outpatient services. However, benefits are limited to short-term care, generally 30 to 45 days of inpatient care and 20 to 35 outpatient visits per calendar year. You typically share costs to benefit limits.

Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features		Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>Illinois</b>													
American HMO - Illinois	AC	1	2	Metro Chicago area	1-800-367-9597	MMP	38.04	143.18	17.56	66.08	Both	No	73-427
BCI HMO, Inc./Chicago Metro Area	LF	1	2	Chicago area	(708) 620-0176	MMP	37.51	103.55	17.31	47.79	Both	No	73-152
BCI HMO, Inc./Downstate Area	JL	1	2	Downstate counties	(618) 632-1900	MMP	51.25	212.34	23.65	98.00	Both	No	73-152
Blackhawk Health Assurance Plan	LH	1	2	Rockford area	(815) 965-6755	IPP	31.10	79.69	14.35	36.78	Both	No	73-149
BlueChoice	M4	1	2	St. Clair and Madison Counties	(800) 634-4395	IPP	41.34	132.95	19.08	61.36	Both	Yes	73-516
CarleCare	FX	1	2	East Central Illinois	(217) 337-8100	MMP	36.01	86.57	16.62	39.95	Both	No	73-168
Chicago HMO Ltd	FJ	1	2	Chicago area	(312) 751-4460	MMP	36.38	124.46	16.79	57.44	Both	Yes	73-199
Dreyer HMO	EU	1	2	Greater Fox Valley and Dekalb areas	(708) 859-0400	GPP	33.07	92.62	15.26	42.75	Both	No	73-300
Foundation Program	LG	1	2	Springfield area	(217) 753-5280	IPP	64.79	245.16	29.90	113.15	Both	No	73-151
Great Lakes Health Plan, Inc.	FY	1	2	Chicago area	1-800-325-7498	IPP	40.19	110.87	18.55	51.17	Both	No	73-231
Group Health Plan St. Louis	MM	1	2	St. Louis area	(314) 453-1700	MMP	42.98	146.88	19.84	67.79	Both	Yes	73-104
HealthChicago, Inc.	GQ	1	2	Chicago Metro area	(708) 964-2700	MMP	44.70	179.79	20.63	82.98	Both	No	73-310
Humana Michael Reese HMO	75	1	2	Chicago Metro area	(312) 808-3801	GPP	31.87	89.25	14.71	41.19	Both	No	73-25
Maxicare Illinois	FV	1	2	Chicago/Champaign areas	(312) 220-9830	MMP	30.66	85.07	14.15	39.26	Both	No	73-58
MetLife HCN of St. Louis	12	1	2	St. Louis area	(800) 552-4679	MMP	64.74	143.46	29.88	66.21	Both	Yes	73-32
PARTNERS HMO	RN	1	2	Madison and St. Clair Counties	1-800-338-4123	IPP	43.58	134.73	20.11	62.18	Both	No	73-541
PersonalCare's HMO	GE	1	2	East Central, Northeast IL	(800) 431-1211	MMP	33.37	92.84	15.40	42.85	Both	No	73-257
RUSH-ANCHOR HMO	17	1	2	Chicago Metro area	(312) 347-0163	MMP	38.64	140.04	17.83	64.63	Both	No	73-29
SANUS Health Plan	H8	1	2	St. Louis Metro area	(314) 434-6010	IPP	53.48	141.60	24.68	65.35	Both	Yes	73-345
Share Health Plan of Illinois	FP	1	2	Chicago area	800-MD-SHARE	MMP	41.39	93.13	19.10	42.98	Both	Yes	73-187
Union Health Service, Inc.	76	1	2	Chicago Metropolitan area	(312) 829-4224	GPP	30.43	86.43	14.04	39.89	Both	No	73-26
<b>Indiana</b>													
American HMO - Illinois	AC	1	2	Northwest Indiana	1-800-367-9597	MMP	38.04	143.18	17.56	66.08	Both	No	73-427
Arnett HMO	G2	1	2	Greater Lafayette area	(317) 448-8200	GPP	38.25	114.82	17.65	52.99	Both	No	73-288
BCI HMO, Inc.	LF	1	2	Lake and Porter Counties	(708) 620-0176	MMP	37.51	103.55	17.31	47.79	Both	No	73-152
Great Lakes Health Plan, Inc.	FY	1	2	Lake County	1-800-325-7498	IPP	40.19	110.87	18.55	51.17	Both	No	73-231
HealthChicago, Inc.	GQ	1	2	Lake, LaPorte and Porter Counties	(708) 964-2700	MMP	44.70	179.79	20.63	82.98	Both	No	73-310
Humana Care Plan	18	1	2	Southern Indiana	(800) 448-0222	MMP	34.36	107.47	15.86	49.60	Both	No	73-238
Humana Health Plan	D2	1	2	Clark, Floyd and Harrison Counties	(800) 448-0222	IPP	34.31	108.14	15.83	49.91	Both	No	73-434
Humana Michael Reese HMO	75	1	2	Lake County	(312) 808-3801	GPP	31.87	89.25	14.71	41.19	Both	No	73-25

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	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>Indiana (cont.)</b>													
Key Health Plan	GH	1	2	North and Central Indiana	1-800-321-8961	IPP	40.88	174.83	18.87	80.69	Both	Yes	73-163
Maxicare Illinois	FV	1	2	Lake and Porter Counties	(312) 220-9830	MMMP	30.66	85.07	14.15	39.26	Both	No	73-58
Maxicare Indiana	GK	1	2	Indianapolis area	(317) 843-9989	MMMP	36.78	139.84	16.97	64.54	Both	No	73-183
PARTNERS National Health of Indiana	MC	1	2	Elkhart/South Bend	(219) 233-4677	IPP	38.39	134.81	17.72	62.22	Both	No	73-506
RUSH-ANCHOR HMO	17	1	2	Lake and Porter Counties	(312) 347-0163	MMMP	38.64	140.04	17.83	64.63	Both	No	73-29
The M Plan	IN	1	2	Indianapolis Metro area	(317) 571-5300	MMMP	33.35	102.29	15.39	47.21	Both	No	73-578
Wellborn HMO	H3	1	2	Evansville area	(812) 425-3939	GPP	36.46	113.99	16.83	52.61	Both	No	73-430
<b>Iowa</b>													
Care Choices	FA	1	2	Sioux City area	1-712-252-2344	IPP	40.22	149.87	18.56	69.17	Both	No	73-444
HMO Iowa	56	1	2	Des Moines area	(515) 282-2000	IPP	41.17	194.22	19.00	89.64	Both	No	73-554
Principal Health Care of Nebraska	GU	1	2	Council Bluffs	(402) 333-1720	IPP	31.30	84.51	14.45	39.00	Both	Yes	73-453
Share Health Plan of Iowa	GS	1	2	Central Iowa	(515) 225-1234	IPP	42.41	98.76	19.57	45.58	Both	Yes	73-186
Share Health Plan of Nebraska	NF	1	2	Omaha/Council Bluffs area	(402) 345-5500	IPP	41.54	107.49	19.17	49.61	Both	Yes	73-265
<b>Kansas</b>													
CIGNA Healthplan of Kansas	HC	1	2	Wichita area	(316) 636-1152	GPP	39.62	138.41	18.29	63.88	Both	No	73-175
HMO Kansas	HM	1	2	Capital area/Wichita area/Central Kansas	(800) 332-0028	MMMP	28.63	77.35	13.21	35.70	Both	Yes	73-232
Kaiser-Kansas City	HA	1	2	Kansas City area	(913) 469-5607	GPP	35.24	104.76	16.26	48.35	Both	Yes	73-128
Prime Health (High)	MS	1	2	Kansas City area	(816) 941-8003	MMMP	38.99	135.25	17.99	62.42	Both	No	73-54
Prime Health (Std)	MS	4	5	Kansas City area	(816) 941-8003	MMMP	35.62	100.56	16.44	46.41	Both	No	73-54
Principal Health Care of Kansas City	N3	1	2	Kansas City area	(816) 941-3030	IPP	36.24	110.05	16.73	50.79	Both	No	73-275
Total Health Care	LZ	1	2	Kansas City area	(816) 395-2323	IPP	72.20	211.06	33.32	97.41	Both	No	73-142
<b>Kentucky</b>													
HealthWise of Kentucky	DU	1	2	28 counties in Central Kentucky	(800) 543-8339	IPP	33.71	117.31	15.56	54.14	Both	No	73-433
Humana Care Plan	18	1	2	Louisville area	(800) 448-0222	MMMP	34.36	107.47	15.86	49.60	Both	No	73-238
Humana Care Plan	HR	1	2	Lexington area	(800) 221-8390	MMMP	30.34	84.35	14.00	38.93	Both	No	73-238
Humana Health Plan	D2	1	2	Louisville and Lexington areas	(800) 448-0222	IPP	34.31	108.14	15.83	49.91	Both	No	73-434
Lincoln National Health Plan	R8	1	2	Northern Kentucky	1-800-999-6019	MMMP	40.75	116.55	18.81	53.79	Both	Yes	73-254
<b>Louisiana</b>													
Community Health Network of LA	RY	1	2	Baton Rouge area	1-800-349-1000	IPP	37.75	106.30	17.42	49.06	Both	No	73-575
Community Health Network of LA	SG	1	2	New Orleans area	1-800-349-1000	IPP	37.69	105.72	17.40	48.79	Both	No	73-575
Community Health Network of LA	S8	1	2	Shreveport area	1-800-349-1000	IPP	39.19	121.23	18.09	55.95	Both	No	73-575
Gulf South Health Plans, Inc.	LY	1	2	Baton Rouge area	(504) 927-7212	IPP	35.85	105.67	16.54	48.77	Both	No	73-576
Maxicare Louisiana	JA	1	2	New Orleans area	(504) 836-2022	MMMP	38.60	110.24	17.82	50.88	Both	No	73-244
PARTNERS Health Plan of Louisiana	NG	1	2	New Orleans area	1-800-877-7997	IPP	36.53	118.93	16.86	54.89	Both	No	73-570
Principal Health Care of Louisiana	RP	1	2	New Orleans and River Region	(504) 834-0840	IPP	32.27	87.14	14.89	40.22	Both	No	73-542

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	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>Maine</b>													
Healthsource Maine	MY	1	2	North, Central and Southern Maine	(800) 642-5551	IPP	71.18	194.35	32.85	89.70	Both	No	73-515
HMO Maine	CU	1	2	Southern and Central Maine	1-800-527-7706	IPP	54.17	181.51	25.00	83.77	Both	No	73-443
<b>Maryland</b>													
AETNA HEALTH PLAN	V8	1	2	DC and Baltimore Metro areas	1-800-537-5096	IPP	37.50	104.46	17.31	48.21	Both	Yes	73-250
CareFirst	JQ	1	2	DC area/Most of Maryland	(301) 528-7000	MMP	35.09	93.00	16.19	42.92	Both	Yes	73-268
Chesapeake Health Plan	BL	1	2	Baltimore City & Co./Harford/Anne Arundel	(301) 539-8622	MMP	34.55	92.81	15.95	42.84	Both	Yes	73-441
Columbia Medical Plan	67	1	2	Central Maryland	(301) 997-8500	GPP	39.50	143.65	18.23	66.30	Both	Yes	73-20
Free State Health Plan	LD	1	2	Central Maryland	(301) 964-8168	MMP	39.11	139.56	18.05	64.41	Both	Yes	73-146
George Washington Univ HP (High)	E5	1	2	Washington, DC area	(202) 416-0400	MMP	60.91	128.79	28.11	59.44	Both	Yes	73-46
George Washington Univ HP (Std)	E5	4	5	Washington, DC area	(202) 416-0400	MMP	35.84	76.88	16.54	35.48	Both	Yes	73-46
Group Health Association (High)	50	1	2	Mntgmry/P.G./ Hwrdr/Part of Chrs Cos.	(202) 966-4357	GPP	56.51	165.41	26.08	76.34	Both	Yes	73-8
Group Health Association (Std)	50	4	5	Mntgmry/P.G./ Hwrdr/Part of Chrs Cos.	(202) 966-4357	GPP	28.97	73.80	13.37	34.06	Both	Yes	73-8
HealthPlus (High)	JN	1	2	DC Metro area	(301) 441-1600	IPP	40.13	94.34	18.52	43.54	Both	Yes	73-67
HealthPlus (Std)	JN	4	5	DC Metro area	(301) 441-1600	IPP	29.68	68.25	13.70	31.50	Both	Yes	73-67
HealthPlus (High)	JW	1	2	Baltimore Metro Area	(301) 441-1600	IPP	36.59	85.98	16.89	39.68	Both	Yes	73-67
HealthPlus (Std)	JW	4	5	Baltimore Metro Area	(301) 441-1600	IPP	27.01	62.13	12.47	28.67	Both	Yes	73-67
Kaiser/Mid-Atlantic	E3	1	2	Washington, DC area	(202) 364-3400	GPP	35.67	96.25	16.46	44.42	Both	Yes	73-47
Kaiser/Mid-Atlantic	E7	1	2	Baltimore area	(301) 281-6123	GPP	32.52	88.10	15.01	40.66	Both	Yes	73-47
Lincoln National Health Plan	DS	1	2	Prince George's and Montgomery Cos.	1-800-782-0622	IPP	43.38	142.20	20.02	65.63	Both	Yes	73-442
M.D. IPA	JP	1	2	Most of Maryland	(301) 294-5100	IPP	31.03	87.66	14.32	40.46	Both	Yes	73-100
Physicians Care	X9	1	2	DC Metro area	1-800-542-7258	IPP	52.03	229.50	24.01	105.92	Both	Yes	73-331
Potomac Health	JM	1	2	Most of Maryland	(301) 528-7000	MMP	38.79	120.56	17.90	55.64	Both	Yes	73-225
Prudential Health Plan/Mid-Atlantic	HD	1	2	Montgomery and Prince George's Cos.	1-800-888-5447	MMP	41.43	165.65	19.12	76.45	Both	Yes	73-413
Prudential Health Plan/Mid-Atlantic	JB	1	2	Central Maryland	1-800-888-5447	MMP	37.02	117.94	17.08	54.43	Both	Yes	73-413
<b>Massachusetts</b>													
Bay State Health Care	KW	1	2	Eastern Massachusetts	1-800-525-5151	IPP	67.86	254.31	31.32	117.37	Both	Yes	73-193
Central Massachusetts Health Care	J1	1	2	Worcester County	(508) 754-1870	IPP	77.94	260.00	35.97	120.00	Both	Yes	73-291
CIGNA Healthplan of Massachusetts	G6	1	2	Gtr Springfield and Worcester areas	(800) 345-9458	IPP	57.46	159.51	26.52	73.62	Both	No	73-295
CIGNA Healthplan of Massachusetts	TR	1	2	Eastern Massachusetts	(800) 345-9458	IPP	67.02	222.20	30.93	102.55	Both	No	73-295
Community Health Plan	SM	1	2	Berkshire/Franklin/Hampshire Cos.	(413) 584-0600	MMP	45.05	169.07	20.79	78.03	Both	No	73-53

Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features ECF and/or HHC	Dental Care	Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family			
Massachusetts (cont.)													
Fallon Community Health Plan	JV	1	2	Central Massachusetts	(800) 636-1221	GPP	38.83	122.12	17.92	56.36	Both	Yes	73-90
Harvard Community Health Plan, Inc.	68	1	2	Eastern and Western Massachusetts	(617) 739-6161	GPP	61.62	239.49	28.44	110.53	Both	Yes	73-21
Harvard Health - New England	70	1	2	Southeastern Massachusetts	(401) 331-4034	GPP	33.85	81.63	15.62	37.67	Both	Yes	73-23
Health New England	DJ	1	2	Hampden and Hampshire Cos.	(413) 787-4000	IPP	55.34	128.99	25.54	59.53	Both	No	73-437
HMO Blue	JT	1	2	Eastern/Central Massachusetts	(617) 246-8140	MAMP	50.62	189.48	23.36	87.45	Both	Yes	73-112
HMO IPA Network	KH	1	2	Portions of Massachusetts	(413) 499-4009	IPP	42.90	163.26	19.80	75.35	Both	No	73-194
HMO Rhode Island	DA	1	2	Portions of Southeastern MA	(401) 274-6674	MAMP	49.19	149.72	22.70	69.10	Both	No	73-489
Kaiser Massachusetts	K1	1	2	Parts of Western Massachusetts	(413) 256-0151	GPP	49.66	114.71	22.92	52.94	Both	Yes	73-86
Lafayette Clinic-BCBS HMP	JX	1	2	Greater Burlington area	(617) 246-8140	GPP	54.47	218.14	25.14	100.68	Both	No	73-106
Matthew Thornton Health Plan	NX	1	2	Northern Massachusetts	1-800-544-8333	GPP	43.00	179.95	19.84	83.05	Both	No	73-76
Medical West Corp	JZ	1	2	Springfield area	(413) 781-7320	GPP	43.60	111.18	20.12	51.31	Both	Yes	73-139
Pilgrim Health Care	JU	1	2	Eastern Massachusetts	(617) 871-3950	IPP	62.01	257.73	28.62	118.95	Both	Yes	73-139
Tufts Associated Health Plan	K2	1	2	Eastern and Central Massachusetts	(617) 466-1000	IPP	74.65	293.13	34.45	135.29	Both	No	73-134
U.S. Healthcare-Massachusetts	NE	1	2	Boston Metropolitan area	1-800-537-9384	IPP	43.54	182.18	20.09	84.08	Both	Yes	73-526
Michigan													
Blue Care Network Great Lakes	G7	1	2	North Michigan	(616) 941-7823	IPP	40.33	126.95	18.61	58.59	Both	No	73-272
Blue Care Network Great Lakes	KF	1	2	Southwest Michigan	(616) 388-9500	IPP	37.25	130.24	17.19	60.11	Both	No	73-272
Blue Care Network Great Lakes	KR	1	2	West Michigan	(616) 957-5057	IPP	29.41	85.46	13.57	39.44	Both	No	73-272
Blue Care Network of East MI/Flint	KN	1	2	Greater Flint area	(313) 733-9593	MAMP	35.89	148.36	16.56	68.47	Both	No	73-88
Blue Care Network of East MI/Saginaw	K5	1	2	Saginaw, Bay City, Midland	(517) 791-3222	MAMP	34.96	87.33	16.14	40.30	Both	No	73-88
Blue Care Network of SE Michigan	LX	1	2	Detroit area	(800) 662-6667	MAMP	29.71	112.91	13.71	52.11	Both	No	73-153
Blue Care Network-Health Central	LN	1	2	Lansing area	(517) 322-8022	MAMP	34.24	148.53	15.80	68.55	Both	No	73-154
Butterworth HMO	BC	1	2	Grand Rapids Metro area	(616) 942-1221	IPP	34.66	105.26	16.00	48.58	Both	No	73-550
Care Choices/Ann Arbor	KZ	1	2	Ann Arbor area	1-800-852-9780	IPP	49.66	186.58	22.92	86.11	Both	No	73-444
Care Choices/Grand Rapids & Muskegon	BA	1	2	Grand Rapids/Muskegon areas	(616) 957-1100	IPP	34.14	92.78	15.76	42.82	Both	No	73-444
Care Choices/Lansing	FE	1	2	Lansing area	1-800-642-0119	IPP	40.57	153.06	18.72	70.64	Both	No	73-444
Comprehensive Health Services, Inc.	K3	1	2	Southeastern Michigan	(313) 875-5222	MAMP	35.59	88.96	16.42	41.06	Both	No	73-75
Grand Valley Health Plan	RL	1	2	Grand Rapids area	(616) 949-2410	GPP	32.66	90.59	15.07	41.81	Both	No	73-567
Health Alliance Plan of Michigan	52	1	2	Southeastern Michigan	(313) 872-8100	MAMP	38.21	114.64	17.64	52.91	HHC	No	73-15
M-Care	EG	1	2	Southeastern Michigan	(313) 747-8700	MAMP	42.71	146.86	19.71	67.78	Both	No	73-445
Medical Value Plan	EV	1	2	Monroe and Lenawee Counties	(419) 244-2902	MAMP	40.14	198.58	18.53	91.65	Both	No	73-473
OmniCare Health Plan	KA	1	2	Southeastern Michigan	(313) 873-2813	MAMP	37.83	93.44	17.46	43.12	Both	No	73-62
SelectCare HMO	K6	1	2	Detroit Metro area	(313) 880-1100	MAMP	35.62	94.64	16.44	43.68	Both	No	73-69
Total Health Care	N2	1	2	Detroit Metro area	(313) 871-2000	GPP	36.85	89.96	17.01	41.52	Both	No	73-534

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 GPP — Group Practice Plan MMP — Mixed Model Plan  
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## Prepaid Plans (Commonly referred to as CMP/HMOs)

- Every Prepaid plan provides physicals, immunizations, and prescription drug benefits and all Prepaid plan benefit packages include catastrophic coverage, since these plans provide for necessary care during a year.
- Every Prepaid plan provides benefits for mental conditions/substance abuse inpatient and outpatient services. However, benefits are limited to short-term care, generally 30 to 45 days of inpatient care and 20 to 35 outpatient visits per calendar year. You typically share costs to benefit limits.

Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features		Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>Minnesota</b>													
Group Health (High)	53	1	2	Minneapolis and St. Paul	(612) 623-8400	GPP	29.14	83.98	13.45	38.76	Both	Yes	73-9
Group Health (Std)	53	4	5	Minneapolis and St. Paul	(612) 623-8400	GPP	23.82	68.63	10.99	31.68	Both	No	73-9
Medica Choice	DR	1	2	Minnesota	(612) 936-1821	IPP	37.27	121.94	17.20	56.28	Both	Yes	73-169
Medica Primary	11	1	2	Minneapolis and St. Paul	(612) 936-6000	MMP	31.58	88.93	14.57	41.04	Both	Yes	73-30
<b>Mississippi</b>													
CIGNA Healthplan of Tennessee	SR	1	2	Memphis area	(915) 683-3311	IPP	49.77	172.86	22.97	79.78	Both	No	73-356
<b>Missouri</b>													
BlueChoice	M4	1	2	St. Louis area	(800) 634-4395	IPP	41.34	132.95	19.08	61.36	Both	Yes	73-516
Group Health Plan St. Louis	MM	1	2	St. Louis area	(314) 453-1700	MMP	42.98	146.88	19.84	67.79	Both	Yes	73-104
Kaiser Kansas City	HA	1	2	Kansas City area	(913) 469-5607	GPP	35.24	104.76	16.26	48.35	Both	Yes	73-128
MetLife HCN of St. Louis	12	1	2	St. Louis area	(800) 552-4679	MMP	64.74	143.46	29.88	66.21	Both	Yes	73-32
PARTNERS HMO	RN	1	2	St. Louis Metro area	1-800-338-4123	IPP	43.58	134.73	20.11	62.18	Both	No	73-541
Prime Health (High)	MS	1	2	Kansas City area	(816) 941-8003	MMP	38.99	135.25	17.99	62.42	Both	No	73-54
Prime Health (Std)	MS	4	5	Kansas City area	(816) 941-8003	MMP	35.62	100.56	16.44	46.41	Both	No	73-54
Principal Health Care of Kansas City	N3	1	2	Kansas City area	(816) 941-3030	IPP	36.24	110.05	16.73	50.79	Both	No	73-275
SANUS Health Plan	H8	1	2	St. Louis Metro area	(314) 434-6010	IPP	53.48	141.60	24.68	65.35	Both	Yes	73-345
Total Health Care	LZ	1	2	Kansas City area	(816) 395-2323	IPP	72.20	211.06	33.32	97.41	Both	No	73-142
<b>Nebraska</b>													
Care Choices	FA	1	2	Dakota/Dixon/Thurston Cos.	1-712-252-2344	IPP	40.22	149.87	18.56	69.17	Both	No	73-444
Principal Health Care of Nebraska	GU	1	2	Omaha and Lincoln areas	(402) 333-1720	IPP	31.30	84.51	14.45	39.00	Both	Yes	73-453
Share Health Plan of Nebraska	NF	1	2	Omaha/Council Bluffs area	(402) 345-5500	IPP	41.54	107.49	19.17	49.61	Both	Yes	73-265
<b>Nevada</b>													
Health Plan of Nevada	NM	1	2	Las Vegas area	(702) 646-8350	MMP	42.02	112.11	19.39	51.74	Both	Yes	73-129
Humana Health Plan (Las Vegas)	TL	1	2	Las Vegas area	(702) 737-7211	IPP	32.14	89.99	14.83	41.53	Both	No	73-580
<b>New Hampshire</b>													
Harvard Community Health Plan, Inc.	68	1	2	Southern New Hampshire	(617) 739-6161	GPP	61.62	239.49	28.44	110.53	Both	Yes	73-21
Healthsource New Hampshire	J2	1	2	New Hampshire	(800) 531-3121	IPP	41.81	180.77	19.30	83.43	Both	No	73-312
HMO Blue	JT	1	2	Southeast New Hampshire Towns	(617) 246-8140	MMP	50.62	189.48	23.36	87.45	Both	Yes	73-112
Kaiser Massachusetts	K1	1	2	Southwestern New Hampshire	(413) 256-0151	GPP	49.66	114.71	22.92	52.94	Both	Yes	73-86
Matthew Thornton Health Plan	NX	1	2	South Central New Hampshire	1-800-544-8333	GPP	43.00	179.95	19.84	83.05	Both	No	73-76

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	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family			
<b>New Hampshire (cont.)</b>													
U.S. Healthcare-Massachusetts	QN	1	2	Salem, New Hampshire area	1-800-537-9384	IPP	55.38	205.38	25.56	94.79	Both	Yes	73-526
<b>New Jersey</b>													
Aetna Health Plans	PC	1	2	New Jersey	(800) 223-0812	IPP	58.61	227.70	27.05	105.09	Both	No	73-127
COMED HMO	P4	1	2	New Jersey	(201) 361-8808	IPP	44.46	176.05	20.52	81.25	Both	No	73-87
GHI Health Plan	80	1	2	Northern New Jersey	(201) 623-6000	IPP	41.03	170.69	18.94	78.78	HHC	Yes	73-7
Greater Atlantic Health Service	27	1	2	Camden/Burl/Glu Cos.	(215) 823-8610	MMP	35.15	92.06	16.22	42.49	Both	No	73-40
HIP of New Jersey	P9	1	2	Northern and Southern New Jersey	(609) 654-9424	GPP	42.86	153.79	19.78	70.98	Both	Yes	73-84
Medigroup HMO	E4	1	2	New Jersey	(201) 593-4481	MMP	89.31	268.06	41.22	123.72	Both	No	73-983
Oxford Health Plans/New Jersey	GD	1	2	Northern New Jersey	(800) 444-6222	IPP	51.64	178.13	23.83	82.21	Both	Yes	73-466
ProCare New Jersey	PB	1	2	New Jersey	(800) 422-7399	IPP	71.94	296.84	33.20	137.00	Both	No	73-73
Rutgers Community Health Plan	PA	1	2	Central and Northern New Jersey	(908) 560-9898	GPP	42.86	153.79	19.78	70.98	Both	Yes	73-57
Sanus Health Plan	HK	1	2	New York Metro area	(800) 338-8113	IPP	31.54	85.15	14.56	39.30	Both	Yes	73-468
US Healthcare/NJ (High)	P3	1	2	New Jersey	1-800-537-9384	IPP	59.20	224.49	27.32	103.61	Both	Yes	73-116
US Healthcare/NJ (Std)	P3	4	5	New Jersey	1-800-537-9384	IPP	43.13	175.72	19.91	81.10	Both	No	73-116
<b>New Mexico</b>													
FHP/New Mexico	P2	1	2	Albuquerque/Santa Fe areas	(505) 881-7900	MMP	36.53	95.34	16.86	44.00	Both	Yes	73-563
Lovelace Health Plan	Q1	1	2	Albuquerque/Santa Fe	(505) 262-7363	GPP	32.28	83.92	14.90	38.73	Both	No	73-79
Qual-Med New Mexico	PX	1	2	Greater Albuquerque/Santa Fe areas	(505) 889-8800	IPP	31.81	83.31	14.68	38.45	Both	Yes	73-251
<b>New York</b>													
Aetna Health Plans	PC	1	2	Metropolitan New York	(800) 223-0812	IPP	58.61	227.70	27.05	105.09	Both	No	73-127
Blue Choice of New York	MK	1	2	Rochester area	(716) 454-4810	IPP	29.10	74.29	13.43	34.29	Both	No	73-510
BlueCare Plus	AH	1	2	Greater Utica/Home & So. Tier areas	(315) 798-4395	IPP	42.89	146.21	19.79	67.48	Both	No	73-460
Capital District Physicians HP	SG	1	2	Capital District area	(518) 452-1941	IPP	40.28	147.88	18.59	68.25	Both	No	73-549
ChoiceCare	J6	1	2	Queens/Nassau/Suffolk Counties	(516) 694-4000	IPP	42.59	165.39	19.66	76.33	Both	No	73-294
CHP/Hudson Valley Region	QB	1	2	Dutchess/Orange/Ulster/Putnam Cos.	(914) 471-2368	MMP	38.82	126.69	17.92	58.47	Both	No	73-136
Community Blue	J7	1	2	Western New York	(716) 884-2800	IPP	32.17	87.58	14.85	40.42	Both	No	73-298
Community Health Plan	PW	1	2	Capital Area/Central Clinton Co.	(518) 783-1864	MMP	37.64	105.20	17.37	48.55	Both	No	73-53
Empire BC/BS HEALTHNET/Cap/AD	S1	1	2	Catskills/NY Adirondacks	(800) 453-0113	MMP	40.95	149.55	18.90	69.02	Both	No	73-33
Empire BC/BS HEALTHNET/Subrt	S7	1	2	Suburban/Metro	(800) 453-0113	MMP	53.80	191.06	24.83	88.18	Both	No	73-33
Empire BC/BS HEALTHNET/Cap/MHU	S2	1	2	Capitol Dist./Mid-Hudson	(800) 453-0113	MMP	42.68	159.49	19.70	73.61	Both	No	73-33
Empire BC/BS HLTHNET/Manhattan	S5	1	2	Manhattan	(800) 453-0113	MMP	73.39	242.15	33.87	111.76	Both	No	73-33
Foundation Health Plan	CE	1	2	Southern Tier	(607) 754-3380	IPP	40.84	130.39	18.85	60.18	Both	No	73-461
GHI Health Plan	80	1	2	New York State	(212) 721-2020	IPP	41.03	170.69	18.94	78.78	HHC	Yes	73-7
Group Health of New York	21	1	2	Rochester area	(716) 325-3630	GPP	27.60	71.07	12.74	32.80	Both	No	73-35
Health Care Plan	Q8	1	2	Buffalo area	(716) 847-1480	GPP	31.74	84.70	14.65	39.09	Both	No	73-71

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	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>New York (cont.)</b>													
HIP of New York	51	1	2	Greater New York area	1-800-HIP-TALK	GPP	40.53	132.21	18.70	61.02	Both	No	73-1
Independent Health Association	C1	1	2	Hudson Valley area	(914) 631-0939	IPP	41.66	158.58	19.23	73.19	Both	No	73-103
Independent Health Association	QA	1	2	Western New York	(716) 631-5392	IPP	26.70	74.74	12.32	34.50	Both	No	73-103
Independent Prepaid Health Plan	EB	1	2	Syracuse area	(315) 638-4900	IPP	40.70	132.37	18.78	61.09	Both	No	73-462
Kaiser New York	QH	1	2	Westchester County	(914) 682-0025	GPP	43.68	103.22	20.16	47.64	Both	Yes	73-55
Mid-Hudson Health Plan	F4	1	2	Hudson Valley area	(914) 338-0202	IPP	36.63	98.22	16.91	45.33	Both	No	73-464
Mohawk Valley Health Plan	GA	1	2	Eastern Region	(518) 370-4793	IPP	43.57	162.57	20.11	75.03	Both	No	73-465
Mohawk Valley Health Plan	M9	1	2	Central and Northern Region	(800) 777-4793	IPP	37.26	94.64	17.20	43.68	Both	No	73-465
Mohawk Valley Health Plan	MX	1	2	Mid-Hudson Region	(914) 473-1762	IPP	81.64	258.86	37.68	119.47	Both	No	73-465
Oxford Health Plans/New York	GC	1	2	Metropolitan New York	(800) 444-6222	IPP	62.53	204.02	28.86	94.16	Both	Yes	73-466
PHP/Slocum Dickson Medical Network	SH	1	2	Utica area	(315) 797-7019	GPP	37.94	101.10	17.51	46.66	Both	No	73-560
Physicians Health Services/NY	PD	1	2	Westchester County	(800) 732-5357	IPP	82.25	275.37	37.96	127.09	Both	No	73-531
Preferred Care	GV	1	2	Rochester area	(716) 325-3113	IPP	31.17	79.14	14.39	36.53	Both	No	73-467
Prepaid Health Plan	QE	1	2	Syracuse area	(315) 638-2133	GPP	37.86	110.83	17.47	51.15	Both	Yes	73-98
Sanus Health Plan	HK	1	2	New York Metro area	(718) 899-3600	IPP	31.54	85.15	14.56	39.30	Both	Yes	73-468
TOTAL HEALTH	HU	1	2	Metropolitan New York	(516) 466-1000	IPP	33.89	92.35	15.64	42.62	Both	No	73-469
US Healthcare-New York	JC	1	2	Metropolitan and Greater New York	1-800-537-9384	IPP	37.66	94.71	17.38	43.71	Both	Yes	73-365
<b>North Carolina</b>													
Carolina Physicians' Health Plan	RQ	1	2	Central and Eastern North Carolina	(919) 833-8000	IPP	41.29	144.52	19.06	66.70	Both	No	73-566
Kaiser North Carolina	QT	1	2	Triangle area/Charlotte	(919) 981-6000	GPP	37.10	99.09	17.12	45.73	Both	No	73-240
Maxicare North Carolina	Q5	1	2	Charlotte, Greensboro and Raleigh	(800) 822-0012	MMP	40.10	138.69	18.51	64.01	Both	No	73-227
ProCare of Charlotte	Q4	1	2	Portions of North Carolina	(704) 365-6070	GPP	31.86	89.21	14.70	41.17	Both	No	73-340
<b>North Dakota</b>													
Heart of America HMO	RU	1	2	Northcentral North Dakota	(701) 776-5848	GPP	31.65	82.16	14.61	37.92	Both	No	73-543
Medica Choice	DR	1	2	Fargo/Moorehead area	1-800-642-0477	IPP	37.27	121.94	17.20	56.28	Both	Yes	73-169
<b>Ohio</b>													
AETNA Health Plan	RD	1	2	Northern Ohio	(216) 486-8979	IPP	41.06	94.82	18.95	43.76	Both	No	73-273
CIGNA Healthplan of Ohio	AT	1	2	Central Ohio	(800) 541-7526	IPP	53.95	173.01	24.90	79.85	Both	No	73-471
Health Guard	MA	1	2	Portions of Ohio	(614) 676-4623	MMP	32.23	82.93	14.87	38.28	Both	No	73-504
Health Plan of the Upper Ohio Valley	U4	1	2	Eastern Ohio	(614) 695-3585	IPP	32.72	81.89	15.10	37.79	Both	No	73-553

Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992		1992		Other Benefit Features ECF and/or HHC	Dental Care	Brochure Number RI
	Plan Code	Self Only	Self & Family				Monthly Premium Your Share	Self & Family	Biweekly Premium Your Share	Self & Family			
<b>Ohio (cont.)</b>													
HealthOhio, Inc.	RF	1	2	Marion area	(614) 387-6355	IPP	34.45	87.74	15.90	40.50	Both	Yes	73-56
HHP/Licking Memorial	MG	1	2	Central Ohio	(614) 366-0533	IPP	36.33	93.80	16.77	43.29	Both	No	73-508
HMO Health Ohio	L4	1	2	Northeast Ohio	(800) 634-0977	MMMP	44.66	166.58	20.61	76.88	Both	No	73-157
HMO Health Ohio	MD	1	2	Northwest Ohio	(800) 634-0977	MMMP	37.37	112.80	17.25	52.06	Both	No	73-157
HMO Health Ohio	OH	1	2	Central Ohio	(800) 634-0977	MMMP	44.23	158.08	20.41	72.96	Both	No	73-157
HMP/OHIO	R5	1	2	Portions of Ohio	1-800-342-5467	MMMP	47.91	177.80	22.11	82.06	Both	Yes	73-31
Humana Health Plan/Ohio	SQ	1	2	SW Ohio	(800) 521-3508	MMMP	42.40	151.74	19.57	70.03	Both	No	73-579
Kaiser Ohio	64	1	2	Cleveland and Akron areas	(216) 621-5600	GPP	43.10	120.25	19.89	55.50	Both	No	73-17
Lincoln National Health Plan	R8	1	2	Cincinnati/Dayton areas	1-800-999-6019	MMMP	40.75	116.55	18.81	53.79	Both	Yes	73-254
Medical Value Plan	EV	1	2	Greater Toledo area	(419) 244-2902	MMMP	40.14	198.58	18.53	91.65	Both	No	73-473
Personal Physician Care	PL	1	2	Cleveland Metro area	(216) 687-0015	IPP	39.99	120.25	18.46	55.50	Both	No	73-557
Principal Health Care of Ohio	R4	1	2	Columbus area	(614) 841-1237	GPP	36.35	90.88	16.78	41.94	Both	No	73-99
PrudCare-Central Ohio	AV	1	2	Columbus area	(614) 761-0244	GPP	40.00	123.20	18.46	56.86	Both	No	73-339
Western Ohio Health Care Plan	RH	1	2	Dayton/Springfield area	(513) 439-8903	IPP	44.70	169.35	20.63	78.16	Both	Yes	73-539
<b>Oklahoma</b>													
BlueCross HMO-Oklahoma City	N5	1	2	Oklahoma City area	(405) 841-9777	IPP	37.03	102.99	17.09	47.53	Both	No	73-267
BlueCross HMO-Tulsa	RX	1	2	Greater Tulsa area	(918) 561-9933	IPP	61.02	164.17	28.16	75.77	Both	No	73-267
CIGNA Healthplan of Oklahoma	RT	1	2	Oklahoma City area	(405) 943-7711	MMMP	36.52	107.64	16.86	49.68	Both	No	73-216
PacificCare	PE	1	2	Oklahoma City area	(800) 545-0389	GPP	38.29	112.80	17.67	52.06	Both	Yes	73-530
PacificCare of Oklahoma	N1	1	2	Tulsa area	(918) 496-8181	GPP	41.74	134.51	19.26	62.08	Both	Yes	73-396
PrudCare of Oklahoma City	RR	1	2	Oklahoma City area	(405) 942-6687	GPP	34.03	83.25	15.70	38.42	Both	No	73-108
PrudCare of Tulsa	RS	1	2	Tulsa area	(918) 624-4733	GPP	35.04	95.49	16.17	44.07	Both	No	73-118
<b>Oregon</b>													
Kaiser Northwest (High)	57	1	2	Portland/Salem	(503) 721-2000	GPP	41.40	124.31	19.11	57.37	Both	Yes	73-4
Kaiser Northwest (Std)	57	4	5	Portland/Salem	(503) 721-2000	GPP	35.06	89.34	16.18	41.23	Both	No	73-4
PacificCare of Oregon	SS	1	2	Portland/Salem/Corvallis	(503) 620-9324	GPP	39.05	121.34	18.02	56.00	Both	No	73-362
Qual-Med Oregon	AF	1	2	Portland Metro area	(503) 222-6691	IPP	38.56	121.01	17.80	55.85	Both	No	73-327
SelectCare	SD	1	2	Eugene/Springfield/Albany	(800) 248-2330	IPP	41.22	88.94	19.02	41.05	Both	No	73-83
<b>Pennsylvania</b>													
AETNA Health Plans of Eastern PA	GL	1	2	Phila/Mont/Bucks/Dela/Chester Cos.	1-800-876-5000	IPP	42.53	156.00	19.63	72.00	Both	Yes	73-485
Central Medical Health Plan	24	1	2	Pittsburgh area	(412) 471-6877	MMMP	38.41	131.93	17.73	60.89	Both	Yes	73-42
Foundation Health Plan	CE	1	2	NY Southern Tier	(607) 754-3380	IPP	40.84	130.39	18.85	60.18	Both	No	73-461
Free State Health Plan	LD	1	2	Portions of Southern PA	(301) 964-8168	MMMP	39.11	139.56	18.05	64.41	Both	Yes	73-146
Freedom Health Care	CT	1	2	Harrisburg area	(800) 247-8452	MMMP	37.18	93.61	17.16	43.20	Both	No	73-478

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GPP — Group Practice Plan

MMP — Mixed Model Plan

HHC — Home Health Care

## FEHB Plan Comparison Chart - For Benefits Beginning in January 1992

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- Many Prepaid plans provide "Opt-Out" benefits (see definition).
- Every Prepaid plan provides physicals, immunizations, and prescription drug benefits and all Prepaid plan benefit packages include catastrophic coverage, since these plans provide for necessary care during a year.
- Every Prepaid plan provides benefits for mental conditions/substance abuse inpatient and outpatient services. However, benefits are limited to short-term care, generally 30 to 45 days of inpatient care and 20 to 35 outpatient visits per calendar year. You typically share costs to benefit limits.

Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features		Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>Pennsylvania (cont.)</b>													
Freedom Health Care	KJ	1	2	Philadelphia and Reading area	(800) 822-0505	MMP	38.04	121.01	17.56	55.85	Both	No	73-478
Geisinger Health Plan	N9	1	2	Central, Northeast Pennsylvania	(717) 271-8760	MMP	22.92	73.19	10.58	33.78	Both	No	73-303
Greater Atlantic Health Service	27	1	2	Southeast Pennsylvania	(215) 823-8610	MMP	35.15	92.06	16.22	42.49	Both	No	73-40
HealthAmerica Pennsylvania	26	1	2	Pittsburgh area	(412) 553-7300	MMP	33.23	93.03	15.34	42.94	Both	Yes	73-255
HealthAmerica Pennsylvania	SW	1	2	Central Pennsylvania	(717) 763-9313	MMP	33.18	86.53	15.31	39.94	Both	Yes	73-255
HealthGuard of Lancaster	NQ	1	2	Lancaster County	(717) 560-9049	IPP	30.57	83.50	14.11	38.54	Both	No	73-311
HMO of Northeastern Pennsylvania	C8	1	2	Northeastern Pennsylvania	(717) 821-1241	IPP	30.86	79.37	14.24	36.63	Both	Yes	73-480
Keystone Health Plan Central	S4	1	2	Harrisburg area	1-800-622-2843	IPP	33.19	81.90	15.32	37.80	Both	No	73-241
Keystone Health Plan Central	ST	1	2	Lehigh Valley area	1-800-622-2843	IPP	34.46	91.57	15.90	42.26	Both	No	73-241
Keystone Health Plan East	ED	1	2	Greater Philadelphia area	(215) 558-3337	IPP	37.70	108.38	17.40	50.02	Both	Yes	73-483
Keystone Health Plan West	EF	1	2	Pittsburgh area	(412) 937-4330	IPP	34.80	122.68	16.06	56.62	Both	No	73-484
Medigroup HMO	E4	1	2	Portion of Lower Bucks County	(609) 259-5965	MMP	89.31	268.06	41.22	123.72	Both	No	73-393
Riverside Health Plan	HG	1	2	Beaver Valley area in Southwest PA	(412) 775-4404	IPP	33.66	88.33	15.53	40.77	Both	No	73-487
US Healthcare/PA (High)	SU	1	2	Southeastern PA	1-800-537-9384	IPP	39.97	131.89	18.45	60.87	Both	Yes	73-52
US Healthcare/PA (Std)	SU	4	5	Southeastern PA	1-800-537-9384	IPP	32.94	85.85	15.20	39.62	Both	No	73-52
US Healthcare/PA (Pitt.) (High)	KL	1	2	Pittsburgh area	1-800-537-9384	IPP	37.48	132.65	17.30	61.22	Both	Yes	73-52
US Healthcare/PA (Pitt.) (Std)	KL	4	5	Pittsburgh area	1-800-537-9384	IPP	32.49	89.44	15.00	41.28	Both	No	73-52
<b>Puerto Rico</b>													
Health Plus, Inc.	ME	1	2	Puerto Rico	(809) 782-7900	IPP	24.35	59.27	11.24	27.36	Both	No	73-507
SSS Plan	89	1	2	Puerto Rico	(809) 749-4777	IPP	32.87	73.00	15.17	33.69	Both	Yes	73-16
<b>Rhode Island</b>													
Harvard Community Health Plan, Inc.	68	1	2	Northern Rhode Island	(617) 739-6161	GPP	61.62	239.49	28.44	110.53	Both	Yes	73-21
Harvard Health - New England	70	1	2	Rhode Island	(401) 331-4034	GPP	33.85	81.63	15.62	37.67	Both	Yes	73-23
HMO Rhode Island	DA	1	2	Rhode Island	(401) 274-6674	MMP	49.19	149.72	22.70	69.10	Both	No	73-489
Pilgrim Health Care	PZ	1	2	Rhode Island	(617) 871-3950	IPP	50.34	225.03	23.23	103.86	Both	Yes	73-139
<b>South Carolina</b>													
Companion Health Care	SE	1	2	Portions of South Carolina	1-800-868-2528	IPP	36.71	113.58	16.94	52.42	Both	Yes	73-548
Healthsource South Carolina	M3	1	2	Charleston area	(803) 723-5520	IPP	39.21	109.20	18.10	50.40	Both	No	73-536
Maxicare North Carolina	Q5	1	2	Chester and York Counties	(800) 822-0012	MMP	40.10	138.69	18.51	64.01	Both	No	73-227
Maxicare South Carolina	TA	1	2	Columbia/Greenville/Spartanburg	(800) 334-6294	MMP	69.47	197.13	32.06	90.98	Both	No	73-180

Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features		Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>South Carolina (cont.)</b>													
PruCare-Charlotte	Q4	1	2	York County	(704) 365-6070	GPP	31.86	89.21	14.70	41.17	Both	No	73-340
<b>Tennessee</b>													
AETNA Health Plans of Tennessee	TN	1	2	Nashville and Central Tennessee	1-800-537-5097	IPP	40.74	165.08	18.80	76.19	Both	No	73-571
CIGNA Healthplan of Tennessee	SR	1	2	Memphis area	(915) 683-3311	IPP	49.77	172.86	22.97	79.78	Both	No	73-356
PruCare of Memphis	UB	1	2	Shelby County	(901) 766-7908	GPP	32.59	93.84	15.04	43.31	Both	No	73-122
PruCare of Nashville	UA	1	2	Nashville area	(615) 248-7156	GPP	37.76	109.83	17.43	50.69	Both	No	73-92
Tennessee First Health Plan	HT	1	2	Knoxville area	(800) 634-1454	IPP	32.47	112.65	14.98	51.99	Both	No	73-491
<b>Texas</b>													
CIGNA Healthplan of Texas-Dallas	UG	1	2	Dallas/Ft. Worth area	(214) 401-5310	MMP	55.21	164.84	25.48	76.08	Both	Yes	73-119
CIGNA Healthplan of Texas-Houston	UH	1	2	Houston area	(713) 552-7600	MMP	43.97	207.20	20.29	95.63	Both	No	73-124
Coastal Bend Health Plan	T5	1	2	Corpus Christi area	(512) 887-0101	IPP	39.66	172.10	18.30	79.43	Both	No	73-299
EQUICOR Healthplan of Houston	V1	1	2	Houston area	(713) 552-7600	IPP	43.97	207.20	20.29	95.63	Both	No	73-271
FIRSTCARE	CK	1	2	Potter/Randall/Carson/Armstrng Cos.	(806) 358-5151	IPP	91.26	195.37	42.12	90.17	Both	No	73-496
Harris Methodist Health Plan	SC	1	2	Ft. Worth/Dallas Metroplex	(817) 878-5880	IPP	82.27	175.85	37.97	81.16	Both	No	73-547
Humana Care Plan	UR	1	2	San Antonio area	(512) 617-1010	MMP	37.89	106.52	17.49	49.16	Both	Yes	73-70
Humana of Corpus Christi	TX	1	2	Corpus Christi area	(512) 994-2020	IPP	33.19	118.00	15.32	54.46	Both	No	73-237
Kaiser Texas	UK	1	2	Dallas/Ft. Worth area	(214) 458-8645	GPP	38.00	121.19	17.54	55.93	Both	No	73-63
PacifiCare of Texas	GF	1	2	San Antonio area	(512) 641-7838	MMP	33.64	94.19	15.52	43.47	Both	No	73-498
PCA Health Plans of Texas	TW	1	2	Austin/Waco/Temple/Bryan/College Station	1-800-234-7912	IPP	37.20	124.85	17.17	57.62	Both	No	73-198
PruCare Austin	UN	1	2	Austin area	(512) 465-6661	GPP	31.48	84.92	14.53	39.19	Both	No	73-91
PruCare Houston	UP	1	2	Houston Metro area	(713) 993-3801	GPP	28.63	83.25	13.21	38.42	Both	Yes	73-48
SANUS/New York Life Health Plan	UM	1	2	Houston Metro area	(713) 993-9982	MMP	43.51	172.45	20.08	79.59	Both	No	73-120
SANUS Texas Health Plan	V2	1	2	Dallas/Ft. Worth Metroplex	(214) 929-0376	IPP	40.62	125.89	18.75	58.10	Both	Yes	73-264
Scott and White Health Plan	UF	1	2	Bryan/College Station/Temple/Killeen/Waco	(817) 774-4000	GPP	41.04	141.81	18.94	65.45	Both	No	73-102
Southwest, an AETNA Health Plan	TS	1	2	Dallas/Ft. Worth area	1-800-992-7947	IPP	42.08	179.99	19.42	83.07	Both	No	73-572
<b>Utah</b>													
FHP/Utah	KU	1	2	Ogden/Salt Lake areas	(801) 355-1234	GPP	33.48	107.58	15.45	49.65	Both	Yes	73-564
PHP/UT	UT	1	2	Salt Lake City area (6 counties)	(801) 942-6967	IPP	43.36	93.23	20.01	43.03	Both	No	73-581
<b>Vermont</b>													
Community Health Plan	PW	1	2	Most of Vermont (7 Counties)	(802) 878-1008	MMP	37.64	105.20	17.37	48.55	Both	No	73-53
Harvard Community Health Plan, Inc.	68	1	2	Southern Vermont	(617) 739-6161	GPP	61.62	239.49	28.44	110.53	Both	Yes	73-21
Kaiser Massachusetts	K1	1	2	Southeastern Vermont	(413) 256-0151	GPP	49.66	114.71	22.92	52.94	Both	Yes	73-86
<b>Virginia</b>													
AETNA HEALTH PLAN	V8	1	2	Northern Virginia	1-800-537-5096	IPP	37.50	104.46	17.31	48.21	Both	Yes	73-250
CIGNA Healthplan of Virginia/Central VA	W3	1	2	Central Virginia	(804) 273-1150	IPP	38.28	126.84	17.67	58.54	Both	No	73-270

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Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features		Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>Virginia (cont.)</b>													
CIGNA Healthplan of Virginia/Southeast VA	W2	1	2	Southeastern Virginia	(804) 498-1555	IPP	39.48	139.73	18.22	64.49	Both	No	73-270
George Washington Univ HP (High)	E5	1	2	Washington, DC area	(202) 416-0400	MMP	60.91	128.79	28.11	59.44	Both	Yes	73-46
George Washington Univ HP (Std)	E5	4	5	Washington, DC area	(202) 416-0400	MMP	35.84	76.88	16.54	35.48	Both	Yes	73-46
Group Health Association (High)	50	1	2	Northern Virginia	(202) 966-4357	GPP	56.51	165.41	26.08	76.34	Both	Yes	73-8
Group Health Association (Std)	50	4	5	Northern Virginia	(202) 966-4357	GPP	28.97	73.80	13.37	34.06	Both	Yes	73-8
HealthPlus (High)	JN	1	2	DC Metro area	(301) 441-1600	IPP	40.13	94.34	18.52	43.54	Both	Yes	73-67
HealthPlus (Std)	JN	4	5	DC Metro area	(301) 441-1600	IPP	29.68	68.25	13.70	31.50	Both	Yes	73-67
HMO Virginia	V7	1	2	Hampton Roads area	(800) 421-1880	MMP	37.89	147.51	17.49	68.08	Both	No	73-235
HMO Virginia	X8	1	2	Richmond area	(804) 358-7390	MMP	39.70	160.16	18.32	73.92	Both	No	73-235
Kaiser/Mid-Atlantic	E3	1	2	Washington, DC area	(202) 364-3400	GPP	35.67	96.25	16.46	44.42	Both	Yes	73-47
Lincoln National Health Plan	DS	1	2	Northern Virginia	1-800-782-0622	IPP	43.38	142.20	20.02	65.63	Both	Yes	73-442
M.D. IPA	JP	1	2	Northern Virginia, Richmond and Tidewater	(301) 294-5100	IPP	31.03	87.66	14.32	40.46	Both	Yes	73-100
OPTIMA (High)	V9	1	2	Peninsula/Southside Hampton Roads	(804) 552-7410	IPP	66.98	150.91	30.91	69.65	Both	Yes	73-253
OPTIMA (Std)	V9	4	5	Peninsula/Southside Hampton Roads	(804) 552-7410	IPP	23.62	89.79	10.90	41.44	Both	Yes	73-253
Physicians Care	X9	1	2	DC Metro area	1-800-542-7258	IPP	52.03	229.50	24.01	105.92	Both	Yes	73-331
PruCare of Richmond	V6	1	2	Richmond area	(804) 323-0900	MMP	31.42	85.78	14.50	39.59	Both	No	73-132
Prudential Health Plan/Mid-Atlantic	HD	1	2	Northern Virginia	1-800-888-5447	MMP	41.43	165.65	19.12	76.45	Both	Yes	73-413
Sentara Health Plan	V5	1	2	Peninsula/Southside Hampton Roads	(804) 552-7110	MMP	55.73	118.87	25.72	54.86	Both	Yes	73-228
<b>Washington</b>													
Group Health Cooperative (High)	54	1	2	Puget Sound area	(206) 448-4140	MMP	55.15	164.00	25.45	75.69	HHC	Yes	73-12
Group Health Cooperative (Std)	54	4	5	Puget Sound area	(206) 448-4140	MMP	36.79	85.18	16.98	39.31	HHC	No	73-12
Group Health Northwest	VR	1	2	Spokane/Tri Cit./Yak./Ellens./Walla W.	(509) 783-3484	MMP	39.55	120.41	18.25	55.57	Both	Yes	73-96
Kaiser Northwest (High)	57	1	2	Vancouver/Longview	(503) 721-2000	GPP	41.40	124.31	19.11	57.37	Both	Yes	73-4
Kaiser Northwest (Std)	57	4	5	Vancouver/Longview	(503) 721-2000	GPP	35.06	89.34	16.18	41.23	Both	No	73-4
Kitsap Physicians Service (High)	VT	1	2	Kitsap, Mason, Jefferson Counties	1-800-552-7114	IPP	101.60	213.92	46.89	98.73	Both	No	73-51
Kitsap Physicians Service (Std)	VT	4	5	Kitsap, Mason, Jefferson Counties	1-800-552-7114	IPP	38.41	82.03	17.73	37.86	Both	Yes	73-51
Pacific Health Plans	WB	1	2	King/Snohomish/Kitsap/Pierce/Thurston	1-800-722-4666	MMP	32.87	89.71	15.17	41.40	Both	No	73-329
PacificCare of Oregon	SS	1	2	Clark County	1-800-922-1444	GPP	39.05	121.34	18.02	56.00	Both	No	73-362
Qual-Med Oregon	AF	1	2	Clark County	1-800-388-8335	IPP	38.56	121.01	17.80	55.85	Both	No	73-327
Qual-Med Washington	TM	1	2	Most of Washington	1-800-869-7165	IPP	39.18	127.64	18.08	58.91	Both	No	73-287

Prepaid Plan Name and Option	Enrollment Code			General Location	Plan Telephone Number	Plan Type	1992 Monthly Premium Your Share		1992 Biweekly Premium Your Share		Other Benefit Features		Brochure Number RI
	Plan Code	Self Only	Self & Family				Self Only	Self & Family	Self Only	Self & Family	ECF and/or HHC	Dental Care	
<b>Washington (cont.)</b>													
SelectCare	SD	1	2	Cowlitz & Wahkiakum Counties	(206) 577-4419	IPP	41.22	88.94	19.02	41.05	Both	No	73-83
<b>West Virginia</b>													
Free State Health Plan	LD	1	2	Portions of Northeastern WV	(301) 964-8168	MMP	39.11	139.56	18.05	64.41	Both	Yes	73-146
Health Guard	MA	1	2	Portions of West Virginia	(614) 676-4623	MMP	32.23	82.93	14.87	38.28	Both	No	73-504
Health Plan of the Upper Ohio Valley	U4	1	2	Northern West Virginia	(614) 695-3585	IPP	32.72	81.89	15.10	37.79	Both	No	73-553
<b>Wisconsin</b>													
Chicago HMO Ltd	FJ	1	2	Kenosha area	(312) 751-4460	MMP	36.38	124.46	16.79	57.44	Both	Yes	73-199
CompCare Health Services	69	1	2	Southeastern Wisconsin	(414) 226-6744	MMP	38.26	112.74	17.66	52.03	Both	Yes	73-22
DeanCare HMO	WD	1	2	South Central Wisconsin	(608) 828-1301	GPP	32.69	88.27	15.09	40.74	Both	No	73-189
Family Health Plan	WH	1	2	Metropolitan Milwaukee	(414) 256-0040	GPP	34.56	89.75	15.95	41.42	Both	Yes	73-81
Greater Marshfield Health Plan	WY	1	2	Marshfield and surrounding counties	(800) 472-2363	MMP	181.31	416.72	83.68	192.33	Both	Yes	73-38
Group Health Coop of Eau Claire	WT	1	2	West Central Wisconsin	(715) 836-8552	GPP	40.87	142.33	18.86	65.69	Both	No	73-552
Group Health Coop/South Central WI	WJ	1	2	Madison and adjacent areas	(608) 251-3356	GPP	31.79	84.82	14.67	39.15	Both	Yes	73-61
HMO Midwest	CV	1	2	West Central & Northwestern Wisconsin	(800) 535-4041	MMP	30.45	90.02	14.05	41.55	Both	No	73-454
HMO of Wisconsin	W4	1	2	Southern/Central Wisconsin	(800) 362-3308	IPP	37.55	115.01	17.33	53.08	Both	No	73-317
Maxicare Wisconsin	WG	1	2	Milwaukee area	(414) 271-6865	MMP	33.38	86.15	15.41	39.76	Both	Yes	73-179
Physicians Plus HMO	29	1	2	South Central Wisconsin	(608) 282-8505	MMP	38.45	116.96	17.74	53.98	Both	No	73-559
PrimeCare Health Plan, Inc.	WK	1	2	Milwaukee area	(414) 453-9070	IPP	41.20	129.59	19.01	59.81	Both	Yes	73-172
U-Care HMO	WC	1	2	Dane County area	(608) 833-6666	MMP	33.12	88.25	15.28	40.73	Both	Yes	73-562
Wisconsin Health Organization	X1	1	2	Southeastern Wisconsin	(414) 223-3300	IPP	36.36	95.25	16.78	43.96	Both	No	73-367

ABBREVIATIONS: ECF — Extended Care Facility    IPP — Individual Practice Plan  
 GPP — Group Practice Plan    MMP — Mixed Model Plan  
 HHC — Home Health Care



**FEDERAL EMPLOYEES  
HEALTH BENEFITS PROGRAM**

**INFORMATION FOR FEDERAL CIVILIAN EMPLOYEES  
AND U.S. POSTAL SERVICE EMPLOYEES**



United States  
Office of  
Personnel  
Management

FPM Supplement 890-1  
GSA Control No. 2809-219  
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SF 2809-A  
Rev. June 1990

## TO EMPLOYEES:

One of the benefits of working for the Government is the protection against the cost of medical care available to you through the Federal Employees Health Benefits (FEHB) Program. This pamphlet contains information about your rights and obligations under the Program and describes its major features. The information may be subject to change because of statutory or regulatory revisions that take effect after publication. Your employing office can give you the most up-to-date information.

To aid you in selecting the health care protection best suited to your needs, you should review the most current FEHB Enrollment Information Guide and Plan Comparison Chart applicable to you (see below) and the official brochure for the health benefits plan or plans in which you are interested. These may be obtained from your employing office.

UNITED STATES  
OFFICE OF PERSONNEL MANAGEMENT

### FEHB Enrollment Information Guide and Plan Comparison Chart Booklets for Employees

**RI 70-1** Federal Employees (Non-Postal)

**RI 70-2** Postal Employees

**RI 70-5** Individuals Eligible for Temporary Continuation of FEHB Coverage

**RI 70-6** Individuals Receiving Compensation from the Office of Workers' Compensation Programs (OWCP)

**RI 70-7** Employees in Positions Outside the Continental U.S. (including Alaska, Hawaii, Guam and Puerto Rico)

**RI 70-8** Temporary Employees Eligible for FEHB under 5 U.S.C. 8906a

**RI 70-10** Visually Impaired Employees

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## PARTICIPATION IS VOLUNTARY

The Federal Employees Health Benefits Program helps protect you and your eligible family members from the expenses of illness and accident. It is a voluntary program. Whether you enroll or not is entirely up to you; but, if you are eligible, you are encouraged to enroll for this protection. If you do enroll, you may cancel your enrollment at any time. If you don't enroll at your first opportunity, you won't be able to enroll until Open Season or until another event permitting enrollment occurs (see the table on page 13).

### IMPORTANT

You will not be eligible for health benefits coverage after retirement unless you are enrolled before you retire and meet all the requirements for continuation of enrollment after retirement (see page 8).

## WHO IS ELIGIBLE TO ENROLL

All permanent employees with regularly scheduled tours of duty and temporary employees whose appointments are for longer than one year are eligible to enroll in the FEHB Program. Also eligible to enroll are temporary employees with an appointment for one year or less who have completed one year of current, continuous employment, excluding any break in service of five days or less. Employees whose appointments are intermittent (without a prearranged regular tour of duty), or short-term (limited to one year or less) are not eligible to enroll.

## WHAT THE PROGRAM OFFERS YOU

- An opportunity, within 31 days from the date of your appointment (or from the date you become eligible), to enroll in a health benefits plan with group-rated premiums and benefits.
- An annual opportunity, during Open Season, to enroll in a health benefits plan if you are not already enrolled or, if you are enrolled, to change to another plan or option.
- A choice of plans and options so that you can get the kind and amount of protection best suited to your personal and family health needs and finances.
- Guaranteed protection that can't be canceled by the plan.
- Coverage without medical examination or restrictions because of age, current health or pre-existing medical conditions. (Plans may limit benefits for dentistry or cosmetic surgery to conditions arising after the effective date of coverage.)
- Coverage without waiting periods after the effective date of enrollment.
- Catastrophic protection against unusually large medical bills. (Fee-for-service plans limit the amount of covered expenses you would have to pay out-of-pocket for yourself and your family; prepaid plans provide or arrange for all necessary care.)

- A Government contribution toward the cost of your plan (unless you are a temporary employee required to pay both the Government and employee shares of the cost).
- The payroll deduction method of making premium payments.
- Extended protection for 31 days without cost to you after your enrollment or coverage of a family member ends (unless you voluntarily cancel).
- Under certain circumstances, an opportunity for temporary continuation of group coverage or conversion to nongroup coverage if your enrollment ends or a covered family member loses eligibility for coverage.
- If you meet certain requirements, continued protection for you and eligible family members after your retirement or while you are receiving compensation from the Office of Workers' Compensation Programs for a work-related injury.
- If certain conditions are met, continued protection for your eligible family members after your death.

## COST OF ENROLLMENT

Unless you are a temporary employee who is required to pay the total cost, you and the Government share the cost of your enrollment. Under current law, the Government pays 60 percent of the average high option premium of six of the largest health benefits plans in the Program, but not more than 75 percent of the total premium for any plan. (For Postal employees, the Postal Service pays 75 percent of the average of the "Big 6," but not more than 93.75 percent of the total premium.) After the Government contribution is deducted from the total cost, you pay the remainder of the premium through salary withholdings. Premiums are adjusted annually; the amount you would currently pay under any plan in the Program is shown in the most recent **Enrollment Information Guide and Plan Comparison Chart** applicable to you (see page 2).

Note 1: The formula utilized to compute the Government contribution has been modified for 1990 (and 1991), because of the departure from the FEHB Program of the Aetna Indemnity Plan, whose high option premium had been used in computing the Government's share prior to 1990.

Note 2: If you are a part-time employee appointed under the Federal Employees Part-Time Career Employment Act of 1978, you should contact your employing office for information about the cost of enrollment. Only a portion of the Government contribution is paid toward your total premium. Therefore, your share of the premium will be **greater** than the amount that appears in the Enrollment Information Guide and Plan Comparison Chart.

## TYPES OF PLANS AVAILABLE

The two basic types of health benefits plans available to you under the FEHB Program are fee-for-service plans and prepaid plans.

## Fee-for-Service Plans

These plans reimburse you or the health care provider for covered services. If you enroll in one of these plans, you may choose your own physician, hospital and other health care providers.

Fee-for-service plans include the Service Benefit Plan administered by Blue Cross and Blue Shield and plans sponsored by unions and other employee organizations.

The Blue Cross and Blue Shield plan is open to all Federal employees. Some employee organization plans are open to all Federal employees who hold full or associate memberships in the organizations that sponsor the plans; the other employee organization plans are restricted to employees in certain occupational groups and/or agencies. Generally, the employee organizations require you to pay a membership fee or dues in addition to your health plan premium. (Such membership charges are paid directly to the employee organizations and are not part of the FEHB Program.)

## Prepaid Plans

These are the Comprehensive Medical Plans/Health Maintenance Organizations (CMP/HMOs) that provide or arrange for health care by **designated** plan physicians, hospitals, and other providers in particular locations. CMP/HMOs are either Group Practice Plans, Individual Practice Plans or a combination of both (called Mixed Model Plans). Group Practice Plans provide care through a group of physicians who practice at medical centers operated by or under contract to the plans. Individual Practice Plans provide care through participating physicians who practice in their own offices.

Each CMP/HMO is open to all Federal employees who live within the plan's enrollment area. It is very important that you are sure you live in the plan's enrollment area before you enroll in one of these plans. The enrollment area is described in the plan's brochure.

## TYPES OF ENROLLMENT

Each FEHB plan has two types of enrollment: (1) self only and (2) self and family.

### Self Only Enrollment

This enrollment provides benefits only for you.

### Self and Family Enrollment

This enrollment provides benefits for you and your eligible family members.

### Family Members Eligible for Coverage

- Your spouse.
- Your unmarried dependent children under age 22, including legally adopted children.
- Your unmarried dependent recognized children under age 22 born out of wedlock:

Who live with you in a regular parent-child relationship; or

For whom a judicial determination of support has been obtained; or

To whose support you make regular and substantial contributions.

- Your unmarried dependent stepchildren under age 22 if they live with you in a regular parent-child relationship.
- Your unmarried dependent foster child (or children) under age 22 if:

The child (who may or may not be related to you) lives with you in a regular parent-child relationship; and

You are raising the child as your own, exercising full parental responsibility and control; and

You expect to continue to raise the child indefinitely into adulthood.

A child is not a foster child for health benefits purposes if:

The child is temporarily living with you as a matter of convenience; or

A welfare or social service agency places the child in your home and retains control of the child; or

A natural parent of the child also lives with you and is able to exercise or share parental responsibility and control.

- Your unmarried dependent children age 22 or over who are incapable of self-support because of physical or mental incapacity that existed before their 22nd birthday; the incapacity must be expected to last at least one year from the date of medical certification of incapacity. (Ask your employing office about the medical certification required for a child age 22 or over. If the child is not yet 22, you should submit the medical certificate to your employing office at least 30 days before the child's 22nd birthday.)

All eligible family members are covered under a self and family enrollment; you can't decide to cover some and exclude others. However, other relatives -- for example, your parents or grandchildren (unless a foster parent-child relationship exists) -- are not eligible for coverage as family members even though they live with you and are dependent upon you.

## Events Causing Family Members to Lose Eligibility for Coverage

If family member is----	Event----
Your wife or husband . . .	Divorce or annulment of marriage.
A child under age 22 . . .	Marriage or attainment of age 22. (A child whose marriage ends before age 22 may again become eligible.)

Note: You will **not** be notified by either your employing office or your plan when your child loses eligibility because of age. As indicated on page 11, if your child wants to temporarily continue group coverage, you must notify **your employing office** of the child's loss of eligibility for coverage as a family member within **60 days** after his or her 22nd birthday; if he or she wants to convert to nongroup coverage, you or the child must apply to the **carrier of your plan** for a conversion contract within **31 days** after his or her 22nd birthday.

A disabled child age 22  
or over . . . . .

Marriage or recovery of ability  
for self-support.

- Family members lose eligibility for coverage on the day that any of the above events occurs, subject to the 31-day extension of coverage for conversion to a nongroup health benefits contract (see page 10).
- You do not have to notify your employing office when a family member loses eligibility for coverage if at least one other eligible family member remains covered by your self and family enrollment. However, if your spouse loses eligibility because of your divorce, you should promptly notify your plan in writing. (See also Enrollment of Former Spouses below, Conversion Rights on page 10 and Temporary Continuation of Coverage on page 10.)
- If you become the only person covered by your self and family enrollment, you may immediately change to a less expensive self only enrollment. To do this, obtain a Health Benefits Registration Form (Standard Form (SF) 2809) from your employing office, complete the form and return it to your employing office.

## Coverage of New Family Members

### Self Only Enrollment

You must change to a self and family enrollment if you want to provide coverage for a new family member, *e.g.*, a newborn child or a new spouse. To do this, find the event that permits the change in the table on page 13 to determine when you can change. Then complete an SF 2809 and give it to your employing office within 60 days after a change in family status or anytime between 31 days before and 60 days after a change in marital status.

### Self and Family Enrollment

A new family member is automatically covered under your self and family enrollment, but your plan may ask you for information to verify the family member's eligibility when a claim for benefits is filed for that person.

## IMPORTANT

Your employing office does not monitor changes in your marital or family status and will not automatically change your enrollment. If you need to change your enrollment from self only to self and family or vice versa, you must file an SF 2809 with your employing office. See the table on page 13 to find out when such changes may be made.

## ENROLLMENT OF FORMER SPOUSES

Certain former spouses of employees (and of former employees and annuitants), whose marriage ended before the employee's (or former employee's or annuitant's) death, may enroll in the FEHB Program under the Spouse Equity law or similar statutes. Once enrolled, former spouses must pay the total premium for the plan they select, including the Government share. (See Cost of Enrollment on page 4). For further information about the enrollment of former spouses, contact your employing office.

Note: Former spouses who are not eligible to enroll under the Spouse Equity law (or similar statutes) may be eligible to continue FEHB coverage on a temporary basis (see page 10 ).

## DUAL ENROLLMENT

Normally, you may not enroll or be enrolled as an employee if you are covered as a family member under someone else's enrollment in the FEHB Program. However, such dual enrollments may be permitted under certain circumstances in order to --

- Protect the interests of children who otherwise would lose coverage as family members, or
- Enable an employee who is under age 22 and covered under a parent's enrollment and becomes the parent of a child to enroll for self and family coverage.

No person (employee or family member) is entitled to receive benefits under more than one enrollment in the Program.

Your employing office can give you details about permissible dual enrollments.

## OPPORTUNITIES TO ENROLL OR CHANGE ENROLLMENT

### New or Newly Eligible Employees

You are required to complete a Health Benefits Registration Form (Standard Form (SF) 2809) obtained from your employing office. You must indicate on the form whether you want to enroll or do not want to enroll in an FEHB plan.

You must return the completed SF 2809 to your employing office:

**Within 31 days after----**      **If you are a----**

Your date of appointment . . . . New employee.

The date you become eligible to enroll . . . . . Newly eligible employee.

**All Eligible Employees**

If you are not enrolled, you will be able to enroll only when an event permitting enrollment occurs. Such events, which are listed in the table on page 13, include (but are not limited to) --

- Open Season.
- Change in marital status.
- Loss of coverage as a family member under FEHB.
- Loss of coverage under spouse's non-Federal health plan if spouse **involuntarily** loses his or her coverage or coverage for his or her dependents.

If you are enrolled, you may change your enrollment only when an event permitting the change you want to make occurs (see table). However, you may change from self and family to self only at any time.

To enroll or change your enrollment, obtain an SF 2809 from your employing office, complete the form and return it to your employing office within the time limit specified in the table for the event permitting the enrollment or enrollment change.

**IMPORTANT**

You will not be eligible for health benefits coverage after retirement unless you are enrolled before you retire and meet all the requirements for continuation of enrollment after retirement (see page 8).

**Temporary Employees Eligible for FEHB Under 5 U.S.C. 8906a**

If you are a temporary employee with an appointment for one year or less who has completed one year of current continuous employment, excluding any break in service of five days or less, you are eligible under section 8906a of the FEHB law to participate in the FEHB Program. All of the above enrollment and enrollment change information applies to you with one exception. A decision not to enroll will not affect your future eligibility to continue FEHB enrollment after retirement (see page 8).

**EFFECTIVE DATES**

In general, enrollments and enrollment changes take effect on the first day of the pay period that begins after your employing office receives your completed SF 2809 and follows a pay period during any part of which you were in a pay status. (The

pay status requirement doesn't apply to a change from self and family to self only.)

There are exceptions --

- **Open Season.** Your employing office can give you the specific day on which your enrollment or enrollment change will take effect.
- **Change from Self Only to Self and Family Due to the Birth or Addition of a Child as a New Family Member.** This change takes effect on the first day of the pay period in which the child is born or becomes an eligible family member, regardless of your pay status.
- **Cancellation.** See page 9.

Additional information about effective dates appears in the table on page 13.

Note: If you change plans or change options in your current plan, and you or a family member covered by your prior plan or option are confined in a hospital on the date your enrollment change takes effect, benefits of the prior plan or option will continue temporarily for the confined person. Benefits will continue (unless they are exhausted) for each additional day of continuous confinement through the 91st day after the date your enrollment change takes effect. Benefits of the new plan or option will not begin for the confined person until the day after his or her confinement ends or the 92nd day after the date your enrollment change takes effect, whichever is earlier.

**IDENTIFICATION CARDS**

Once your enrollment or enrollment change is processed, your plan will send you an identification card. However, you should keep the copy of the SF 2809 your employing office gives you for your records. If you need to obtain benefits before you receive your identification card, contact your plan for assistance and use your copy of the SF 2809 as proof of your enrollment or enrollment change. Do not send bills or claims to your employing office or the Office of Personnel Management.

**COORDINATION OF BENEFITS**

**Double Coverage**

Because many people covered by FEHB plans also have other health care protection, all FEHB plans have a coordination of benefits (COB), or double coverage, provision. The provision applies when a person covered by an FEHB plan is also entitled to benefits under any other kind of group health insurance, Medicare or no-fault or other automobile insurance that pays benefits without regard to fault. The purpose of the provision is to enable enrollees and covered family members to recover as much of their health care expenses as their total coverage permits, but not more than the actual charges for the care. Under COB, or double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. The combined amount paid by both plans will usually equal 100% of covered, or allowable, expenses.

Say, for example, that a person with double coverage is charged \$100.00 for medical services received, that the actual charge is an allowable expense of both plans, and that the benefit of each plan is 80% of the allowable expense. Normally, the plan designated as the primary payer would pay \$80.00, or its benefit in full, and the plan designated as the secondary payer would pay only the remaining \$20.00.

Except for Medicare, primary and secondary payers are determined according to the guidelines of the National Association of Insurance Commissioners. Generally, the plan that covers you as an enrollee is the primary payer; the plan that covers you as a family member is the secondary payer.

The COB provision helps reduce the FEHB plan premium that you pay.

### FEHB Plans and Medicare

Plans under the FEHB Program typically provide protection against the same kinds of expenses as Medicare, which has two parts (Part A, hospital insurance, and Part B, medical insurance). Under the law, if you're an employee age 65 or over and have Part A, your FEHB plan is the primary payer and Medicare is the secondary payer of benefits provided under both your plan and Medicare Part A or Part B. Medicare is also the secondary payer of mutually provided benefits for your covered spouse, regardless of your age, if he or she is age 65 or over and has Part A.

Note: After you retire, Medicare will become the primary payer and your FEHB plan will be the secondary payer for you (unless you are reemployed by the Government), and for your covered spouse (unless he or she is employed by the Government).

In addition, your FEHB plan is the primary payer and Medicare is the secondary payer of mutually provided benefits for an End Stage Renal Disease (ESRD) Medicare beneficiary under age 65 within the first 12 months of ESRD care. Also, your FEHB plan is the primary payer and Medicare is the secondary payer for a person under age 65 entitled to Medicare on the basis of disability.

### FEHB Plans and Uniformed Services Health Benefits Program

If you are eligible for health care coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), your FEHB plan is the primary payer of benefits, and CHAMPUS is the secondary payer.

## CIRCUMSTANCES PERMITTING CONTINUATION OF ENROLLMENT

### Transfer

Your enrollment will continue without change if --

- You transfer to (or are reemployed by) another Federal agency without a break in service of more than three calendar days, and

- You are eligible for FEHB Program coverage in your new position.

Note: If you are not enrolled in an FEHB plan at the time you transfer, you will have an opportunity to enroll if you have a break in service of more than three days and you are eligible for FEHB coverage in the new position.

### Leave Without Pay (LWOP)

If you go on LWOP (or your pay isn't enough to cover your share of the premium), your enrollment will continue for up to one year, unless you cancel it (see page 9). However, you are responsible for paying your share of the premium. Your employing office will tell you how to make the premium payments.

### Military Service

Your enrollment will continue without change if you enter on active duty in the military service for 30 days or less.

If you enter on active duty for more than 30 days, your enrollment will continue for up to one year, unless you elect to have the enrollment terminated (see page 9). You are responsible, however, for paying your share of the premium (your employing office will explain how to make the premium payments). If you elect to have your enrollment terminated, it will be reinstated at the time you exercise your reemployment rights and return to civilian service. (You may also change your enrollment, or enroll if you were not enrolled when you entered on active duty, within 31 days after returning to civilian service.)

Your decision to have your enrollment terminated will not affect your future eligibility to continue FEHB enrollment after retirement (see below).

### Retirement

Your enrollment will continue without change in benefits or cost (except that Postal Service retirees will pay the same share of the premium as other Federal retirees) if you retire --

- Under a retirement system for Federal civilian employees and
- On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in an FEHB plan for --

- The five years of service immediately before retirement, or
- If fewer than five years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 31 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

Note 1: "Service" means service in which you were eligible to be enrolled in an FEHB plan under conditions that permitted a Government contribution toward the enrollment. Your enrollment (or coverage) need not have been in the same plan, but it must have been in one or more FEHB plans. Coverage under a non-FEHB plan is not creditable toward meeting the five-year or first-opportunity requirement. (In some circumstances, if you are enrolled in an FEHB plan at the time of retirement, your past coverage under CHAMPUS may be creditable toward meeting the five-year or first opportunity requirement. Contact your employing office for details.)

Note 2: While the Office of Personnel Management has the authority to waive the five-year requirement for continuation of enrollment after retirement, **this authority is limited to extraordinary situations only and is rarely exercised.**

### Workers' Compensation

Your enrollment continues while you are receiving compensation from the Office of Workers' Compensation Programs if the Secretary of Labor determines that you are unable to return to duty **and** if you were enrolled in the FEHB Program (or covered as a family member) for (1) the five years of service immediately before the compensation started, or (2) all service since your first opportunity to enroll. (Notes 1 and 2 above also apply to Workers' Compensation.)

### Death

If you die while you are enrolled for self and family, the enrollment will continue for your eligible survivor annuitants and other eligible family members with no change in benefits or cost. (However, survivors of deceased Postal Service employees will pay the same share of the premium as other Federal survivor annuitants.) If there is only one survivor annuitant, and he or she is the sole eligible family member, the enrollment will be changed automatically to self only, with a corresponding reduction in cost.

## CANCELLATION OF ENROLLMENT

You may voluntarily cancel your enrollment at any time by submitting a properly completed Standard Form (SF) 2809 to your employing office.

However, if you cancel your enrollment, neither you nor any family member covered by your enrollment will be entitled to a 31-day extension of coverage for conversion to nongroup coverage (see page 10). Moreover, family members who lose coverage because of your cancellation will not be eligible for temporary continuation of coverage (see page 10).

### Effective Date of Cancellation

If you are on a biweekly pay period --

- The cancellation will take effect on the last day of the pay period in which your employing office receives your SF 2809.

If you are on a monthly or 4-week pay period, and your employing office receives your SF 2809 --

- More than 15 days before the end of the pay period, the cancellation will take effect on the last day of that pay period.
- Less than 15 days before the end of the pay period, the cancellation will take effect on the last day of the following pay period.

Note: If you intend to be covered by someone else's enrollment at the time you cancel and wish to avoid a gap in your coverage, you should coordinate the effective date of your cancellation with the effective date of your new coverage. (See page 7 for additional information on effective dates.)

Once your cancellation becomes effective, you may not enroll again until an event occurs that permits enrollment, such as marriage or Open Season (see the table on page 13).

In addition, you will **not** be eligible for health benefits coverage after retirement unless you reenroll before you retire and meet all the requirements for continuation of enrollment after retirement (see page 8).

Note: Some employees who cancel their enrollment may plan to reenroll in time to qualify for FEHB coverage as a retiree; however, there is always the risk that they will have to retire earlier than expected (e.g., due to disability or involuntary separation) and not be able to meet the five-year requirement for continuing FEHB coverage into retirement. Please understand that when you cancel your enrollment **you are voluntarily accepting this risk.** An alternative would be to change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

## TERMINATION OF ENROLLMENT

Your enrollment will end on the last day of the pay period in which --

- You are separated from your job, unless you are separated under circumstances that allow you to continue your enrollment (see page 8).
- You become ineligible for coverage because of a change in your employment status.
- You die, and there is no eligible survivor annuitant to continue the enrollment.

Your enrollment also will end on --

- The last day of the pay period that includes your 365th day of continuous nonpay status.
- The day you are separated, furloughed or placed on leave of absence to enter military service for more than

30 days, if you elect to have your enrollment terminated (see page 8).

## 31-DAY EXTENSION OF COVERAGE

Your coverage will continue for 31 days after your enrollment ends for any reason except voluntary cancellation in order to give you the opportunity to convert to an individual (nongroup) health benefits contract.

If you are confined in a hospital on the 31st day, the benefits under your FEHB plan will continue for up to 60 more days of continuous confinement.

These extensions of coverage are without cost to you and also apply to your family members who lose coverage for any reason except your voluntary cancellation.

## CONVERSION RIGHTS

- If your enrollment ends for any reason except voluntary cancellation, you may convert to nongroup coverage without giving evidence of good health.
- Any member of your family who loses coverage for any reason except your voluntary cancellation may also convert to nongroup coverage.
- Nongroup coverage under a conversion contract is available **only** from the carrier of the FEHB plan you are enrolled in when your enrollment ends.

### Applying for a Conversion Contract

Within 60 days after your enrollment ends, your employing office **must** give you a notice of termination of your enrollment and the right to convert to an individual contract with the carrier of your plan.

If you want to convert to nongroup coverage, write for information to the nearest office of your plan within:

- 91 days after your enrollment ends, or
- 31 days after the date the notice was signed by an authorized official, whichever is earlier.

Note: If you don't receive the notice within 60 days after your enrollment ends, or you can show that you did not apply for a conversion contract in a timely manner for reasons beyond your control, you may request conversion to nongroup coverage by writing to your plan within six months from the day on which your enrollment ends. Your request must be accompanied by verification of your loss of FEHB coverage, e.g., a Standard Form 50 showing your separation from the service.

If a member of your family wants to convert to nongroup coverage, you or the family member should write to the

nearest office of your plan within 31 days after the family member's FEHB coverage ends. (Although you will be notified when **your** enrollment ends, no one will notify you or the family member when he or she loses coverage.)

The carrier will then send you or the family member an application form as well as benefit and cost information about the nongroup coverage.

### Effective Date of a Conversion Contract

Nongroup coverage takes effect at the end of the 31-day extension of coverage described above. This is true even if you or a family member are confined in a hospital on the 31st day and continue to receive benefits for that confinement under your FEHB plan for up to 60 more days.

### Some Basic Differences Between a Conversion Contract and an FEHB Plan

- Nongroup benefits and premiums are not subject to Government review and approval.
- The benefits available under a conversion contract may not be the same as those under your FEHB plan. In fact, many carriers provide fewer benefits under their nongroup contracts.
- Nongroup coverage is likely to cost you more because the Government doesn't pay part of the premium, and you will not have the advantage of a "group rate."

## TEMPORARY CONTINUATION OF COVERAGE

If your enrollment is terminated because you separate from service on or after January 1, 1990, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program after separation. Temporary continuation of coverage is available to you if your separation is voluntary or involuntary (unless it is for gross misconduct), and you would not otherwise be eligible for continued coverage under the Program. An example is separation for retirement when you are unable to meet the requirements for continuation of enrollment after retirement (see page 8).

Your temporary coverage continues for up to 18 months after your separation from service, and you must pay the total premium (both the Government and employee shares), plus a charge for administrative expenses of 2% of the total premium. When your temporary continuation of coverage ends (except by cancellation or nonpayment of premiums), you will be entitled to a 31-day extension of coverage for conversion to nongroup coverage (see above).

### Electing Temporary Continuation of Coverage

Your employing office will notify you of your opportunity to elect temporary continuation of coverage within 61 days after your enrollment terminates because of separation from service. You have 60 days after separation (or after receiving the notice, if later) to elect continued coverage. Complete a Standard Form (SF) 2809 obtained from your employing office. You may choose --

- The same plan, option and type of enrollment that covered you at the time of separation; or

- Any other plan (for which you are eligible), option or type of enrollment.

Return the properly completed form to the employing office within the 60-day time limit.

### Effective Date of Coverage

Your temporary continuation of coverage takes effect on the day after the 31-day extension of coverage described on page 10. Coverage is retroactive if you return the SF 2809 to the employing office after the 31-day extension period ends.

### Other Individuals Eligible for Temporary Continuation of Coverage

On and after January 1, 1990, children who lose FEHB coverage and former spouses who are not eligible to enroll in the FEHB Program under the Spouse Equity law or similar statutes (see page 6) may also be eligible for temporary continuation of coverage. Their temporary coverage continues for up to 36 months after the qualifying event occurs, e.g., child reaches age 22 or divorce.

Child and former spouse enrollees also must pay the total premium plus the 2% administrative charge and are entitled to a 31-day extension of coverage for conversion to non-group coverage when their temporary continuation of coverage ends (except by cancellation or nonpayment of premiums).

If temporary continuation of coverage is desired for your child or former spouse, **your employing office must be notified when the child or former spouse becomes eligible.** For a child, you must notify the employing office within 60 days after the qualifying event occurs. For a former spouse, you or the former spouse must notify the employing office within 60 days after the former spouse's change in status. The employing office then notifies the child or the former spouse of his or her temporary continuation of coverage rights. If a child wants continued coverage, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants continued coverage, he or she must make the election within 60 days after the later of:

- The date of the qualifying event;
- The date he or she loses coverage as an enrolled former

spouse because of remarriage or loss of qualifying court order; or

- The date he or she receives the notice.

Note: In the case of a child who becomes eligible for temporary continuation of coverage, if the employing office is not notified by the enrollee within the 60-day time limit, the opportunity to elect continued coverage ends 60 days after the qualifying event; in the case of a former spouse, if the employing office is not notified by the enrollee or the former spouse within the 60-day time limit, the opportunity to elect continued coverage ends 60 days after the change in status. If someone other than the enrollee notifies the employing office about a child's eligibility (or someone other than the enrollee or former spouse, in the case of a former spouse's eligibility), the employing office notifies the child (or former spouse) of his or her temporary continuation of coverage rights, but no additional time is given.

For a child who elects temporary continuation of coverage, the effective date of coverage is the same as described above. For a former spouse who elects temporary continuation of coverage, the effective date of coverage is the same as described above or the date of the qualifying event, if later.

### COST CONTAINMENT

To ensure that enrollees and covered family members receive the best quality of care in an environment of constantly rising health care costs, all FEHB plans have instituted cost containment programs. These programs, which include, for example, precertification of hospital admissions and case management, are designed to help make sure that services are performed at the right time, in the right place and at the right price. It is important that you and your covered family members be sound consumers of health care services and adhere to the cost containment programs your plan has established.

## REVIEW OF CLAIMS

Read the plan brochure to become familiar with your plan's benefits and claims procedures. Questions concerning benefits, claim payments and claim processing **must** be addressed to your plan. The Office of Personnel Management (OPM) does not pay or process claims.

If your plan denies your claim for payment or for service, it will reconsider the denial upon receipt of a written request within one year of the denial. The written request should state, in terms of applicable brochure provisions, the reasons you believe the denied claim for payment or service should have been paid or provided. Within 30 days after receipt of your request for reconsideration, the plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information from you or your health care provider reasonably necessary for making a determination. (Your plan must notify you if it has requested additional information from your provider.) If this information is not supplied within 60 days, the plan will base its decision on the information it has on hand. If the plan affirms its denial, you have a right to a review by OPM to determine whether the plan has acted in accordance with its contract. Before seeking OPM review of a claim, these are some of the things you should keep in mind:

- Do not submit initial bills from providers for payment to the below address or any other office within OPM; send them to the plan along with the appropriate claim form.
- Providers may use this procedure only on behalf of and with the specific written consent of the member, and are required to demonstrate that the member has assigned all of his or her rights to the provider with regard to that particular claim.
- You should first check with your provider or facility to be sure the plan was billed correctly; for instance, was the correct procedure code(s) used, were complications correctly indicated on the billing or operative report, etc. Reasonable and customary (R&C) allowances are determined and controlled solely by the plan based upon information available to it.

- Along with your request for review, you must send a copy of the plan's reconsideration decision.

OPM review may be obtained by writing to:

U.S. Office of Personnel Management  
Insurance Review Division  
Retirement and Insurance Group  
P.O. Box 436  
Washington, D.C. 20044

OPM must receive your request for review, along with a copy of your letter to the plan and its reply, within 90 days of the plan's affirmation of the denial. You may also ask OPM for a review if the plan fails to respond within 30 days to your written request for reconsideration or within 30 days after you have supplied additional information. In this case, OPM must receive a request for review within 120 days of your request to the plan for reconsideration or the date you were notified that the plan needed additional information. In your request for review, show (1) the date of your request to the plan or (2) the dates the plan requested and you provided additional information to the plan. OPM will notify you and the plan of its decision.

If you decide to seek judicial review of the denial of a claim, you must file suit no later than December 31 of the third year after the year in which the care or service was provided, or two years after a final determination has been made on the claim by OPM through the disputed claims process, whichever is later. Federal law governs claims for relief that relate to benefits under an FEHB plan. Damages recoverable under Federal law are limited to the amount of benefits in dispute, plus simple interest and court costs. Under Federal regulations (5 CFR 890.107), such legal actions should be brought against the carrier of your plan.

Privacy Act Statement -- If you request OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S. Code, to use the information collected from you and the plan to determine if the plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the plan in support of OPM's decision on the disputed claim.

**TABLE OF PERMISSIBLE CHANGES IN ENROLLMENT**  
**Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time**

No.	Events That Permit Enrollment Change  Event	Change Permitted			Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
		From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	
1	Open Season.	Yes* †	Yes	Yes	As announced by the Office of Personnel Management.
2	Change in marital status. (Marriage, divorce, annulment, death of spouse.)	Yes* †	Yes (Except former spouses)	Yes (Except former spouses)	From 31 days before to 60 days after change in marital status.
3	Other change in family status. (For example, birth of a child, legal separation, discharge from military service of a spouse or of a child under age 22).	No	Yes	No	Within 60 days after change in family status.
4	Move from an area served by a prepaid plan (CMP/HMO) in which enrolled at time of move.	Does not apply	Yes	Yes	At any time after move.
5	Termination of enrollment by employee organization plan because of termination of membership in organization.	Does not apply	No	Yes	Within 31 days after termination of enrollment in plan.
6	Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage other than by cancellation or change to Self Only of the covering enrollment; or employee, covered under Retired Federal Employees Health Benefits Program or under another federally sponsored health benefits program, loses such coverage for any reason.	Yes*	Does not apply	Does not apply	Within 31 days after termination (except, for employees, within 60 days after the death of the enrollee). Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.
7	Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage because of change of the covering enrollment from Family to Self Only.	Yes, for Self Only*	Does not apply	Does not apply	Within 31 days after change of covering enrollment has been filed. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the change to Self Only was filed, there will be a break in coverage.
8	Employee transfers to overseas post of duty from the United States, or reverse.	Yes*	Yes	Yes	Within 31 days before or after move.
9	Employee returns to active civilian duty or annuitant separates from military service which was not limited to 30 days or less.	Yes* †	Yes	Yes	Within 31 days after return to active civilian duty or separation from military service.
10	Your plan stops participating in the FEHB Program.	Does not apply	Yes	Yes	As set by the Office of Personnel Management.
11	Self Only enrollment under this Program of employee's or annuitant's spouse terminates as a result of change in spouse's Federal employment status or 365 days' nonpay status.	No	Yes	No	Within 31 days after termination of spouse's enrollment. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.
12	Employee who is not enrolled loses coverage under parent's non-Federal health plan.	Yes*	Does not apply	Does not apply	Within 31 days after loss of coverage, except within 60 days after the death of the parent.
13	Enrolled employee retires from overseas post of duty and is eligible to continue enrollment as annuitant.	Does not apply	Yes	Yes	Within 60 days after retirement.
14	Enrollee becomes eligible for Medicare.	Does not apply	No	Yes	At any time beginning 30 days before becoming eligible for Medicare.
15	Enrollee's eligible child (or children) loses coverage under another's FEHB enrollment.	No	Yes	No	Within 31 days after child's (children's) loss of coverage. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but after expiration of the 31-day extension of coverage (or too close to the expiration of the 31-day extension of coverage), there will be a break in coverage.

\* Individuals must be otherwise eligible to enroll.  
† Employees only.

\*\* Also selected effective date information.

No.	Events That Permit Enrollment Change Event	Change Permitted			Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
		From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	
16	Employee loses coverage under Medicaid (State program of medical assistance for the needy).	Yes*	Does not apply	Does not apply	Within 31 days after termination of Medicaid.
17	Employee, annuitant or former spouse (spouse equity), covered as a family member under another's FEHB enrollment, loses coverage due to cancellation of the covering enrollment.	Yes*	Does not apply		You must enroll in the same plan and option as that from which coverage is lost, if eligible to enroll in that plan, within 31 days after cancellation of the covering enrollment. If not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day period. Coverage is effective the first day of the pay period that begins after the employing office receives the SF 2809. If election is made within the time limit, but during a pay period following the one in which the cancellation was filed, there will be a break in coverage.
18	Enrolled employee's employment status changes from full-time to part-time career employment as defined in the Federal Employees Part-Time Career Employment Act of 1978.	No	No	Yes	Within 31 days after the change in employment status.
19	Employee or employee's spouse loses coverage under spouse's non-Federal health plan when spouse terminates employment to accompany employee whose reassignment is directed out of commuting area.	Yes*	Yes	No	Within 31 days before or after move.
20	Employee's or annuitant's spouse involuntarily loses his or her non-Federal health insurance coverage, or coverage for his or her dependents; or employee's or annuitant's eligible child (or children) loses non-Federal coverage under the other parent's health plan because the other parent involuntarily loses coverage for his or her dependents.	Yes* †	Yes	No	Within 31 days before or after spouse's or dependent's loss of coverage; or within 31 days before or after child's (or children's) loss of coverage.
21	Former spouse who is eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).	Yes*	Does not apply	Does not apply	Generally, within 60 days after divorce. If divorce occurs after Federal employee retires, within 60 days after divorce or 60 days after retiree election of a survivor annuity for the former spouse. Certain former spouses of employees who retired before May 7, 1985, may be subject to a different time limit and should contact the employee's retirement system for additional information.
22	Temporary employee completes one year of service in accordance with 5 U.S.C. 8906a.	Yes*	Does not apply	Does not apply	Within 31 days after becoming eligible.
23	Temporary employee, eligible under 5 U.S.C. 8906a, changes to a nontemporary appointment.	Yes*	Yes	Yes	Within 31 days after changing to non-temporary appointment.
24	Employee separated from service and eligible for temporary continuation of coverage.	Does not apply	Yes	Yes	Within 60 days after the later of: separation; or receiving notice of the opportunity to elect temporary continuation of coverage. Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.
25	Child of employee, former employee or annuitant stops meeting the requirements for unmarried dependent children.	Yes*	Does not apply	Does not apply	Within 60 days after the later of: the qualifying event; or the child's receiving notice of the opportunity to elect temporary continuation of coverage (based on the enrollee's notification to the employing office of the child's eligibility). Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage. If election is made after the end of the 31-day extension of coverage, the effective date will be retroactive.

\* Individuals must be otherwise eligible to enroll.

\*\* Also selected effective date information.

† Employees only.

No.	Events That Permit Enrollment Change  Event	Change Permitted			Time Limit in Which Registration Form Electing Change Must Be Filed With Employing Office**
		From Not Enrolled to Enrolled	From Self Only to Family	From One Plan or Option to Another	
26	Former spouse meets the requirement in 5 U.S.C. 8901(10) of having been enrolled in an FEHB plan as a covered family member at some time during the 18 months before the marriage ended, but does not meet one or both of the other two requirements of 5 U.S.C. 8901(10).	Yes*	Does not apply	Does not apply	Within 60 days after the later of: the qualifying event; the date coverage under Subpart H of 5 CFR Part 890 was lost, if the loss occurred within 36 months of the qualifying event; or the former spouse's receiving notice of the opportunity to elect temporary continuation of coverage (based on the enrollee's or former spouse's notification to the employing office of the former spouse's eligibility). Coverage is effective the day after other FEHB coverage ends, including the 31-day extension of coverage; or the date of the qualifying event, if later. If election is made after the end of the 31-day extension of coverage or the date of the qualifying event, the effective date will be retroactive.
27	Former employee, former spouse or child whose temporary continuation of coverage under 5 CFR Part 890 Subpart K terminates due to other FEHB coverage, loses the other FEHB coverage.	Yes*	Does not apply		You must reenroll in the same plan and option as that in which you were enrolled prior to obtaining the other FEHB coverage, if eligible to enroll in that plan, within 31 days after the other coverage ends, but not later than the expiration of the period of eligibility for the temporary continuation of coverage. If not eligible to enroll in that plan, you may enroll in the same option of any available plan within the 31-day time limit.

\* Individuals must be otherwise eligible to enroll.

† Employees only.

\*\* Also selected effective date information.