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Blue Cross® and Blue Shield® Service Benefit Plan

1994

A Government-wide Plan Administered by the Blue Cross and Blue Shield Association

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP.

		*Non-Postal Premium				**Postal Premium—Biweekly			
		Biweekly		Monthly		Category A		Category B	
Type of enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
High Option Self Only	101	$ 66.20	$ 74.02	$143.43	$160.38	$ 81.64	$ 58.58	$ 82.75	$ 57.47
High Option Self and Family	102	$141.42	$158.42	$306.41	$343.24	$174.42	$125.42	$176.77	$123.07
Standard Option Self Only	104	$ 62.88	$ 20.96	$136.24	$ 45.41	$ 77.55	$ 6.29	$ 78.60	$ 5.24
Standard Option Self and Family	105	$140.20	$ 46.73	$303.77	$101.25	$172.91	$ 14.02	$175.25	$ 11.68

* Non-Postal rates do not apply to all enrollees. If you are in a special enrollment category, refer to your FEHB Guide or contact the agency that maintains your health benefits enrollment.

** Postal rates apply to United States Postal Service employees as described on page 2.

Authorized for distribution by the

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 71-5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

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Number of Pages (Including Cover): 19

Comments: 1st of 2 transmission revised chart apparently fax did not go through last night

Statistics pg. 3 because of summary sheet

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS/BLUE SHIELD	HEALTH SECURITY ACT
INPATIENT HOSPITAL SERVICES Includes intensive care, semiprivate accommodations, private room if medically necessary to prevent contagion, drugs and medical supplies. Precertification required to determine medical necessity (benefits reduced $500 per admission if consent is not obtained). Cost sharing: •PPO/preferred hospitals - No per admission deductible, Standard Option pays in full for unlimited days. •Member hospitals - After $250 per admission deductible, Standard Option pays in full for unlimited days. •Non-member hospitals - After $250 per admission deductible, Standard Option pays 70% of billed charge or average charge.	HOSPITAL SERVICES Includes inpatient hospital services (defined as bed and board, nursing, medical social services, drugs, biologicals, medical supplies, and diagnostic or therapeutic items and services), outpatient hospital services and emergency services. Cost sharing: •Lower - no copayment for inpatient services. - $10 copayment for outpatient services. - $25 for emergency room, unless patient has emergency medical condition. •Higher - 20% of applicable payment rate.

5/4/94

~~4/27/94~~

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS/BLUE SHIELD	HEALTH SECURITY ACT
PHYSICIAN CARE - Includes home and office visits, physicians' outpatient consultations, and second surgical opinions •Physician is defined as doctors of medicine, osteopathy, dental surgery, medical dentistry, podiatric medicine and optometry, when acting within the scope of their licenses. •Other covered providers (when services are performed within the scope of their license or certification) - qualified clinical psychologist - nurse midwife - nurse practitioner/ clinical specialist - clinical social worker - nursing school administered clinic - in states designated as medically underserved areas, any licensed medical practitioner Cost sharing: • PPO/preferred physicians - $10 copayment for each visit. • Participating physicians - After $200 calendar year deductible, 75% of usual, customary and reasonable charges (UCR). • Non-participating physicians - After $200 calendar year deductible, 75% UCR.	HEALTH PROFESSIONAL SERVICES Includes home, office, inpatient and outpatient visits and consultations. Also includes services and supplies commonly furnished as incident to health professional services. Health professional services are defined as professional services that are lawfully provided by a physician or those services provided by another person who is lawfully authorized to provide those services. Cost sharing: •Lower -$10 per visit •Higher - 20% of applicable payment rate

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS/BLUE SHIELD	HEALTH SECURITY ACT
SURGICAL-MEDICAL BENEFITS Surgical services include allogeneic or autologous bone marrow or stem cell transplant procedures for specified diseases, transplants of specified organs/tissues, specified oral and maxillofacial surgery, reconstructive surgery, anesthesia, diagnostic procedures. Medical services include inhospital physician care, diagnostic services, routine services (pap smear and mammogram, fetal occult blood test for colorectal cancer screening and PSA - prostate specific antigen - test for prostate cancer screening), well child care, including newborn care. Cost sharing: •PPO/preferred physicians - After $200 calendar year deductible, 95% of preferred provider allowance. •Participating physicians - After $200 calendar year deductible, 75% of UCR. •Non-participating physicians - After $200 calendar year deductible, 75% of UCR used to determine participating physician reimbursement. Member is responsible for difference between UCR and physician's actual charge.	EMERGENCY AND AMBULATORY MEDICAL AND SURGICAL SERVICES Cost sharing: •Lower - $10 copayment for ambulatory medical and surgical services - $25 copayment for emergency room, unless patient has emergency medical condition •Higher - 20% of applicable payment rate

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS/BLUE SHIELD	HEALTH SECURITY ACT
PREVENTIVE SERVICES PROVIDED BY PREFERRED PROVIDERS •Clinician visits -$10 copayment for each home and office visit for a routine physical examination. -Covered: -Under 65, once every three years -65 or over, once a year •Tests In addition, the following preventive tests are available with no cost sharing when provided by a preferred physician or facility: **-Cholesterol tests** -Under 65, once every 3 years -65 or over, once a year **-Mammograms** -Age 35-39, one mammogram screening -Age 40-49, one mammogram every two years -Age 50-64, once a year -Age 65 or over, one every two years **-Pap Smears** -Annual coverage of one pap smear for women age 18 and older	CLINICAL PREVENTIVE SERVICES No cost sharing for services on clinical preventive schedule •Clinician visits- -Age 20-39, once every three years -Age 40-65, once every two years -Age 65 or over, once a year •Tests -Age 0-2, 1 hematocrit, 2 blood lead tests if at risk -Age 3-5, 1 urinalysis -Age 13-49, screening for chlamydia and gonorrhea for females at risk **-Cholesterol** -Age 20 or over, every five years **-Mammograms** -Age 50 or over, one every two years **-Pap Smears** -Age 13-19, one every year until three consecutive negatives, then one every three years -Age 20-39, one every three years, but one every year if smear abnormal or if patient sexually active -Age 40-49, one every two years, but one every year if smear abnormal or if patient sexually active -Age 50-or older, every two years as long as sexually active

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
PREVENTIVE SERVICES PROVIDED BY PREFERRED PROVIDERS (cont.)	CLINICAL PREVENTIVE SERVICES (cont.)
-Colorectal cancer screening -Annual coverage for members age 40 and older **-PSA** (prostate specific antigen) test -Annual coverage for men age 40 and older	-No colorectal cancer screening -No prostate cancer screening
●Immunizations for adult - none specified	●Immunizations -Age 0-2, diphtheria, tetanus, pertussis, polio, haemophilus influenzae type B, measles, mumps, rubella, hepatitis B -Age 3-5, diphtheria, tetanus, pertussis, polio, measles,mumps, rubella -Age 13-19, tetanus, diphtheria -Age 20-64, tetanus and diphtheria booster every 10 years -Age 65 or older - tetanus and diphtheria booster every 10 years; age appropriate influenza, pneumococcal invasive disease immunizations
●Well child care - up to age 13, 100% of the allowable charge (PPA or UCR) is paid for first routine newborn examination, including routine screening, and physician office visits for routine physical examinations, laboratory tests and immunizations.	●Well child care- up to age 19, first routine newborn examination and total of 16 other clinician visits for routine physical examination, laboratory tests, and immunizations.
●One smoking cessation program (lifetime maximum $100).	

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
MENTAL CONDITIONS/SUBSTANCE ABUSE BENEFITS Inpatient hospital services for mental conditions Lifetime maximum (see General Limitations). Cost sharing: •PPO/preferred hospitals - No per admission deductible, Standard Option pays 60% of preferred rate. •Member hospitals - $250 per admission deductible, Standard Option pays 60% of member rate. •Non-member hospitals - $250 per admission deductible, Standard Option pays 60% of billed charge or average charge. Substance abuse •Limitation to one 28-day treatment program up to $3,000 lifetime maximum (see General Limitations). Inpatient professional care cost sharing: After the $200 per calendar year deductible, Standard Option pays 60% of the allowable charge.	MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES Inpatient and residential services mental illness and substance abuse Annual limits: •Before January 1, 2000, 30 days plus an additional 30 days under certain circumstances. Cost sharing: •Lower - no copayment •Higher - one day deductible, 20% coinsurance

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
Covers day/night hospital services, partial hospitalization (under outpatient care benefit).	Intensive nonresidential treatment (e.g., partial hospitalization, day treatment, behavioral aide services) Limits: ●Plan discretion ●Treatment purposes criteria ●Before January 1, 2001 -two to one substitute with inpatient treatment plus maximum of 60 additional days at plan discretion ●Before January 1, 2001, expenses do not apply to out-of-pocket maximum if: 1. for substance abuse; or 2. for additional 60 days Cost sharing: ●Lower - no copayment, except $25 per visit for additional 60 days ●Higher- one day deductible, 20% coinsurance, except 50% coinsurance for additional 60 days

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
Outpatient care mental conditions/substance abuse benefits Includes 25 visits per person per calendar year for: (1) individual or group therapy, up to two hours per day, including collateral visits, provided by a physician, qualified clinical psychologists, psychiatric nurse, or clinical social worker; and (2) day/night hospital services (partial hospitalization). Lifetime maximum (see General limitations). Cost sharing: •Professional care - After $200 per calendar year deductible, Standard Option pays 60% of the allowable charge. •Facility Care -PPO/preferred facilities - After $200 calendar year deductible, Standard Option pays 60% of the preferred rate. -Member Facilities - After $200 calendar year deductible, Standard Option pays 60% of the member rate. -Non-member facilities - After $200 calendar year deductible, Standard Option pays 60% of the billed charge.	Outpatient mental illness and substance abuse services Limits: •Annual limit before January 1, 2001. **Psychotherapy** -30 visits for psychotherapy and collateral services. -four to one substitution at discretion of plan. **Substance abuse counseling and relapse prevention** -four to one substitution at discretion of plan. -30 group therapy visits if received treatment within 12 months. •Outpatient detoxification covered only in context of treatment program. •Before Jan 1, 2001, expenses do not apply to out-of-pocket maximum. •Services without specified limit - screening and assessment, diagnosis, medical management, crisis services, somatic treatments, case management. Cost sharing: •Lower - $10 copayment, except $25 for psychotherapy and collateral services (before Jan. 1, 2001) and no copayment for case management. •Higher - 20%, except 50% for psychotherapy and collateral services (before Jan. 1, 2001) and none for case management.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
MATERNITY BENEFITS Includes inpatient hospital services, outpatient care in ambulatory facilities, and obstetrical care covered as surgical - medical benefits (including physician care for pregnancy and resulting childbirth, legal abortion or miscarriage, anesthesia, services of a licensed or certified nurse midwife for pre- and post-partum care and delivery). Also includes oral contraceptives and diagnosis of prescription drugs for treatment of infertility, and sterilization (does not cover contraceptive devices). Cost sharing: •PPO/preferred hospitals - No deductible, Standard Option pays 100% for unlimited days. •Member facilities - After $250 deductible, Standard Option pays 100% for unlimited days. •Non-member facilities - After $250 deductible, 70% of the billed charges.	FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN Same coverage as Standard Option covered under this section, inpatient hospital services, ambulatory, medical and surgical services, and health professional services. Also includes prescription contraceptive devices. Cost sharing: •Lower - no copayment for inpatient hospital services - $10 copayment for clinician visits - no copayment for clinician visits and associated services related to prenatal care and 1 postpartum visit •Higher - 20% of applicable payment rate, except no coinsurance for clinician visits and associated services related to prenatal care and 1 post-partum visit

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
HOME HOSPICE CARE Standard Option pays in full for physician visits, nursing care, medical social services, physical therapy, services of home health aides, durable medical equipment rental, prescription drugs and medical supplies. Inpatient hospice benefits provided to patients receiving home hospice care for five consecutive days in a hospital or hospice inpatient facilities. Stays must be separated by 21 days. Must be terminally ill (life expectancy < 6 months).	HOSPICE CARE Same services, except includes occupational and speech therapy, and same limits on inpatient care (but not strict 21 day separation -- instead requirement that hospitalization be intermittent). Not limited to home hospice care. May be provided in a facility outside the home. Must be terminally ill (life expectancy < 6 months). Cost sharing: •Lower - no copayment •Higher - 20% of applicable payment rate

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
HOME HEALTH CARE Standard Option covers care by a registered nurse or a licensed practical nurse when ordered by a physician. Available for two hours per day up to 25 visits per year. High Option pays in full for 90 days per calendar year for the following services if prior approval is obtained: nursing care, physical therapy, respiratory or inhalation therapy, prescription drugs, medical supplies, intravenous infusion therapy, and other medically necessary services or supplies that would have been provided by a hospital. Cost sharing: •After $200 calendar year deductible, 75% UCR.	HOME HEALTH CARE Covers same services as High Option, except includes occupational and speech therapy, and excludes respiratory or inhalation therapy (only because HSA adopts the Social Security Act definition which is outdated). Limits: (1)Alternative to inpatient treatment after illness or injury. (2)Reevaluation after 60 days; additional periods covered if requirement (1) still satisfied. Cost sharing: •Lower - no copayment •Higher - 20% of applicable payment rate

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
EXTENDED CARE SERVICES None	EXTENDED CARE SERVICES Covers the following services if provided to an inpatient of a SNF or rehabilitation facility: nursing care; bed and board; physical, occupational or speech therapy; medical social services; drugs; supplies and equipment; medical services; other necessary services that would have been provided by a hospital. Limits: •Alternative to inpatient treatment after illness or injury. •100 day annual limit Cost sharing: •Lower - no copayment •Higher - 20% of applicable payment rate

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY Covers 50 visits per person per calendar year for physical therapy, and up to 25 visits per person per calendar year for occupational and speech therapy. Not covered - maintenance or palliative physical, occupational or speech therapy for a chronic disease or condition which does not require the technical proficiency or the skill and training of a physician or qualified therapist, except during acute exacerbations of the disease or condition. Cost sharing: After $200 calendar year deductible, 75% UCR.	OUTPATIENT REHABILITATION SERVICES Covers outpatient physical, occupational, and speech therapy. Limits: •Only to "restore functional capacity or minimize limitations on physical and cognitive functions as a result of illness or injury." •Reevaluation after 60 days; additional periods covered only if functioning is improving. Cost sharing: •Lower: - $10 per visit •Higher: - 20% of applicable payment rate

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
OUTPATIENT DIAGNOSTIC SERVICES Covered as part of outpatient facility care. Includes x-ray, laboratory and pathological services, and machine diagnostic tests. Cost sharing: •PPO/preferred facilities After $200 calendar year deductible, Standard Option pays 95% of the preferred rate. •Member facilities - After the $200 calendar year deductible, Standard Option pays 75% of the member rate. •Non-member facilities - After the $200 calendar year deductible, Standard Option pays 70% of the billed charge. But pays 100% if within 72 hours after accidental injury.	OUTPATIENT LABORATORY, RADIOLOGY AND DIAGNOSTIC SERVICES Same as BC/BS coverage. Cost sharing: •Lower -- no copayment •Higher -- 20% of applicable payment rate
AMBULANCE Covers professional ambulance service to or from nearest hospital equipped to handle patient's condition within 72 hours of accidental injury or medical emergency. Cost sharing: •After $200 calendar year deductible, 75% UCR.	AMBULANCE SERVICES Same coverage, but explicitly permits air and water transport where medically indicated and no 72 hour requirement. Cost sharing: •Lower: -no copayment •Higher: - 20% of applicable payment rate

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
PRESCRIPTION DRUGS Covers drugs requiring a physician's prescription, insulin (including insulin-related disposable syringes), diabetic diagnostic supplies used to test blood and urine for glucose and used by a patient at home, including testing supplies for special diabetic equipment, and disposable syringes necessary to self-administer covered injectable drugs for other than diabetic conditions.	OUTPATIENT PRESCRIPTION DRUGS Covers prescription drugs, biological products, insulin and blood clotting factors.
Cost sharing: •PPO/preferred pharmacies After $50 prescription drug deductible, Standard Option pays 80% of the preferred provider allowance. •Non-preferred pharmacies After $50 deductible, Standard Option pays 60% of the billed charge.	Cost sharing: •Lower - $5 per prescription •Higher - After $250 deductible for drugs 20%.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
DURABLE MEDICAL EQUIPMENT Includes rental or purchase of durable medical equipment (such as respirators and home dialysis equipment), including replacement, repair and adjustment wheelchairs, hospital beds, crutches, orthopedic braces and prosthetic appliances, including replacement, repair and adjustment, and one bra designed for use with an external breast prothesis. Does not include implanted bone condition hearing aids. Cost sharing: ●After $200 calendar year deductible, Standard Option pays 70% UCR.	DURABLE MEDICAL EQUIPMENT Same coverage, except that explicitly includes artificial legs, arms and eyes. Limit: ●Covered to improve functioning or to prevent further deterioration in function. Cost sharing: ●Lower -no copayment ●Higher - 20% of applicable payment rate
VISION CARE Not specifically covered.	VISION CARE Covers routine eye examination and diagnosis and treatment for defects in vision. Limit: Eyeglasses and contact lenses only for individuals under 18. Cost Sharing: ●Lower - $10 copayment ●Higher - 20% of applicable payment rate

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
DENTAL CARE Contains schedule of dental treatments. Includes oral exams, x-rays, emergency, preventive, space maintenance, restorative, extractions.	DENTAL CARE Covers emergency dental treatment, prevention and diagnosis of dental disease, and treatment of dental disease, space maintenance to prevent orthodontic complications and certain orthodontic treatments. Limits: •Before January 1, 2001, prevention and diagnosis and treatment covered only for individuals under 18. After January 1, 2001, dental sealants and endodontic services are not covered for individuals 18 years or older. •Space maintenance to prevent orthodontic complications covered for individuals 3 to 12 and includes additional limitations. •Before January 1, 2001, interceptive orthodontic treatment not covered. After January 1, 2001, covered for individuals 6 to 11 to prevent severe malocclusion. Cost Sharing: •Lower - $10 except $20 for space maintenance •Higher - $50 deductible, 20% coinsurance, except 40% for space maintenance and orthodontic treatment

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

EXCLUSIONS BLUE CROSS/BLUE SHIELD	EXCLUSIONS HEALTH SECURITY ACT
Inpatient private duty nursing.	Private duty nursing.
Standby physicians.	
Biofeedback and other forms of self-care or self-help training.	
Any dental and oral surgical procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically provided.	Any dental procedures involving orthodontic care, inlays, gold or platinum fillings, bridges, crowns, pin/post retention, dental implants, surgical periodontal procedures or the preparation of the mouth for the fitting or continued use of dentures, except as specifically provided.
Custodial care.	Custodial care, except hospice care.
Services in an extended care facility, nursing home or other non-covered facility, except as specifically covered.	
Eyeglasses, contact lenses, routine eye exams or vision testing for prescribing or fitting of eyeglasses or contact lenses.	Eyeglasses and contact lenses for individuals 18 years or older.
Eye exercises, visual training, or orthoptics.	
Hearing aids or examinations for prescribing or fitting of hearing aids	Hearing aids.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

EXCLUSIONS BLUE CROSS / BLUE SHIELD	EXCLUSIONS HEALTH SECURITY ACT
Treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures.	
Personal comfort items.	Personal comfort items, except hospice care.
Cosmetic purposes.	Surgery and other procedures performed for cosmetic purposes.
Routine examinations, periodic physical examinations, immunizations, shots, or x-ray not related to a specific illness, injury, set of symptoms or maternity care, except as specifically described.	
Routine foot care.	
Recreational or educational therapy and any related diagnostic testing, except as provided by a hospital as part of a covered inpatient stay or through an approved home health care program.	
Assistive reproductive technology.	In vitro fertilization.
For or related to sex transformation, sexual dysfunction or sexual inadequacy.	Sex change surgery and related services.
Investigational or experimental treatment.	Investigational or experimental treatment may be covered by plan for life-threatening conditions.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

GENERAL LIMITATIONS

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
Out-of-pocket maximum ●$3,250 (including certain co-insurance, preferred physicians' visit copayment, calendar year deductible, prescription drug deductible and per admission deductibles). ●$2,500 annual out-of-pocket limit when eligible services are provided by Preferred Providers. ●Expenses for mental conditions/substance abuse benefits or dental benefits do not apply to out-of-pocket limits Lifetime maximum ●$50,000 per person per lifetime for mental illness/ substance abuse (OPM is eliminating lifetime maximums for mental illness/substance abuse as of 1/95). ●$150,000 maximum for each of bone marrow, heart, heart-lung, liver, lung, and pancreas transplants. ●Inpatient care for treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime, payable up to a maximum of $3,000.	Out-of pocket maximum ●$1500 for individuals and $3000 for families. No lifetime maximum

Draft 5/4/94

SUMMARY
COMPARISON OF HEALTH SECURITY ACT AND FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

This memo outlines the major differences between ~~For those interested in a detailed comparison of~~ the Health Security Act (HSA) ~~with~~ the Blue Cross / Blue Shield (BC/BS) Standard Option offered under the Federal Employees Health Benefits Program (FEHBP), ~~the attached table provides a side-by-side comparison for each of the major benefit categories~~ benefit package and more detailed

Major Areas of Difference

The major differences between the two benefit packages are in the following areas:

Cost sharing

- Out-of-pocket maximum
  - --HSA uses $1500 for individuals / $3000 per family
  - --BC/BS uses $3,250 for non-PPO provider option — Explain
- Deductibles
  - --HSA uses a $200 for individual / $400 for family comprehensive deductible, with separate deductibles for drugs ($250) and dental ($50)
  - --BC/BS uses a $250 deductible for hospital, $200 outpatient services, $50 drugs
- Coinsurance
  - --HSA uses 20% for most professional services, with 20% cost sharing on drugs
  - --BC/BS uses 25% for most professional services, with 40% cost sharing on drugs

Mental Health and Substance Abuse

- Lifetime maximums
  - --HSA has no lifetime maximums
  - --BC/BS has $50,000 lifetime maximum for mental illness, and one 28-day substance abuse treatment program per lifetime up to a $3,000 maximum

Combine

Other lifetime maximums

- HSA has no lifetime maximums
- BC/BS has $150,000 maximum for each of bone marrow, hear, heart-lung, liver, lung, and pancreas transplants

~~-- HSA has no lifetime maximums~~
-- BC/BS has lifetime maximums for mental illness, substance abuse, and certain types of transplants

Draft 5/4/94

Extended care (nursing home, rehabilitation facility)

- HSA includes coverage of 100 days as alternative to hospital care
- BC/BS not covered

Adult dental care

- HSA prior to January 1, 2001 only covers adults for emergency dental treatment.
- BC/BS includes coverage for a specified list of dental procedures. Different cost sharing on dental?

Vision care

- HSA includes coverage for routine eye examination and diagnosis and treatment for defects in vision. Also covered are eyeglasses and contact lenses for individuals under 18.
- BC/BS does not specifically cover, but does exclude eyeglasses, contact lenses, routine eye exams or vision testing for prescribing or fitting of eyeglasses or contact lenses.

Sharman - Note additional Δes to 1st PP on 1st page.

Actuarial Comparisons

Actuarial comparisons of the HSA with other insurance policies and BC/BS Standard Option have been done from three perspectives[1]:

- **National Average Context**
  - -- HSA is approximately at 60th percentile
  - -- BC/BS is approximately at 30th percentile
- **Fortune 500 Context**
  - -- HSA is at approximately 50th percentile
  - -- FEHBP BC/BS Standard Option is at approximately 20th percentile

NOTE: Small changes in benefits can result in a comparatively larger change in placement in the percentile range because the benefit ranges that exist in plans between the 35th percentile plan and the 50th percentile are not ~~that~~ substantial.

- **Actuarial Value**
  - -- BC/BS Standard Option (Single Premium $1719) is approximately 11% less than HSA (Administration estimate of single premium $1932)

[1]For purposes of all these comparisons the dental benefit was assumed to be the HSA benefit and the BC/BS plan was assumed to be the out-of-network fee-for-service option.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

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Number of Pages (Including Cover): 1

Comments: Revised general limitations table

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

GENERAL LIMITATIONS

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
Out-of-pocket maximum ●$3,250 (including certain co-insurance, preferred physicians' visit copayment, calendar year deductible, prescription drug deductible and per admission deductibles). ●$2,500 annual out-of-pocket limit when eligible services are provided by Preferred Providers. ●Expenses for mental conditions/substance abuse benefits or dental benefits do not apply to out-of-pocket limits Deductibles ●$250 hospital admission ●$200 outpatient services ●$50 drugs Lifetime maximum ●$50,000 per person per lifetime for mental illness/ substance abuse (OPM is eliminating lifetime maximums for mental illness/substance abuse as of 1/95). ●$150,000 maximum for each of bone marrow, heart, heart-lung, liver, lung, and pancreas transplants. ●Inpatient care for treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime, payable up to a maximum of $3,000.	Out-of pocket maximum ●$1500 for individuals and $3000 for families. Deductibles ●$200 for individual / $400 for family comprehensive deductible ●$250 drugs ●$50 dental No lifetime maximum

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS/BLUE SHIELD	HEALTH SECURITY ACT
<u>INPATIENT HOSPITAL SERVICES</u> Includes intensive care, semiprivate accommodations, private room if medically necessary to prevent contagion, drugs and medical supplies. • Precertification required to determine medical necessity (Benefits reduced $500 per admission if consent is not obtained). <u>Cost sharing</u>: •<u>PPO/preferred hospitals</u> - No per admission deductible, Standard Option pays in full for unlimited days. •<u>Member hospitals</u> - After $250 per admission deductible, Standard Option pays in full for unlimited days. •<u>Non-member hospitals</u> - After $250 per admission deductible, Standard Option pays 70% of billed charge or average charge.	<u>HOSPITAL SERVICES</u> Includes inpatient hospital services (defined as bed and board, nursing, medical social services, and diagnostic or therapeutic items and services), outpatient hospital services and emergency services. (drugs, biologicals, and medical supplies) <u>Cost sharing</u>: •<u>Lower</u> - no copayment for inpatient services. - $10 copayment for outpatient services. - $25 for emergency room, unless patient has emergency medical condition. •<u>Higher</u> - 20% of applicable payment rate.

OFFICE OF MANAGEMENT AND BUDGET

Legislative Reference Division

Labor-Welfare-Personnel Branch

Telecopier Transmittal Sheet

URGENT

FROM: Bob Pellicci -- 395-4871

DATE: 4-29-94 **TIME:** 12:20

Pages sent (including transmittal sheet): 19

COMMENTS: MarKup of FEHBP/HSA side-by-side.
The changes on pages 1, 2, 3, 12, were suggested by John Richardson (5-4926)
The changes on pages 4, 5, 6, 9, 18 were suggested by Jill Blickstein (5-4926)
The change on page 17 was suggested by Andrea LeVario (HHS) 690-7450.

TO: JENNIFER KLEIN, Domestic Policy

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

Z

BLUE CROSS/BLUE SHIELD	HEALTH SECURITY ACT
PHYSICIAN CARE - •Includes home and office visits, physicians' outpatient consultations, and second surgical opinions •Physician is defined as doctors of medicine, osteopathy, dental surgery, medical dentistry, podiatric medicine and optometry, when acting within the scope of their licenses. •Other covered providers (when services are performed within the scope of their license or certification) - qualified clinical psychologist - nurse midwife - nurse practitioner/ clinical specialist - clinical social worker - nursing school administered clinic - in states medically designated as underserved areas, any licensed medical practitioner Cost sharing: • PPO/preferred physicians - $10 copayment for each visit. • Participating physicians - After $200 calendar year deductible, 75% of usual, customary and reasonable charges (UCR). • Non-participating physicians - After $200 calendar year deductible, 75% UCR.	HEALTH PROFESSIONAL SERVICES are Defined as professional services that are lawfully provided by a physician or those services provided by another person who is lawfully authorized to provide those services. Cost sharing: •Lower -$10 per visit •Higher - 20% of applicable payment rate HEALTH PROFESSIONAL SERVICES Includes home, office, inpatient and outpatient visits and consultations. Also includes services and supplies commonly furnished as incident to health professional services.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS/BLUE SHIELD	HEALTH SECURITY ACT
SURGICAL-MEDICAL BENEFITS Surgical services include allogeneic or autologous bone marrow or stem cell transplant procedures for specified diseases, transplants of specified organs/tissues, specified oral and maxillofacial surgery, anesthesia, diagnostic procedures, reconstructive surgery, Medical services include inhospital physician care, diagnostic services, routine services (pap smear and mammogram, fetal occult blood test for colorectal cancer screening and PSA - prostate specific antigen - test for prostate cancer screening), well child care, including newborn care. Cost sharing: •PPO/preferred physicians - After $200 calendar year deductible, 95% of preferred provider allowance. •Participating physicians - After $200 calendar year deductible, 75% of UCR. •Non-participating physicians - After $200 calendar year deductible, 75% of UCR used to determine participating physician reimbursement. Member is responsible for difference between UCR and physician's actual charge.	EMERGENCY AND AMBULATORY MEDICAL AND SURGICAL SERVICES Cost sharing: •Lower - $10 copayment for ambulatory medical and surgical services - $25 copayment for emergency room, unless patient has emergency medical condition •Higher - 20% of applicable payment rate.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS/BLUE SHIELD	HEALTH SECURITY ACT
<u>PREVENTIVE SERVICES PROVIDED BY PREFERRED PROVIDERS</u> •Clinician visits -$10 copayment for each home and office visit for a routine physical examination. -Covered: -Under 65, once every three years -65 or over, once a year •Tests In addition, the following preventive tests are available with no cost sharing <u>when provided by a preferred physician or facility</u>: -Cholesterol tests -Under 65, once every 3 years -65 or over, once a year -Mammograms -Age 35-39, one mammogram screening -Age 40-49, one mammogram every two years -Age 50-64, once a year -Age 65 or over, one every two years -Pap Smears -Annual coverage of one pap smear for women age 18 and older -Colorectal cancer screening -Annual coverage for members age 40 and older -PSA (prostate specific antigen) test -Annual coverage for men age 40 and older	<u>CLINICAL PREVENTIVE SERVICES</u> No cost sharing for services on clinical preventive schedule •Clinician visits- -Age 20-39, once every three years -Age 40-65, once every two years -Age 65 or over, once a year •Tests -Age 0-2, 1 hematocrit, 2 blood lead tests if at risk -Age 3-5, 1 urinalysis -Age 13-49, screening for chlamydia and gonorrhea for females at risk -Cholesterol -Age 20 or over, every five years -Mammograms -Age 50 or over, one every two years -Pap Smears -Age 13-19, one every year until three consecutive negatives, then one every three years 3 -Age 20-49, one every three years, but one every year if smear abnormal or if patient sexually active -Age 50-or older, every two years as long as sexually active -No colorectal cancer screening -No prostate cancer screening

- Age 40-49, one every two years, but one every year if smear abnormal or if patient sexually active

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
PREVENTIVE SERVICES PROVIDED BY PREFERRED PROVIDERS (cont.)	CLINICAL PREVENTIVE SERVICES (cont.)
•Immunizations for adult - none specified	•Immunizations -Age 0-2, diphtheria, tetanus, pertussis, polio, haemophilus influenzae type B, measles, mumps, rubella, hepatitis B -Age 3-5, diphtheria, tetanus, pertussis, polio, measles, mumps, rubella -Age 13-19, tetanus, diphtheria -Age 20-64, tetanus and diphtheria booster every 10 years -Age 65 or older - tetanus and diphtheria booster every examination 10 years; age appropriate influenza, pneumococcal invasive disease immunizations.
•Well child care - up to age 13, 100% of the allowable charge (PPA or UCR) is paid for first routine newborn examination, including routine screening, and physician office visits for routine physical examinations, laboratory tests and immunizations.	•Well child care- up to age 19, first routine newborn examination and total of 16 other clinician visits for routine physical examination, laboratory tests, and immunizations.

• One smoking cessation program (lifetime max. $100)

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
MENTAL CONDITIONS/SUBSTANCE ABUSE BENEFITS Inpatient hospital services for mental conditions Lifetime maximum (see General Limitations). Cost sharing: •PPO/preferred hospitals - No per admission deductible, Standard Option pays 60% of preferred rate. •Member hospitals - $250 per admission deductible, Standard Option pays 60% of member rate. •Non-member hospitals - $250 per admission deductible, Standard Option pays 60% of billed charge or average charge. Substance abuse (28-day) •Limitation to one treatment program (see General Limitations). (up to $3,000 lifetime max) Inpatient professional care cost sharing: After the $200 per calendar year deductible, Standard Option pays 60% of the allowable charge.	MENTAL ILLNESS AND SUBSTANCE ABUSE SERVICES Inpatient and residential services mental illness and substance abuse Annual limits: •Before January 1, 2000, 30 days plus an additional 30 days under certain circumstances. Cost sharing: •Lower - no copayment •Higher - one day deductible, 20% coinsurance

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
MATERNITY BENEFITS Includes inpatient hospital services, outpatient care in ambulatory facilities, and obstetrical care covered as surgical - medical benefits (including physician care for pregnancy and resulting childbirth, legal abortion or miscarriage, anesthesia, services of a licensed or certified nurse midwife for pre- and post-partum care and delivery). Also includes oral contraceptives and diagnosis of prescription drugs for treatment of infertility, and sterilization (does not cover contraceptive devices).	FAMILY PLANNING SERVICES AND SERVICES FOR PREGNANT WOMEN Same coverage as Standard Option covered under this section, inpatient hospital services, ambulatory, medical and surgical services, and health professional services. Cost sharing: •Lower - $10 copayment •Higher - 20% of applicable payment rate. Also includes prescription contraceptive devices.

Cost-Sharing

PPO/Preferred Hospitals -- no deductible, standard option pays 100 percent for unlimited days.

Member Facilities -- After $250 deductible, standard option pays 100 percent for unlimited days.

Non-Member Facilities -- After $250 deductible, 70 percent of the billed charges

unclear - this should differentiate between special family planning services & those covered under inpatient benefit.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
HOME HOSPICE CARE Standard Option pays in full for physician visits, nursing care, medical social services, physical therapy, services of home health aides, durable medical equipment rental, prescription drugs and medical supplies. Inpatient hospice benefits provided to patients receiving home hospice care for five consecutive days in a hospital or hospice inpatient facilities. Stay must be separated by 21 days. Must be terminally ill. (life expectancy <6 months)	HOSPICE CARE Same services, except includes occupational and speech therapy, and same limits on inpatient care (but not strict 21 day separation -- instead requirement that hospitalization be intermittent). Not limited to home hospice care. May be provided in a facility outside the home. Must be terminally ill. Cost sharing: •Lower - no copayment •Higher - 20%
HOME HEALTH CARE Standard Option covers care by a registered nurse or a licensed practical nurse when ordered by a physician. Available for two hours per day up to 25 visits per year. High Option pays in full for 90 days per calendar year for the following services if prior approval is obtained: nursing care, physical therapy, respiratory or inhalation therapy, prescription drugs, medical supplies, intravenous infusion therapy, and other medically necessary services or supplies that would have been provided by a hospital.	HOME HEALTH CARE Covers same services as High Option, except includes occupational and speech therapy, and excludes respiratory or inhalation therapy (only because HSA adopts the Social Security Act definition which is outdated). Limits: (1)Alternative to inpatient treatment after illness or injury. (2)Reevaluation after 60 days; additional periods covered if requirement (1) still satisfied. Cost sharing: •Lower - no copayment •Higher - 20%

Note, You don't reference high option for other areas such as mental health - you may want to delete this
4/27/94

75% UCR after $200 calendar year deductible

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
EXTENDED CARE SERVICES None	EXTENDED CARE SERVICES Covers the following services if provided to an inpatient of a SNF or rehabilitation facility: nursing care; bed and board; physical, occupational or speech therapy; medical social services; drugs; supplies and equipment; medical services; other necessary services that would have been provided by a hospital. Limits: •Alternative to inpatient treatment after illness or injury. •100 day annual limit
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY Covers 50 visits per person per calendar year for physical therapy, and up to 25 visits per person per calendar year for occupational and speech therapy. Not covered - maintenance or palliative physical, occupational or speech therapy for a chronic disease or condition which does not require the technical proficiency or the skill and training of a physician or qualified therapist, except during acute exacerbations of the disease or condition.	OUTPATIENT REHABILITATION SERVICES Covers outpatient physical, occupational, and speech therapy. Limits: •Only to "restore functional capacity or minimize limitations on physical and cognitive functions as a result of illness or injury." •Reevaluation after 60 days; additional periods covered only if functioning is improving. Cost sharing: •Lower: - $10 copayment •Higher: - 20%

75% UCR after $200 calendar year deductible

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
HOME HOSPICE CARE Standard Option pays in full for physician visits, nursing care, medical social services, physical therapy, services of home health aides, durable medical equipment rental, prescription drugs and medical supplies. Inpatient hospice benefits provided to patients receiving home hospice care for five consecutive days in a hospital or hospice inpatient facilities. Stays must be separated by 21 days. Must be terminally ill.	HOSPICE CARE Same services, except includes occupational and speech therapy, and same limits on inpatient care (but not strict 21 day separation -- instead requirement that hospitalization be intermittent). Not limited to home hospice care. May be provided in a facility outside the home. Must be terminally ill. Cost sharing: •Lower - no copayment •Higher - 20% of applicable payment rate.
HOME HEALTH CARE Standard Option covers care by a registered nurse or a licensed practical nurse when ordered by a physician. Available for two hours per day up to 25 visits per year. High Option pays in full for 90 days per calendar year for the following services if prior approval is obtained: nursing care, physical therapy, respiratory or inhalation therapy, prescription drugs, medical supplies, intravenous infusion therapy, and other medically necessary services or supplies that would have been provided by a hospital.	HOME HEALTH CARE Covers same services as High Option, except includes occupational and speech therapy, and excludes respiratory or inhalation therapy (only because HSA adopts the Social Security Act definition which is outdated). Limits: (1)Alternative to inpatient treatment after illness or injury. (2)Reevaluation after 60 days; additional periods covered if requirement (1) still satisfied. Cost sharing: •Lower - no copayment •Higher - 20% of applicable payment rate.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
EXTENDED CARE SERVICES None	EXTENDED CARE SERVICES Covers the following services if provided to an inpatient of a SNF or rehabilitation facility: nursing care; bed and board; physical, occupational or speech therapy; medical social services; drugs; supplies and equipment; medical services; other necessary services that would have been provided by a hospital. Limits: •Alternative to inpatient treatment after illness or injury. •100 day annual limit
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY Covers 50 visits per person per calendar year for physical therapy, and up to 25 visits per person per calendar year for occupational and speech therapy. Not covered - maintenance or palliative physical, occupational or speech therapy for a chronic disease or condition which does not require the technical proficiency or the skill and training of a physician or qualified therapist, except during acute exacerbations of the disease or condition.	OUTPATIENT REHABILITATION SERVICES Covers outpatient physical, occupational, and speech therapy. Limits: •Only to "restore functional capacity or minimize limitations on physical and cognitive functions as a result of illness or injury." •Reevaluation after 60 days; additional periods covered only if functioning is improving. Cost sharing: per visit •Lower: - $10 ~~copayment~~ •Higher: - 20% of applicable payment rate.

OUTPATIENT

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
DIAGNOSTIC SERVICES Covered as part of outpatient facility care. Includes x-ray, laboratory and pathological services, and machine diagnostic tests. Cost sharing: •PPO/preferred facilities After $200 calendar year deductible, Standard Option pays 95% of the preferred rate. •Member facilities - After the $200 calendar year deductible, Standard Option pays 75% of the member rate. •Non-member facilities - After the $200 calendar year deductible, Standard Option pays 70% of the billed charge. But pays 100% if within 72 hours after accidental injury.	OUTPATIENT LABORATORY, RADIOLOGY AND DIAGNOSTIC SERVICES Same as BC/BS coverage. Cost sharing: •Lower -- no copayment •Higher -- 20% of applicable payment rate.
AMBULANCE Covers professional ambulance service to or from nearest hospital equipped to handle patient's condition within 72 hours of accidental injury or medical emergency. Cost sharing: •After $200 calendar year deductible, 75% UCR.	AMBULANCE SERVICES Same coverage, but explicitly permits air and water transport where medically indicated and no 72 hour requirement. Cost sharing: •Lower: -no copayment •Higher: - 20% of applicable payment rate.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

13

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
PRESCRIPTION DRUGS Covers drugs requiring a physician's prescription, insulin (including insulin-related disposable syringes), diabetic diagnostic supplies used to test blood and urine for glucose and used by a patient at home, including testing supplies for special diabetic equipment, and disposable syringes necessary to self-administer covered injectable drugs for other than diabetic conditions.	OUTPATIENT PRESCRIPTION DRUGS Covers prescription drugs, biological products, insulin and blood clotting factors.
Cost sharing: •PPO/preferred pharmacies After $50 prescription drug deductible, Standard Option pays 80% of the preferred provider allowance. •Non-preferred pharmacies After $50 deductible, Standard Option pays 60% of the billed charge.	Cost sharing: •Lower - $5 per prescription •Higher - After $250 deductible for drugs 20%.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
DURABLE MEDICAL EQUIPMENT Includes rental or purchase of durable medical equipment (such as respirators and home dialysis equipment), including replacement, repair and adjustment wheelchairs, hospital beds, crutches, orthopedic braces and prosthetic appliances, including replacement, repair and adjustment, and one bra designed for use with an external breast prothesis. Does not include implanted bone condition hearing aids. Cost sharing: •After $200 calendar year deductible, Standard Option pays 70% UCR.	DURABLE MEDICAL EQUIPMENT Same coverage, except that explicitly includes artificial legs, arms and eyes. Limit: •Covered to improve functioning or to prevent further deterioration in function. Cost sharing: •Lower -no copayment •Higher - 20% of applicable payment rate.
VISION CARE Not specifically covered.	VISION CARE Covers routine eye examination and diagnosis and treatment for defects in vision. Limit: Eyeglasses and contact lenses only for individuals under 18. Cost sharing: •Lower - $10 copayment •Higher - 20% of applicable payment rate.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

EXCLUSIONS BLUE CROSS / BLUE SHIELD	EXCLUSIONS HEALTH SECURITY ACT
Treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures.	
Personal comfort items.	Personal comfort items, except hospice care.
Cosmetic purposes.	Surgery and other procedures performed for cosmetic purposes.
Routine examinations, periodic physical examinations, immunizations, shots, or x-ray not related to a specific illness, injury, set of symptoms or maternity care, except as specifically described.	
Routine foot care.	
Recreational or educational therapy and any related diagnostic testing, except as provided by a hospital as part of a covered inpatient stay or through an approved home health care program.	
Assistive reproductive technology.	In vitro fertilization and other hi-tech associated reproductive technologies
For or related to sex transformation, sexual dysfunction or sexual inadequacy.	Sex change surgery and related services.
Investigational or experimental treatment.	Investigational or experimental treatment may be covered by plan for life-threatening conditions.

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

GENERAL LIMITATIONS

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
Out-of-pocket maximum •$3,250 (including certain co-insurance, preferred physicians' visit copayment, calendar year deductible, prescription drug deductible and per admission deductibles). • Lifetime maximum •$50,000 per person per lifetime for mental illness/ substance abuse •$150,000 maximum for bone marrow, heart, heart-lung, liver, lung, and pancreas transplants. •Inpatient care for treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime, payable up to a maximum of $3,000.	Out-of pocket maximum •$1500 for individuals and $3000 for families. No lifetime maximum

each of

$2,500 annual out of pocket limit when eligible services are provided by Preferred Providers.

Expenses for mental conditions/ substance abuse benefits or dental benefits do not apply to out-of-pocket limits

COMPARISON OF BENEFITS HEALTH SECURITY ACT WITH FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

GENERAL LIMITATIONS

BLUE CROSS / BLUE SHIELD	HEALTH SECURITY ACT
Out-of-pocket maximum •$3,250 (including certain co-insurance, preferred physicians' visit copayment, calendar year deductible, prescription drug deductible and per admission deductibles). Lifetime maximum •$50,000 per person per lifetime for mental illness/ substance abuse (OPM is eliminating lifetime maximums for mental health/substance abuse as of 1/1/95). •$150,000 maximum for bone marrow, heart, heart-lung, liver, lung, and pancreas transplants. •Inpatient care for treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime, payable up to a maximum of $3,000.	Out-of pocket maximum •$1500 for individuals and $3000 for families. No lifetime maximum

United States
Office of
Personnel
Management

FAX TRANSMITTAL SHEET

Office of Congressional Relations
Date: 6/13/94

Number of Pages (including this one)

Please Deliver To:

Name: Jennifer Klein	
Office: HCFF	Room:
Telephone: 456-2878	

From:

Name: C. Brockschmidt	
Office: OCR	Room:
Telephone: 606-1300	

Remarks

WARNING: Most Fax machines produce copies on thermal paper. The image produced is highly unstable will deteriorate significantly in a few years. It should be co l a plain paper copier prior to filing.

United States
Office of
Personnel Management

Washington, D.C. 20415

In Reply Refer To: Your Reference:

JUN 13 1994

MEMORANDUM FOR MS. STEPHANIE WARD
SENATOR DURENBERGER'S OFFICE

FROM: RALPH PIERCE Ralph Pierce
PROGRAM ANALYST
OFFICE OF INSURANCE PROGRAMS

SUBJECT: Mental Conditions/Substance Abuse Benefits

In response to your request, I am sending you descriptions of the Mental Conditions and Substance Abuse Benefits offered by Blue Cross and Blue Shield, Government Employees Hospital Association Benefits Plan (GEHA) and Kaiser Health Plan of the Mid-Atlantic States. As I mentioned during our telephone discussion, the Federal Employees Health Benefits (FEHB) law, title 5 U.S.C., Chapter 89, Section 8904 does not specifically mandate mental health and substance abuse benefits. However, OPM requires all FEHB Plans to offer a minimum level of benefits for Mental Conditions and Substance Abuse.

The benefits offered by the Plans above are typical of those offered by other fee-for-service and prepaid plans (HMOs) under the FEHB Program. If you have any further questions you may contact me or the Office of Congressional Relations directly at (202) 606-1300.

Attachment

cc: Cynthia Brocksmith, OCR

6-13-94

Post-it™ brand fax transmittal memo 7671	# of pages ▸ 12
To Ms. Stephanie WARD	From Ralph Pierce
Co. Senator Durenberger	Co. OPM/OIP
Dept. 224-9462 (voice)	Phone # 606-0745
Fax # 224-9931 (FAX)	Fax # 606-0767

Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan High Option—1994

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan.

All items below with an asterisk (*) are subject to the calendar year deductible. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). A summary of benefits for the Standard Option is located on page 52 of this brochure.

	Benefits	High Option pays	Page
Inpatient Care	Hospital	PPO benefit: 100% for unlimited days with no per admission deductible Non-PPO benefit: After $100 per admission deductible, 100% for unlimited days	20
	Surgical	PPO benefit: 95% PPA for physician services Non-PPO benefit: For physician services, 80% UCR	22-25
	Medical	PPO benefit: 95% PPA for physician medical care Non-PPO benefit: For physician medical care, 80% UCR	24
	Maternity	Same benefits as for illness or injury	26-27
*	Mental Conditions/ Substance Abuse	PPO benefit: 80% PPO rate with no per admission deductible for covered hospital services; 80%* Allowable charge for inpatient physician care up to benefit maximums Non-PPO benefit: After $100 per admission deductible, 80% Covered charges for unlimited days for covered hospital services; 80%* Allowable charge for inpatient physician care; one substance abuse treatment program (28-day maximum) payable up to $4,000; $75,000 per member lifetime maximum on all benefits for mental conditions/substance abuse	28-29
Outpatient Care	Hospital	PPO benefit: 100% in connection with outpatient surgery; 95%* PPO rate for other hospital outpatient care not related to outpatient surgery or accidental injury care Non-PPO benefit: 80% Member rate in connection with outpatient surgery; 80%* Member rate for other hospital outpatient care not related to outpatient surgery or accidental injury care	30, 35
	Surgical	PPO benefit: 95% PPA for physician services Non-PPO benefit: For physician services, 80% UCR	22-23
	Medical	PPO benefit: $10 copay per covered visit Non-PPO benefit: For home and office visits, 80%* UCR	30
	Maternity	Same benefits as for illness or injury	26-27
	Home Health Care	100% of covered home health care agency charges up to 90 days per calendar year. (Also see page 32 for Home nursing care benefit.)	34-35
*	Mental Conditions/ Substance Abuse	PPO benefit: No current benefit Non-PPO benefit: 70%* Covered charges for outpatient mental conditions/substance abuse care up to 50 visits per calendar year and up to the $75,000 lifetime maximum	29
Emergency Care (Outpatient accidental injury care)		100% for hospital and physician services rendered within 72 hours of injury	34
Prescription Drugs		PPO benefit: (Retail Pharmacy Program) After $50 prescription drug deductible, 85% PPA Non-PPO benefit: (Retail Pharmacy Program) After $50 prescription drug deductible, 65% of Billed charge Mail Order Prescription Drug Program: $8 per prescription copay	32-33 32-33 36
Dental Care		Dental services required due to accidental injury; and covered oral and maxillofacial surgery	23, 31
Additional Benefits		Preventive services provided by PPO providers, Home hospice care, Well child care and Skilled nursing facility care	32, 34-36
Catastrophic Protection		100% Covered charges when applicable coinsurance and deductibles reach $1,500 per contract in a calendar year when PPO providers are used and $2,200 when they are not 100% Covered charges for inpatient care of mental conditions/substance abuse after out-of-pocket expenses reach $4,000 per member in a calendar year up to the $75,000 per member lifetime maximum	15 15

Summary of Benefits — the Blue Cross and Blue Shield Service Benefit Plan Standard Option—1994

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan.

All items below with an asterisk (*) are subject to the calendar year deductible. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). This Plan has two options; a summary of benefits for the High Option is located on page 51 of this brochure.

	Benefits	Standard Option pays	Page
Inpatient Care	Hospital	PPO benefit: 100% for unlimited days with no per admission deductible Non-PPO benefit: After $250 per admission deductible, 100% for unlimited days	20
	Surgical	PPO benefit: 95%* PPA for physician services Non-PPO benefit: For physician services, 75%* UCR	22-25
	Medical	PPO benefit: 95%* PPA for physician medical care Non-PPO benefit: For physician medical care, 75%* UCR	24
	Maternity	Same benefits as for illness or injury	26-27
*	Mental Conditions/ Substance Abuse	PPO benefit: 60% PPO rate with no per admission deductible for covered hospital services; 60%* Allowable charge for inpatient physician care up to benefit maximums Non-PPO benefit: After $250 per admission deductible, 60% Covered charges for unlimited days for covered hospital services; 60%* Allowable charge for inpatient physician care; one substance abuse treatment program (28-day maximum) payable up to $3,000; $50,000 per member lifetime maximum on all benefits for mental conditions/ substance abuse	28-29
Outpatient Care	Hospital	PPO benefit: 100% in connection with outpatient surgery; 95%* PPO rate for other hospital outpatient care not related to outpatient surgery or accidental injury care Non-PPO benefit: 75% Member rate in connection with outpatient surgery; 75%* Member rate for other hospital outpatient care not related to outpatient surgery or accidental injury care	30, 35
	Surgical	PPO benefit: 95%* PPA for physician services Non-PPO benefit: For physician services, 75%* UCR	22-23
	Medical	PPO benefit: $10 copay per covered visit Non-PPO benefit: For home and office visits, 75%* UCR	30
	Maternity	Same benefits as for illness or injury	26-27
	Home Health Care	No current Home health care benefit. (See page 32 for Home nursing care benefit.)	32
*	Mental Conditions/ Substance Abuse	PPO benefit: No current benefit Non-PPO benefit: 60%* Covered charges for outpatient mental conditions/substance abuse care up to 25 visits per calendar year and up to the $50,000 lifetime maximum	29
Emergency Care (Outpatient accidental injury care)		100% for hospital and physician services rendered within 72 hours of injury	34
Prescription Drugs		PPO benefit: (Retail Pharmacy Program) After $50 prescription drug deductible, 80% of PPA Non-PPO benefit: (Retail Pharmacy Program) After $50 prescription drug deductible, 60% of Billed charge Mail Order Prescription Drug Program: $12 per prescription copay	32-33 32-33 36
Dental Care		Fee schedule allowances for diagnostic and preventive services, fillings, and extractions. Higher level fee schedule allowances for children up to age 13; dental services required due to accidental injury; and covered oral and maxillofacial surgery	23, 31, 38-39
Additional Benefits		Preventive services provided by PPO providers, Home hospice care, Well child care and Skilled nursing facility care	32, 34-36
Catastrophic Protection		100% Covered charges when applicable coinsurance and deductibles reach $2,500 per contract in a calendar year when PPO providers are used and $3,250 when they are not 100% Covered charges for inpatient care of mental conditions/substance abuse after out-of-pocket expenses reach $8,000 per member in a calendar year up to the $50,000 per member lifetime maximum	15 15

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan provides coverage at the benefit levels indicated below for services provided by t following facilities when furnished and billed as regular inpatient hospital services:

Mental conditions

Precertification

You must follow the precertification procedure described on pages 40 and 41 in order to qualify f full Plan benefits. Precertification is a mandatory requirement for all inpatient admissions under bo High Option and Standard Option. If precertification is not obtained, the Plan will reduce benefi by $500 on the inpatient charges otherwise payable. Emergency admissions must be reported with two business days following admission even if the patient has been discharged. Otherwise, benefi for the admission will be reduced by $500. If the admission is precertified, but you remain confin beyond the number of days certified as medically necessary, the Plan will not pay for charges incurr on the extra days. (See page 41 for information on Precertification waiver.)

Contact your Local Plan for more information on these requirements.

Inpatient hospital care

	[redacted]	[redacted]
Member hospitals	After a $100 per admission deductible, **High Option** pays **80%** of the **Member rate**	After a $250 per admission deductibl **Standard Option** pays **60%** of th **Member rate**
Non-member hospitals	After a $100 per admission deductible, **High Option** pays **80%** of the **Billed charge or Average charge**	After a $250 per admission deductibl **Standard Option** pays **60%** of th **Billed charge or Average charge**

See Definitions for an explanation of Covered charges, Preferred rate, Member rate, Billed charg and Average charge.

Room and board and other hospital services (see Inpatient Hospital Benefits for a description of al covered services), limited to the hospital's average semiprivate rate, not to exceed the averag semiprivate rate charged by similar institutions in the same area.

Covered services are noted below:

Substance abuse

Inpatient care for the treatment of alcoholism and drug abuse is available for one treatment progran (28-day maximum) per lifetime up to a maximum payment of **$4,000** under **High Option** and $3,00 under **Standard Option**. Treatment is also payable in a freestanding alcoholism or drug abuse facilit approved by the Local Plan.

Inpatient professional care

The Plan provides coverage at the benefit levels indicated below for inpatient professional care:

After the $150 calendar year deductible, **High Option pays 80% of the Allowable charge**	After the $200 calendar year deductible **Standard Option pays 60% of th Allowable charge**

See the Definitions section for an explanation of Allowable charge under Covered charges and Participating and Non-participating physician.

Catastrophic protection

See page 15 for the Catastrophic Protection Benefit for inpatient care of mental conditions/substance abuse.

BBBS 3 of 6

Mental Conditions/Substance Abuse Benefits *continued*

Outpatient care

The Plan pays all covered outpatient care (including related services and supplies, such as psychological testing) for the treatment of a mental condition, including substance abuse, as follows:

Professional care

After the $150 calendar year deductible, **High Option pays 70% of the Allowable charge**	After the $200 calendar year deductible, **Standard Option pays 60% of the Allowable charge**

See Definitions for an explanation of Allowable charge under Covered charges and Participating and Non-participating physician.

Facility care

[redacted]

Member facilities	After the $150 calendar year deductible, **High Option pays 70% of the Member rate**	After the $200 calendar year deductible, **Standard Option pays 60% of the Member rate**
Non-member facilities	After the $150 calendar year deductible, **High Option pays 70% of the Billed charge**	After the $200 calendar year deductible, **Standard Option pays 60% of the Billed charge**

See Definitions for an explanation of Covered charges, Preferred rate, Member rate and Billed charge.

Therapy

Outpatient visits are available up to **50 visits under High Option** and **25 visits under Standard Option** per person per calendar year for:

- Individual or group therapy, up to two hours per day, including collateral visits with members of the patient's immediate family, provided by a physician, qualified clinical psychologist, psychiatric nurse, or clinical social worker.
- Day-night hospital services (sometimes called partial hospitalization)

The number of visits for which you receive reimbursement will be reduced if these services are used to meet part or all of your calendar year deductible.

Lifetime maximum

Benefits for the treatment of mental conditions/substance abuse are limited to **$75,000** per person per lifetime under **High Option** and **$50,000** per person per lifetime under **Standard Option**. This includes all related benefits, such as diagnostic tests. In addition, inpatient care for treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime, payable up to a maximum of **$4,000** under **High Option** and **$3,000** under **Standard Option**.

What is not covered

- Marital, family, educational, or other counseling or training services
- Services rendered or billed by a school or halfway house or a member of its staff
- Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present
- Services and supplies that are not medically necessary (see Definitions and General Exclusions)

How to Obtain Precertification

Precertify before admission

Precertification does not guarantee benefit payments. Precertification of an inpatient admission means that based on the information given, the admission meets the medical necessity requirements of the Plan. It is your responsibility to ensure that precertification is obtained. If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500. The following steps must be followed to obtain precertification.

- A telephone call must be made to the Local Plan by you, your physician or your hospital prior to admission. Prior to being admitted to a hospital, contact the Local Plan serving the area where the services will be rendered for information and procedures for precertification.
- The following information must be provided: enrollee's name, Service Benefit Plan identification number and Social Security Number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital (facility); name and phone number of admitting physician; and number of planned days of confinement.

When the above requirements are met, the Local Plan will tell the physician and/or hospital the number of approved days of confinement for the care of the patient's condition.

Prior approval

Before the following services are rendered, you or your provider should contact the Local Plan where the services will be rendered (or for certain drugs and supplies, the Retail Pharmacy Program) for information and procedures for prior approval.

- **Home health care (High Option)**—The Plan will request the medical evidence it needs to make its coverage determination (see pages 34 and 35).
- **Organ/tissue transplants**—The Plan will request the medical evidence it needs to make its coverage determination. The Plan will consider whether the facility is approved for the procedure and whether the patient meets the facility's criteria (see page 23).
- **Prescription drugs and supplies**—The Retail Pharmacy Program will request the medical evidence it needs to make its coverage determination. Drugs and supplies that require prior approval also require 1) payment in full at time of purchase (including PPO pharmacies) and 2) the member's submission of the expense(s) on a claim form. Preferred pharmacies will not file these expenses for you.

Written confirmation

Written confirmation of the Plan's precertification decision will be sent to you in case of a denial. If it is determined that the length of stay needs to be extended, follow the procedures listed below. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are not determined by the Plan during the claim review to be medically necessary.

Need additional days?

If any additional days are required, your physician or the hospital must request certification for the additional days.

Maternity or emergency admissions

When there is a maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, the physician, a family member or the hospital must telephone the Local Plan within two business days following admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by $500.

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Plan unless the Local Plan is misled by the information given to it. After the claim is received, the Plan will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If a member believes the Plan failed to follow the precertification procedure described above, he or she must first submit a written request to the Plan for a review of the decision. If the Plan then fails to certify the admission or length of stay continuation, the member may write to OPM for a review.

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following a maternity or emergency admission), a medical necessity determination will need to be made at the time the claim is filed. In such an instance the Plan must certify that the admission and length of stay were medically necessary before any benefit determination can be made. Benefits are not payable if the admission is not certified. If the claim review results in the admission being certified, any benefits payable according to all of the terms of this brochure will be reduced by $500 for failing to have the admission precertified. If the admission is certified, but it is determined that part of the length of stay was not medically necessary, benefits will not be paid for the portion of the confinement that was not medically necessary.

RC RS 5 of 6

How to Obtain Precertification *continued*

When you don't need precertification

Precertification is not required when:

- Medicare Part A is the primary payer for the hospital confinement (see pages 46 and 47). Precertification is required if you are not enrolled in Medicare Part A.
- You are confined in a hospital outside the United States.

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Summary of Benefits for the GEHA Benefit Plan-1994

For services provided in a Limited Network area

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $250 calendar year deductible.

Benefits		Plan Pays/Provides	Page
Inpatient care	Hospital	**Non-PPO benefit: 100%** room and board, **80%** of other hospital charges with no per-admission deductible **PPO benefit: 100%** room and board; **90%** of other hospital charges with no per-admission deductible	17
	Surgical	**Non-PPO benefit: 80%*** of covered surgical charges, including oral surgery **PPO benefit: 90%*** of covered surgical charges	18-20
	Medical	**Non-PPO benefit: 80%*** of covered professional services **PPO benefit: 90%*** of covered professional services	23-25
	Maternity	Same benefits as for illness or injury	21
*	Mental Conditions/ Substance Abuse	**50%** of covered hospital charges and intensive hospital day treatment charges after a separate **$500** deductible has been met. For professional services, the Plan pays **50%*** of the reasonable and customary charge of covered providers for hospital visits including psychotherapy session, up to the lifetime maximum	22
Outpatient care	Hospital	**Non-PPO benefit: 80%*** of covered hospital charges **PPO benefit: 90%*** of covered hospital charges	23-25
	Surgical	**Non-PPO benefit: 80%*** of covered surgical charges, including oral surgery **PPO benefit: 90%*** of covered surgical charges	18-20
	Medical	**$10** copayment per covered office visit (for doctor's professional fee only) **Non-PPO benefit: 80%*** of other covered professional services **PPO benefit: 90%*** of other covered professional services	23-25
	Maternity	Same benefits as for illness or injury	21
	Home Health Care	**Non-PPO benefit: 80%*** limited to 120 visits in a calendar year **PPO benefit: 90%*** limited to 120 visits in a calendar year	24
*	Mental Conditions/ Substance Abuse	For professional services, the Plan pays covered providers for home and office visits for psychotherapy sessions, including group sessions, up to a maximum of **30** sessions per calendar year, and up to a maximum payable of **50%*** of the reasonable and customary charge per session up to the lifetime maximum	22
Emergency care (accidental injury)		**100%** of covered charges (no deductible) incurred within 72 hours of an accident	26
Prescription Drugs	Retail card program	Member pays **$15** for name brand or **$5** for generic drugs for 30 day supply for initial prescription and one refill. Subsequent refills are paid at **50%**	27-29
	Mail order	Member pays **$20** for name brand, **$5** for generic for maintenance medications and oral contraceptives	27-29
Dental care		Routine preventive dental care and accidental injury to sound natural teeth	25, 30
Additional benefits		Preferred Provider Organization	26-27
Catastrophic protection		**100%** after applicable coinsurance reach **$2,800** (Self and Family) or **$2,300** (Self Only)	12-13
		100% for Mental Conditions and Substance Abuse after applicable coinsurances and deductibles reach **$8,000** for all covered family members combined, up to a lifetime maximum of **$50,000** per person	12-13, 22

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Summary of Benefits for the GEHA Benefit Plan-1994 *continued*

For services provided in a Comprehensive Network area

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $250 calendar year deductible.

Benefits		Plan Pays/Provides	Page
Inpatient care	Hospital	Non-PPO benefit: 100% room and board, 75% of other hospital charges after $250 per-admission deductible PPO benefit: 100% room and board; 90% of other hospital charges with no per-admission deductible	17
	Surgical	Non-PPO benefit: 75%* of covered surgical charges, including oral surgery PPO benefit: 90%* of covered surgical charges	18-20
	Medical	Non-PPO benefit: 75%* of covered professional services PPO benefit: 90%* of covered professional services	23-25
	Maternity	Same benefits as for illness or injury	21
*	Mental Conditions/ Substance Abuse	50% of covered hospital charges and intensive hospital day treatment charges after a separate $500 deductible has been met. For professional services, the Plan pays 50%* of the reasonable and customary charge of covered providers for hospital visits including psychotherapy session, up to the lifetime maximum	22
Outpatient care	Hospital	Non-PPO benefit: 75%* of covered hospital charges PPO benefit: 90%* of covered hospital charges	23-25
	Surgical	Non-PPO benefit: 75%* of covered surgical charges, including oral surgery PPO benefit: 90%* of covered surgical expenses	18-20
	Medical	Non-PPO benefit: 75%* of other covered professional services PPO benefit: $10 copay per covered office visit (for doctor's professional fee only) and 90%* of other covered professional services	23-25
	Maternity	Same benefits as for illness or injury	21
	Home Health Care	Non-PPO benefit: 75%* limited to 120 visits in a calendar year PPO benefit: 90%* limited to 120 visits in a calendar year	24
*	Mental Conditions/ Substance Abuse	For professional services, the Plan pays covered providers for home and office visits for psychotherapy sessions, including group sessions, up to a maximum of 30 sessions per calendar year, and up to a maximum payable of 50%* of the reasonable and customary charge per session up to the lifetime maximum	22
Emergency care (accidental injury)		100% of covered charges (no deductible) incurred within 72 hours of an accident	26
Prescription Drugs	Retail card program	Member pays $15 for name brand or $5 for generic drugs for 30 day supply for initial prescription and one refill. Subsequent refills are paid at 50%	27-29
	Mail order	Member pays $20 for name brand, $5 for generic for maintenance medications and oral contraceptives	27-29
Dental care		Routine preventive dental care and accidental injury to sound natural teeth	25, 30
Additional benefits		Preferred Provider Organization	26-27
Catastrophic protection		100% after applicable coinsurance reach $2,800 (Self and Family) or $2,300 (Self Only) when Preferred providers are used, and $5,000 (Self and Family) or $4,500 (Self Only) when they are not	12-13
		100% for Mental Conditions and Substance Abuse after applicable coinsurances and deductibles reach $8,000 for all covered family members combined, up to a lifetime maximum of $50,000 per person	12-13, 22

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Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Inpatient care

Inpatient hospital expenses are limited to 50% of reasonable and customary charges subject to the $500 hospital inpatient and intensive day treatment mental conditions/substance abuse deductible, per member, per calendar year, for treatment of mental conditions and substance abuse including treatment of alcoholism. All reasonable and customary charges count toward the deductible.

Precertification

You must follow the precertification procedure described on page 31 in order to qualify for full Plan benefits. Precertification is a mandatory requirement for all inpatient admissions. If precertification is not obtained, the Plan will reduce benefits by $500 on the inpatient charges otherwise payable. Emergency admissions must be reported within two business days following admission even if the patient has been discharged. Otherwise, benefits for the admission will be reduced by $500. If the admission is precertified, but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on the extra days.

Inpatient visits

The Plan pays 50% of reasonable and customary charges for inpatient visits by covered providers and for psychotherapy sessions, after the Plan's overall $250 calendar year deductible has been met. All reasonable and customary charges count toward the calendar year deductible.

Outpatient care

Home and office visits by covered providers are covered, including visits for psychotherapy sessions and group sessions, up to a maximum of 30 sessions per calendar year. The Plan pays 50% of reasonable and customary charges for up to 30 sessions per calendar year, after the Plan's overall $250 calendar year deductible has been met. All reasonable and customary charges count toward the calendar year deductible.

Intensive day treatment

The Plan provides intensive hospital day treatment, limited to 50% of reasonable and customary charges, after the $500 hospital inpatient and intensive day treatment mental conditions/substance abuse deductible, per member, per calendar year. All reasonable and customary charges count toward the deductible. If you are uncertain if treatment will be considered intensive day treatment you may contact the Plan's Customer Service Department.

Catastrophic protection

When the deductibles and coinsurance for all covered family members (or an individual under Self Only) exceeds $8,000 for treatment of mental conditions and substance abuse in any one calendar year, the Plan will pay in full all remaining reasonable and customary charges incurred during the remainder of that same year up to the lifetime maximum.

Lifetime maximum

Benefits are limited to a lifetime maximum of $50,000 per person.

What is not covered

- Marital, family and other counseling services including therapy for sexual problems
- Services rendered or billed by a school or halfway house or a member of its staff

GEHA 3 of 3

Summary of Benefits for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. — 1994

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

Benefits		Plan pays/provides	Page
Inpatient care	Hospital	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care. Private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing	11
	Extended Care	All necessary services, for up to 100 days per calendar year. You pay nothing	11
*	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay nothing	13
*	Substance Abuse	Inpatient rehabilitation services; You pay all charges in excess of $120 per day for up to 30 days in a hospital or specialized facility	13
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay nothing per office visit; nothing per house call by a doctor	10–11
	Home Health Care	All necessary visits by nurses. You pay nothing per visit	10
*	Mental Conditions	Up to 25 outpatient visits per year. You pay $10 for visits 1-8; thereafter $20 per individual therapy visit; $10 per group therapy visit; you pay $10 for visits for evaluation and management of medications	13
*	Substance Abuse	Outpatient counseling and treatment; you pay nothing	13
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay nothing, except for any charges for services which are not covered benefits of this Plan	12
Prescription drugs		Drugs prescribed by a Plan doctor or dentist and obtained at a Plan pharmacy. You pay $7 per prescription unit or refill	13–14
Dental care		Accidental injury benefit; you pay nothing. Preventive dental care, comprehensive range of restorative, orthodontic, and other services. You pay copays for these services	14–16
Vision care		Refractions including lens prescription; You pay $10 per examination. One pair of frames and lenses or contact lenses every 24 months with a credit of $40 for the purchase of lenses and frames. You pay any additional charges	16
Out-of-pocket limit		Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits, such as mental health outpatient visits, substance abuse inpatient rehabilitation services and prescription drugs and the copayments required for dental services	7

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Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 25 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; you pay $10 for the 1st through 8th visit; thereafter, you pay $20 for an individual visit; $10 for a group visit; $10 for a visit primarily for evaluation and maintenance of drugs associated with treatment of a psychiatric condition.

Inpatient care

Up to 30 days of hospitalization each calendar year; you pay nothing for the first 30 days — all charges thereafter.

What is not covered

- Care for psychiatric conditions which in the professional judgement of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance abuse

What is covered

This Plan provides medical and hospital services for acute detoxification for the medical non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Outpatient visits to Plan providers for treatment; you pay nothing for each visit.

Inpatient care

Acute detoxification; you pay nothing; the Plan provides up to $120 per day for up to 30 days per calendar year for rehabilitative services in a hospital or specialized facility; you pay all charges over the $120 per day limit.

What is not covered

- Treatment that is not authorized by a Plan doctor
- Methadone treatment for narcotic addiction

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor or dentist and obtained at a Plan pharmacy will be dispensed for up to a 60 day supply; you pay $7 per prescription unit or refill. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the $7 copay per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Dental prescriptions are limited to formulary products for pain relief and antibiotics only.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Implanted time release medications; you pay a one-time copayment equal to the $7 per prescription charge times one half the expected number of months the medication will be effective, not to exceed $200. There will be no refund of any portion of these copayments if the implanted time release medication is removed before the end of its expected life.
- Oral contraceptive drugs and the implanted time release contraceptive, Norplant (You pay a $200 copay for Norplant, with no refund if it is removed before the end of its expected life)
- Insulin
- Diabetic supplies including disposable insulin syringes, needles, blood glucose test strips, and acetone test tablets
- Disposable needles and syringes needed for self injection of covered prescribed drugs
- Drugs for smoking cessation treatment will be limited to one treatment therapy per lifetime per member. A member may be required to participate in a behavior modification program or counseling sessions.
- Intravenous fluids and medications for home use (covered under Medical and Surgical Benefits as a home health services, see page 10)

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****
*** ACTIVITY REPORT ***
****

TRANSMISSION OK

TX/RX NO.	4696	
CONNECTION TEL		92249931
CONNECTION ID		
START TIME	06/13 14:23	
USAGE TIME	12'49	
PAGES	12	
RESULT	OK	

Re: Package Sent to Ms. Stephanie Hirst of Senator Domenici's Office —

R Pierce
6/13/94

Confirmation!

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

EXHIBIT H2: Number of Employees, Annuitants, and Dependents Covered Under the FEHB Program, September 30, 1993

State	Code	Carrier name	Employees	Annuitants	Total enrollment	Dependents	Total coverage
Governmentwide							
	10	Blue Cross and Blue Shield	706,687	962,304	1,668,991	1,202,619	2,871,610
		High option	15,555	43,035	58,590	13,256	71,846
		Standard option	691,132	919,269	1,610,401	1,189,363	2,799,764
Subtotal			706,687	962,304	1,668,991	1,202,619	2,871,610
Employee Organizations							
	31	GEHA	170,250	129,225	299,475	389,896	689,371
	32	NALC	71,482	99,544	171,026	199,534	370,560
	36	Postmasters	7,354	11,586	18,940	14,118	33,058
		High option	2,555	2,822	5,377	3,853	9,230
		Standard option	4,799	8,764	13,563	10,265	23,828
	38	Rural Carrier Benefit Plan	19,559	29,518	49,077	52,944	102,021
	40	Foreign Service	5,283	5,800	11,083	8,451	19,534
	43	Panama Canal Area	4,535	9,930	14,465	19,624	34,089
	44	SAMBA	11,409	7,928	19,337	21,692	41,029
	45	Mail Handlers	370,867	120,051	490,918	710,509	1,201,427
		High option	346,807	109,021	455,828	677,342	1,133,170
		Standard option	24,060	11,030	35,090	33,167	68,257
	47	APWU	52,747	72,878	125,625	129,077	254,702
	Y2	BACE	9,290	393	9,683	5,883	15,566
	Y7	Secret Service	1,625	822	2,447	3,167	5,614
	YK	Alliance	4,878	10,572	15,450	12,137	27,587
	YP	NAPUS	4,326	5,640	9,966	11,571	21,537
Subtotal			733,605	503,887	1,237,492	1,578,603	2,816,095
Comprehensive Plans - Experience Rated							
AL	C2	Principal HC of Florida	770	320	1,090	1,372	2,462
CA	61	CIGNA Medical Group Healthplan	931	296	1,227	1,326	2,553
CA	M5	Blue Cross CaliforniaCare	6,241	571	6,812	10,221	17,033
CA	SJ	Blue Shield of California HMO	713	73	786	950	1,736
CA	SK	CIGNA Healthplans of CA	238	99	337	266	603
GA	CR	HMO Georgia	966	178	1,144	1,060	2,204
GU	ZA	Guam Memorial Health Plan	800	364	1,164	2,367	3,531
		High option	762	332	1,094	2,243	3,337
		Standard option	38	32	70	124	194
HI	87	HMSA	13,641	11,621	25,262	47,134	72,396
IA	56	HMO Iowa	383	39	422	353	775
IL	FX	CarleCare	1,460	678	2,138	3,068	5,206
IL	LG	Foundation Program	567	194	761	624	1,385
NJ	80	GHI Health Plan	37,496	13,883	51,379	62,317	113,696
OH	R4	Principal Health Care of Ohio	2,302	367	2,669	3,789	6,458
OH	R5	HMP/Ohio	3,659	703	4,362	5,328	9,690
OH	RH	Western Ohio Health Care Plan	7,447	1,207	8,654	11,765	20,419
PR	89	SSS Plan	10,630	6,539	17,169	30,280	47,449
WA	VT	Kitsap Physicians Service	2,100	2,423	4,523	4,713	9,236
		High option	620	913	1,533	1,432	2,965
		Standard option	1,480	1,510	2,990	3,281	6,271
WI	29	Physicians Plus HMO	298	60	358	490	848
WI	CV	HMO Midwest	360	128	488	822	1,310
Subtotal			91,002	39,743	130,745	188,245	318,990

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FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

EXHIBIT H2: Number of Employees, Annuitants, and Dependents Covered Under the FEHB Program, September 30, 1993—Continued

State	Code	Carrier name	Employees	Annuitants	Total enrollment	Dependents	Total coverage
Comprehensive Plans - Community Rated							
AL	AA	PrimeHealth	201	116	317	515	832
AL	DF	Health Partners of Alabama	2,099	210	2,309	3,632	5,941
AL	NJ	Complete Health of Alabama	1,552	134	1,686	2,744	4,430
AL	NL	Complete Health of Alabama	572	79	651	1,073	1,724
AL	NS	Humana Health Plan of Alabama	845	192	1,037	1,045	2,082
AL	NY	Complete Health of Alabama	1,201	201	1,402	2,231	3,633
AL	PY	Humana Health Plan of Alabama	177	64	241	86	327
AR	QC	Complete Health of Arkansas	681	33	714	1,313	2,027
AR	RB	American HMO Health Plan	739	144	883	1,512	2,395
AZ	16	CIGNA HP of AZ-Phoenix	2,927	1,539	4,466	5,705	10,171
AZ	A3	FHP	3,335	681	4,016	6,718	10,734
AZ	A7	Intergroup of Arizona, Inc.	5,476	1,332	6,808	11,837	18,645
AZ	B1	CIGNA HP of AZ-Tucson	720	463	1,183	1,258	2,441
AZ	DY	Humana Phoenix	733	142	875	954	1,829
AZ	K9	FHP	371	125	496	611	1,107
AZ	QS	PARTNERS, an Aetna Health Plan	542	50	592	1,063	1,655
AZ	TD	PARTNERS, an Aetna Health Plan	1,673	230	1,903	3,492	5,395
CA	59	Kaiser Permanente	50,905	35,624	86,529	99,484	186,013
CA	62	Kaiser Permanente	40,199	21,617	61,816	77,361	139,177
CA	86	FHP	4,641	736	5,377	5,346	10,723
CA	BE	ValuCare/Central Valley Health	1,860	213	2,073	2,604	4,677
CA	BG	CareAmerica HP	1,250	100	1,350	2,042	3,392
CA	BU	Aetna HPs of N. California	1,631	461	2,092	2,303	4,395
CA	C4	United Health Plan	30	6	36	29	65
CA	C6	Foundation Health	3,764	2,219	5,983	6,501	12,484
CA	CC	QualMed Plans for Health	3,308	771	4,079	7,088	11,167
CA	CD	Lifeguard Health Plan	1,713	257	1,970	2,747	4,717
CA	CF	Qual-Med California	1,534	415	1,949	2,205	4,154
CA	CL	Qual-Med CA Valley Plan	99	34	133	164	297
CA	CM	Maxicare Southern California	1,008	71	1,079	1,478	2,557
CA	CQ	PacifiCare of California	6,809	876	7,685	15,099	22,784
CA	CW	Health Plan of the Redwoods	506	301	807	741	1,548
CA	CX	Maxicare Northern California	736	94	830	1,022	1,852
CA	CY	TakeCare Health Plan (CA)	8,287	437	8,724	6,406	15,130
CA	HN	Omni Health Plan	1,138	281	1,419	724	2,143
CA	LB	Health Net	11,826	1,639	13,465	18,971	32,436
CA	LC	TakeCare Health Plan, Inc.	2,337	668	3,005	3,341	6,346
CA	MN	National Med	259	68	327	613	940
CA	NI	Aetna HPs of San Diego, Inc.	299	56	355	435	790
CA	RC	Kaiser Permanente	747	190	937	1,757	2,694
CA	RG	Aetna HPs of Southern CA, Inc.	282	125	407	374	781
CO	65	Kaiser Permanente	7,936	3,094	11,030	13,764	24,794
CO	88	Rocky Mountain HMO	625	469	1,094	1,563	2,657
CO	D6	COMPRECARE	14,632	2,071	16,703	21,951	38,654
		High option	12,724	1,865	14,589	19,173	33,762
		Standard option	1,908	206	2,114	2,778	4,892
CO	DC	Humana Health Plan - Colorado	58	7	65	50	115
CO	DD	TakeCare Colorado	2,996	1,078	4,074	6,499	10,573
CO	L2	HMO Colorado/Nevada	1,018	226	1,244	1,652	2,896
CO	MT	QualMed Plans for Health	277	88	365	562	927
CT	71	Community Health Care Plan	872	349	1,221	1,337	2,558
CT	DJ	Health New England	2,060	221	2,281	3,937	6,218

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

EXHIBIT H2: Number of Employees, Annuitants, and Dependents Covered Under the FEHB Program, September 30, 1993—Continued

State	Code	Carrier name	Employees	Annuitants	Total enrollment	Dependents	Total coverage
CT	DM	Kaiser Permanente	960	148	1,108	1,540	2,648
CT	DP	Physicians Health Services/CT	2,037	492	2,529	2,975	5,504
CT	H1	US Healthcare	1,896	164	2,060	1,733	3,793
CT	QF	HMO Blue	1,196	331	1,527	2,032	3,559
DC	50	Group Health Association	17,764	8,259	26,023	23,506	49,529
		High option	10,430	5,081	15,511	13,396	28,907
		Standard option	7,334	3,178	10,512	10,110	20,622
DC	DS	Principal HC of Mid-Atlantic	207	17	224	177	401
DC	E3	Kaiser Permanente	40,014	4,267	44,281	56,545	100,826
DC	E5	George Washington Univ HP	14,828	1,325	16,153	12,545	28,698
		High option	12,298	1,236	13,534	11,379	24,913
		Standard option	2,530	89	2,619	1,166	3,785
DC	HD	Prudential Health Plan/Mid-Atl	1,700	88	1,788	1,667	3,455
DC	JN	HealthPlus	25,842	1,458	27,300	35,803	63,103
		High option	21,274	1,306	22,580	30,058	52,638
		Standard option	4,568	152	4,720	5,745	10,465
DC	JP	M.D. IPA	18,319	1,265	19,584	25,825	45,409
DC	JQ	CareFirst	5,909	464	6,373	8,523	14,896
DC	US	US Healthcare	211	4	215	90	305
DC	V8	Aetna HPs of the Mid-Atlantic	13,207	507	13,714	16,730	30,444
		High option	13,202	507	13,709	16,724	30,433
		Standard option	5	0	5	6	11
DC	X9	HealthKeepers	424	47	471	275	746
DE	MR	Healthcare Delaware	287	87	374	509	883
DE	NK	US Healthcare	511	69	580	524	1,104
DE	SP	Delaware Valley HMO	511	81	592	734	1,326
FL	D5	Health Options-Pensacola	354	120	474	614	1,088
FL	D7	Health Options-Tampa Bay	170	68	238	257	495
FL	E8	Health Options-Jackson/Gaines	971	169	1,140	1,624	2,764
FL	EA	Capital Health Plan	603	140	743	1,262	2,005
FL	EC	PruCare of Jacksonville	2,585	426	3,011	3,781	6,792
FL	EE	Humana Medical Plan	3,237	368	3,605	6,478	10,083
FL	EH	PruCare of Orlando	879	251	1,130	1,358	2,488
FL	EJ	CIGNA Healthplan of Florida	418	151	569	403	972
FL	EM	AV-MED Health Plan	626	83	709	573	1,282
FL	EN	CIGNA Healthplan of Florida	282	101	383	317	700
FL	FH	PruCare of Tampa Bay	461	114	575	709	1,284
FL	FN	Health Options-South Florida	136	36	172	323	495
FL	FQ	Family Health Plan/FL	461	35	496	997	1,493
FL	FR	Health Options-South Florida	448	75	523	772	1,295
FL	GP	AV-MED Health Plan	244	83	327	428	755
FL	HS	AV-MED Health Plan	304	98	402	473	875
FL	HE	PruCare of South Florida	223	44	267	317	584
FL	HW	AV-MED Health Plan	417	108	525	443	968
FL	JF	AV-MED Health Plan	307	51	358	474	832
FL	JH	Humana Medical Plan	2,015	437	2,452	4,014	6,466
FL	K7	HIP Network of Florida	209	91	300	298	598
FL	P5	Humana Medical Plan	786	150	936	1,709	2,645
FL	P7	Humana Medical Plan	310	208	518	739	1,257
FL	PJ	PCA Health Plans of Florida	467	25	492	944	1,436
FL	QK	CAC-Ramsay, Inc.	40	6	46	46	92
FL	QW	PCA Health Plans of Florida	183	11	194	371	565
GA	EZ	PruCare of Atlanta	2,876	247	3,123	3,896	7,019

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

EXHIBIT H2: Number of Employees, Annuitants, and Dependents Covered Under the FEHB Program, September 30, 1993—Continued

State	Code	Carrier name	Employees	Annuitants	Total enrollment	Dependents	Total coverage
GA	F3	Aetna HPs of Georgia, Inc.	1,854	131	1,985	1,747	3,732
GA	F8	Kaiser Permanente	7,675	625	8,300	12,471	20,771
GU	28	Health Maintenance Life	185	214	399	854	1,253
GU	JK	FHP	1,060	709	1,769	4,413	6,182
HI	63	Kaiser Permanente	4,499	4,459	8,958	9,512	18,470
		High option	4,304	4,383	8,687	9,269	17,956
		Standard option	195	76	271	243	514
HI	F6	HMSA's CHP	607	383	990	1,042	2,032
HI	F9	Island Care	141	81	222	228	450
IA	FA	Care Choices	298	86	384	758	1,142
IA	GS	United Healthcare of Iowa	1,052	122	1,174	2,149	3,323
IA	GU	Principal HC of Nebraska	1,362	166	1,528	2,768	4,296
IA	NF	Share Health Plan of Nebraska	761	119	880	1,555	2,435
ID	GM	Idaho Preferred Healthcare	647	120	767	1,196	1,963
ID	TM	Qual-Med Washington Hlth Plan	3,372	659	4,031	6,286	10,317
ID	VR	Group Health Northwest	3,062	781	3,843	6,382	10,225
IL	12	MetLife HealthCare Network	1,414	642	2,056	2,866	4,922
IL	17	Rush Prudential HMO, Inc.	2,112	501	2,613	3,278	5,891
IL	75	Humana Michael Reese HMO	7,221	1,895	9,116	12,607	21,723
IL	76	Union Health Service	151	78	229	218	447
IL	AC	American HMO Health Plan	150	27	177	279	456
IL	EU	Dreyer HMO	523	89	612	1,267	1,879
IL	FJ	Chicago HMO Ltd	7,152	419	7,571	11,286	18,857
IL	FP	Share Health Plan of Illinois	2,933	180	3,113	5,688	8,801
IL	FV	Maxicare Illinois	668	98	766	1,154	1,920
IL	FY	TakeCare Health Plan of IL	931	124	1,055	1,765	2,820
IL	GE	PersonalCare's HMO	497	285	782	844	1,626
IL	GQ	Humana HealthChicago	345	49	394	584	978
IL	H8	GenCare/SANUS Health Plan	2,828	276	3,104	5,683	8,787
IL	JL	BCI HMO, Inc.	192	59	251	249	500
IL	LF	BCI HMO, Inc.	1,062	174	1,236	1,504	2,740
IL	LH	Blackhawk Hlth. Assurance Plan	462	87	549	947	1,496
IL	M4	BlueChoice	3,280	405	3,685	5,433	9,118
IL	MM	Group Health Plan St. Louis	2,800	522	3,322	4,828	8,150
IL	RN	PARTNERS HMO	663	107	770	1,017	1,787
IN	18	Humana Care Plan	1,444	282	1,726	2,587	4,313
IN	D2	Humana Health Plan	3,858	513	4,371	7,001	11,372
IN	DQ	Physicians HP of N. Indiana	58	2	60	66	126
IN	G2	Arnett HMO	176	78	254	407	661
IN	GH	Key Health Plan	1,291	215	1,506	1,253	2,759
IN	GK	Maxicare Indiana	2,816	590	3,406	4,225	7,631
IN	H3	Welborn HMO	322	83	405	717	1,122
IN	IN	The M*Plan	915	234	1,149	1,742	2,891
IN	MC	PARTNERS Nat'l HPs of Indiana	158	39	197	326	523
KS	HA	Kaiser Permanente	3,657	309	3,966	6,531	10,497
KS	HM	HMO Kansas	1,458	187	1,645	3,180	4,825
KS	MS	Humana Prime Health	3,896	522	4,418	6,338	10,756
		High option	3,627	512	4,139	5,938	10,077
		Standard option	269	10	279	400	679
KS	N3	Principal HC of Kansas City	1,377	136	1,513	2,473	3,986
KY	DU	HealthWise of Kentucky	1,618	261	1,879	1,515	3,394
KY	HR	Humana Care Plan	1,265	305	1,570	2,425	3,995
KY	R8	TakeCare Health Plan	3,884	260	4,144	7,377	11,521

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

EXHIBIT H2: Number of Employees, Annuitants, and Dependents Covered Under the FEHB Program, September 30, 1993—Continued

State	Code	Carrier name	Employees	Annuitants	Total enrollment	Dependents	Total coverage
KY	S3	PruCare of Cincinnati	297	31	328	547	875
LA	JA	Maxicare Louisiana	984	150	1,134	1,726	2,860
LA	LY	Gulf South Health Plan, Inc.	109	10	119	222	341
LA	NG	Aetna HPs of Louisiana, Inc.	83	7	90	101	191
LA	RP	Principal HC of Louisiana	1,696	89	1,785	3,119	4,904
LA	RY	Community Health Network of LA	450	26	476	970	1,446
LA	S6	Community Health Network of LA	397	7	404	850	1,254
LA	S8	Community Health Network of LA	153	17	170	284	454
MA	68	Harvard CHP	6,582	1,538	8,120	7,506	15,626
MA	70	HARVARD CHP - New England	3,167	937	4,104	5,567	9,671
MA	DA	HMO Rhode Island	1,149	175	1,324	2,112	3,436
MA	J1	Central Mass. Health Care	650	145	795	1,082	1,877
MA	JV	Fallon Community Health Plan	1,875	436	2,311	3,610	5,921
MA	K1	Kaiser Permanente	720	167	887	1,305	2,192
MA	KW	Bay State Health Care	1,704	372	2,076	1,806	3,882
MA	NE	US Healthcare	4,226	204	4,430	8,961	13,391
MA	NX	Matthew Thornton Health Plan	1,166	223	1,389	1,378	2,767
MA	QD	HMO Blue	3,904	950	4,854	5,194	10,048
MA	QG	HMO Blue	122	22	144	144	288
MA	SM	Community Health Plan	398	104	502	656	1,158
MA	VF	Ocean State Physicians HP	762	100	862	1,332	2,194
MD	67	Columbia Medical Plan	6,910	1,064	7,974	8,607	16,581
MD	BL	Chesapeake Health Plan	2,277	136	2,413	4,099	6,512
MD	E7	Kaiser Permanente	1,652	144	1,796	2,273	4,069
MD	JB	Prudential Health Plan/Mid-Atl	6,368	512	6,880	10,036	16,916
MD	JM	Potomac Health	1,435	124	1,559	1,307	2,866
MD	JW	HealthPlus	2,773	167	2,940	4,367	7,307
		High option	2,290	134	2,424	3,773	6,197
		Standard option	483	33	516	594	1,110
MD	LD	Free State Health Plan	3,324	512	3,836	2,998	6,834
ME	CU	HMO Maine	103	33	136	84	220
ME	MY	Healthsource Maine	148	28	176	260	436
MI	52	Health Alliance Plan of MI	5,886	1,177	7,063	10,162	17,225
MI	BA	Care Choices	635	106	741	1,404	2,145
MI	BQ	Priority Health	294	31	325	643	968
MI	EG	M-CARE	684	50	734	1,142	1,876
MI	EV	Medical Value Plan	243	49	292	312	604
MI	FE	Care Choices	257	31	288	424	712
MI	G7	Blue Care Network, Great Lakes	191	68	259	425	684
MI	K3	The Wellness Plan	741	70	811	1,261	2,072
MI	K5	Blue Care Network of East MI	641	125	766	1,321	2,087
MI	K6	SelectCare HMO	3,319	436	3,755	6,372	10,127
MI	KA	OmniCare Health Plan	1,488	149	1,637	2,537	4,174
MI	KF	Blue Care Network, Great Lakes	976	156	1,132	1,760	2,892
MI	KN	Blue Care Network of East MI	253	51	304	423	727
MI	KR	Blue Care Network, Great Lakes	485	73	558	1,001	1,559
MI	KZ	Care Choices	607	83	690	764	1,454
MI	LN	Blue Care Ntwk-Health Central	860	142	1,002	1,421	2,423
MI	LX	Blue Care Network of SE MI	1,456	237	1,693	1,574	3,267
MI	N2	Total Health Care	131	11	142	238	380
MI	RL	Grand Valley Health Plan	81	3	84	136	220
MN	11	Medica Primary	2,656	722	3,378	4,644	8,022
MN	53	Group Health, Inc.	6,649	2,428	9,077	12,996	22,073

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

EXHIBIT H2: Number of Employees, Annuitants, and Dependents Covered Under the FEHB Program, September 30, 1993—Continued

State	Code	Carrier name	Employees	Annuitants	Total enrollment	Dependents	Total coverage
		High option	6,522	1,917	8,439	12,679	21,118
		Standard option	127	511	638	317	955
MN	DR	Medica Choice	5,104	1,048	6,152	8,436	14,588
MN	HQ	MedCenters Health Plan	389	48	437	664	1,101
MS	SR	CIGNA Healthplan of Tennessee	994	59	1,053	1,501	2,554
NC	EQ	PARTNERS NHP of North Carolina	338	37	375	579	954
NC	Q4	PruCare of Charlotte	493	110	603	743	1,346
NC	Q5	Maxicare North Carolina	721	123	844	1,223	2,067
NC	QT	Kaiser Permanente	2,939	417	3,356	5,256	8,612
NC	RQ	Carolina Physicians' Hlth Plan	457	43	500	733	1,233
ND	RU	Heart of America HMO	18	4	22	58	80
NH	J2	Healthsource New Hampshire	251	72	323	303	626
NH	QN	US Healthcare	356	13	369	392	761
NJ	27	Grt. Atlantic Health Service	1,574	465	2,039	1,773	3,812
NJ	E4	HMO BLUE	445	158	603	605	1,208
NJ	FK	Delaware Valley HMO	98	12	110	221	331
NJ	GD	Oxford Health Plans	373	33	406	476	882
NJ	HK	SANUS Health Plan	2,547	133	2,680	3,831	6,511
NJ	P3	US Healthcare	12,570	2,699	15,269	17,490	32,759
		High option	11,193	2,515	13,708	15,244	28,952
		Standard option	1,377	184	1,561	2,246	3,807
NJ	P4	CoMED HMO	1,642	471	2,113	2,475	4,588
NJ	P9	HIP/Rutgers Health Plan	5,207	1,254	6,461	9,154	15,615
NJ	SU	US Healthcare	19,339	4,546	23,885	33,554	57,439
		High option	18,693	4,427	23,120	32,547	55,667
		Standard option	646	119	765	1,007	1,772
NM	P2	FHP New Mexico	1,853	350	2,203	3,796	5,999
NM	PX	QualMed Plans for Health	1,534	255	1,789	2,984	4,773
NM	Q1	Lovelace Health Plan	6,266	2,506	8,772	12,167	20,939
NV	NM	Health Plan of Nevada	1,460	700	2,160	2,806	4,966
NV	TL	Humana Health Plan, Inc.	66	64	130	125	255
NY	15	Empire BC/BS HEALTHNET	119	85	204	100	304
NY	51	HIP of New York	11,117	5,679	16,796	18,306	35,102
NY	AH	BlueCARE Plus	64	73	137	93	230
NY	C1	Independent Health Association	313	21	334	520	854
NY	CE	Foundation Health Plan	323	75	398	691	1,089
NY	EB	Independent Prepaid HP	706	122	828	1,383	2,211
NY	F4	Mid-Hudson Health Plan	145	28	173	302	475
NY	GA	Mohawk Valley Health Plan	858	254	1,112	1,905	3,017
NY	GC	Oxford Health Plans	348	17	365	375	740
NY	GV	Preferred Care	1,833	341	2,174	3,925	6,099
NY	HU	CIGNA Healthplan of New York	246	49	295	411	706
NY	J6	ChoiceCare	655	56	711	1,123	1,834
NY	J7	Community Blue	1,479	600	2,079	3,065	5,144
NY	JC	US Healthcare	11,546	603	12,149	18,175	30,324
NY	M9	Mohawk Valley Health Plan	1,485	381	1,866	3,481	5,347
NY	MK	Blue Choice	1,277	352	1,629	2,601	4,230
NY	MX	Mohawk Valley Health Plan	262	33	295	368	663
NY	PD	Physicians Health Services/NY	159	36	195	145	340
NY	PW	Community Health Plan	3,307	829	4,136	6,734	10,870
NY	Q8	Health Care Plan	1,438	350	1,788	2,804	4,592
NY	QA	Independent Health Association	3,404	785	4,189	5,793	9,982
NY	QB	CHP/Hudson Valley Region	522	116	638	900	1,538

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

EXHIBIT H2: Number of Employees, Annuitants, and Dependents Covered Under the FEHB Program, September 30, 1993—Continued

State	Code	Carrier name	Employees	Annuitants	Total enrollment	Dependents	Total coverage
NY	QE	Prepaid Health Plan	752	176	928	1,590	2,518
NY	QH	Kaiser Permanente	387	141	528	707	1,235
NY	S1	Empire BC/BS HEALTHNET	215	80	295	470	765
NY	S2	Empire BC/BS HEALTHNET	352	86	438	618	1,056
NY	S7	Empire BC/BS HEALTHNET	1,143	348	1,491	1,689	3,180
NY	SG	Capital District Physicians'HP	1,649	325	1,974	2,666	4,640
NY	SH	PHP/Slocum-Dickson	286	82	368	647	1,015
NY	X4	WellCare of New York	114	5	119	209	328
OH	64	Kaiser Permanente	3,447	1,167	4,614	6,358	10,972
OH	AY	PruCare of Central Ohio	1,626	188	1,814	2,500	4,314
OH	L4	HMO Health Ohio	2,363	339	2,702	4,198	6,900
OH	MD	HMO Health Ohio	553	33	586	1,244	1,830
OH	MG	Licking Memorial Hospital HP	1,284	450	1,734	2,837	4,571
OH	OH	HMO Health Ohio	470	44	514	642	1,156
OH	PL	Personal Physician Care	174	9	183	271	454
OH	QJ	HEALTH GUARD	127	24	151	278	429
OH	QL	HEALTH GUARD	176	18	194	376	570
OH	RD	Aetna HPs of Ohio, Inc.	654	75	729	1,173	1,902
OH	RF	HealthOhio, Inc.	171	110	281	459	740
OH	SQ	Humana Health Plan of Ohio	427	74	501	695	1,196
OH	U4	Health Plan Upper Ohio Valley	286	56	342	535	877
OK	N1	PacifiCare of Oklahoma	1,228	170	1,398	2,676	4,074
OK	N5	BlueLincs HMO	2,590	408	2,998	4,827	7,825
OK	PE	PacifiCare	2,987	428	3,415	6,320	9,735
OK	RR	PruCare of Oklahoma City	2,974	920	3,894	5,717	9,611
OK	RS	PruCare of Tulsa	316	100	416	669	1,085
OK	RT	CIGNA Healthplan of Oklahoma	344	80	424	757	1,181
OK	RX	BlueLincs HMO	110	35	145	246	391
OR	57	Kaiser Permanente	8,770	5,657	14,427	17,742	32,169
		High option	7,809	4,273	12,082	15,578	27,660
		Standard option	961	1,384	2,345	2,164	4,509
OR	AF	QualMed Oregon	868	201	1,069	1,594	2,663
OR	SD	SelectCare Plus	824	416	1,240	1,741	2,981
OR	SS	PacifiCare of Oregon	1,196	395	1,591	2,254	3,845
PA	24	Advantage Health Plan	530	378	908	1,062	1,970
PA	26	HealthAmerica Pennsylvania	5,723	1,034	6,757	10,862	17,619
PA	C8	HMO of Northeastern PA	1,345	245	1,590	2,956	4,546
PA	CT	Aetna HP/Central & Eastern PA	512	97	609	939	1,548
PA	ED	Keystone Health Plan East	11,436	1,602	13,038	17,518	30,556
PA	EF	Keystone Health Plan West	593	145	738	1,187	1,925
PA	HG	Riverside Health Plan	304	69	373	728	1,101
PA	KJ	Aetna HP/Central & Eastern PA	612	104	716	1,255	1,971
PA	KL	US Healthcare	2,232	250	2,482	4,015	6,497
		High option	2,204	249	2,453	3,979	6,432
		Standard option	28	1	29	36	65
PA	N9	Geisinger Health Plan	4,269	1,078	5,347	8,499	13,846
PA	NQ	HealthGuard of Lancaster	401	111	512	846	1,358
PA	S4	Keystone Health Plan Central	440	100	540	892	1,432
PA	ST	Keystone Health Plan Central	114	24	138	233	371
PA	SW	HealthAmerica Pennsylvania	4,157	511	4,668	7,549	12,217
SC	M3	Healthsource South Carolina	842	186	1,028	1,508	2,536
SC	SE	Companion HealthCare	331	80	411	391	802
SC	TA	Maxicare South Carolina	868	237	1,105	1,622	2,727

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

EXHIBIT H2: Number of Employees, Annuitants, and Dependents Covered Under the FEHB Program, September 30, 1993—Continued

State	Code	Carrier name	Employees	Annuitants	Total enrollment	Dependents	Total coverage
TN	HT	Healthsource Tennessee, Inc.	499	82	581	1,018	1,599
TN	UA	PruCare of Nashville	846	153	999	1,273	2,272
TN	UB	PruCare of Memphis	2,114	259	2,373	3,078	5,451
TX	CK	FIRSTCARE	556	92	648	1,202	1,850
TX	GF	PacifiCare of Texas	5,196	650	5,846	10,712	16,558
TX	SC	Harris Methodist Health Plan	1,481	253	1,734	3,117	4,851
TX	T5	Coastal Bend Health Plan	602	167	769	1,041	1,810
TX	TS	SOUTHWEST, an Aetna HP	938	86	1,024	1,063	2,087
TX	TW	PCA Health Plans of Texas	3,513	390	3,903	5,802	9,705
TX	TX	Humana of Corpus Christi	2,547	586	3,133	6,721	9,854
TX	UF	Scott and White Health Plan	3,786	2,103	5,889	6,898	12,787
TX	UK	Kaiser Permanente	5,988	835	6,823	11,408	18,231
TX	UM	SANUS/New York Life Hlth Plan	2,374	359	2,733	4,273	7,006
TX	UN	PruCare of Austin	3,347	402	3,749	5,476	9,225
TX	UP	PruCare of Houston	5,090	472	5,562	10,173	15,735
TX	UR	Humana Health Plan	9,445	2,546	11,991	20,938	32,929
TX	V2	SANUS Texas Health Plan	5,452	310	5,762	10,155	15,917
UT	KU	FHP Utah	3,192	1,245	4,437	8,529	12,966
UT	UT	United HealthCare of Utah	1,410	111	1,521	3,602	5,123
VA	V5	Sentara Health Plan	6,480	560	7,040	12,130	19,170
VA	V6	PruCare of Richmond	834	171	1,005	1,264	2,269
VA	V7	HMO Virginia	666	124	790	885	1,675
VA	V9	OPTIMA Health Plan	4,866	779	5,645	8,625	14,270
		High option	2,037	548	2,585	4,187	6,772
		Standard option	2,829	231	3,060	4,438	7,498
VA	W2	CIGNA HP of Virginia	967	142	1,109	1,200	2,309
VA	W3	CIGNA HP of Virginia	1,585	174	1,759	2,362	4,121
VA	X8	HMO Virginia	878	128	1,006	1,214	2,220
WA	54	Group Health Cooperative	17,774	6,605	24,379	32,882	57,261
		High option	9,127	4,428	13,555	15,129	28,684
		Standard option	8,647	2,177	10,824	17,753	28,577
WA	WB	Pacific Health Plans	1,080	173	1,253	1,500	2,753
WI	69	Compcare Health Services	3,139	581	3,720	5,166	8,886
WI	W4	HMO OF WISCONSIN	584	169	753	1,303	2,056
WI	WC	U-CARE HMO, Inc.	286	52	338	466	804
WI	WD	DeanCareHMO	1,931	721	2,652	4,105	6,757
WI	WG	Maxicare Wisconsin	181	35	216	332	548
WI	WH	Family Health Plan	1,788	292	2,080	3,309	5,389
WI	WJ	Group Health Coop/S.C. WI	848	149	997	1,314	2,311
WI	WK	PrimeCare Health Plan, Inc.	1,075	203	1,278	2,001	3,279
WI	WT	Group Hlth Coop of Eau Claire	158	77	235	385	620
WI	X1	Wisconsin Health Organization	494	139	633	891	1,524
Subtotal			825,792	204,453	1,030,245	1,394,901	2,425,146
Total			2,357,086	1,710,387	4,067,473	4,364,368	8,431,841

NOTE: Dependents are not included in the headcount report, they are estimated using the following formula:

$$\frac{\text{Carrier data: Number of dependents}}{\text{Carrier data: Total enrollees}} \times \text{Headcount data: Total enrollees}$$

SOURCE: Semiannual headcount report, September 30, 1993.

F:\USERS\LPEARSON\STATAB-2.93

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
HEALTH LEGISLATION
WASHINGTON, D.C. 20201

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NAME: Jen Kline

OFFICE:

ROOM NO.:

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TOTAL PAGES (INCLUDING COVER): 3

DEPARTMENT OF HEALTH & HUMAN SERVICES

Karen L. Pollitz
Deputy Assistant Secretary for Legislation (Health)

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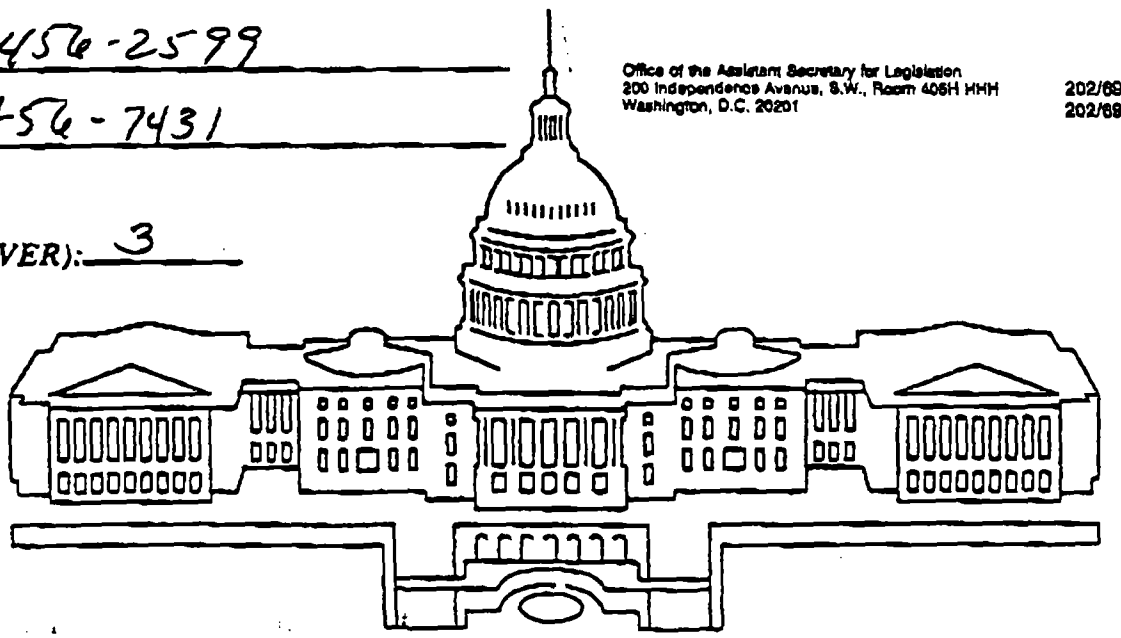

REMARKS:

Ken Thorpe reviewed text & says it's accurate. Table attachment is already cleared & around town. Apparently we have not released our dollar estimates of premiums by state.

Karen

Pls keep me when you get this. 668-7317

WHAT EFFECT WILL REGIONALIZATION HAVE ON PREMIUMS IN THE DISTRICT OF COLUMBIA?

An exact comparison of health insurance premiums in D.C. prior to and after reform would require more data than is currently available. Administration analysis of state-by-state impact of the Health Security Act, however, reveals that reform would be extremely beneficial to the residents, employers, and taxpayers of the District of Columbia:

* While we do not have comparable data on current premiums, we anticipate premiums in D.C. would be lower under the HSA than they are today. Guarantee of universal coverage and application of effective cost containment permits the removal of cost shifting due to uncompensated care from private rates.

* If the HSA were implemented today, premiums for the guaranteed benefits package in D.C. would be about 16% above the national average. Premiums in D.C. would be comparable to those charged in Maryland, Pennsylvania, New Jersey, and Connecticut and lower than those in Massachusets or New York.

* The District government would realize an estimated savings of $179 million on its medicaid program. Private sector employers in D.C. would save an estimated $21 million in health benefits spending. District residents would save $118 million in health care spending under the HSA.

(see attached)

SUMMARY: IMPACT ANALYSIS OF HSA ON STATES (Dollars in Millions)

STATE	COMBINED SAVINGS* (1)	PUBLIC SECTOR				PRIVATE SECTOR****	
		MEDICAI 97-2000	CB LTC 96-2000	MEDICAID PLUS LTC** 96-2000	ST. EMPLOYEE SAVINGS *** 2000	EMPLOYER SAVINGS 2000	WORKER SAVINGS 2000
AK	227	151	11	162	65	231	66
AL	639	543	40	583	56	799	771
AR	152	75	45	120	32	510	413
AZ	744	548	52	601	143	700	303
CA	6,457	5,583	186	5,751	707	11,910	3,275
CO	518	361	138	499	19	1,048	406
CT	1,247	439	583	1,022	225	1,135	296
DC	162	179	(17)	162	na	21	116
DE	203	55	25	80	123	77	95
FL	1,281	1,662	(527)	1,135	146	2,270	2,453
GA	1,077	861	107	968	109	879	1,474
HI	98	134	(29)	105	(7)	366	80
IA	339	134	137	271	68	343	220
ID	82	28	26	54	28	270	75
IL	1,499	1,464	(157)	1,308	191	3,657	1,308
IN	822	476	53	531	91	1,676	695
KS	548	373	45	418	129	385	205
KY	582	471	82	553	29	477	397
LA	928	968	(25)	943	(14)	630	763
MA	2,414	1,438	686	2,123	291	913	703
MD	1,001	678	247	925	75	129	625
ME	372	256	62	318	53	188	84
MI	2,548	1,752	357	2,109	440	3,287	342
MN	789	321	376	697	92	389	274
MO	806	616	134	750	56	1,212	418
MS	230	206	9	215	15	343	402
MT	95	27	57	84	11	235	85
NC	902	540	247	787	115	387	775
ND	71	20	43	63	8	120	43
NE	201	72	78	150	50	391	127
NH	248	94	94	188	60	310	192
NJ	3,743	2,935	378	3,313	430	1,843	482
NM	151	88	42	128	23	537	225
NV	131	102	(8)	95	36	748	153
NY	8,623	6,552	2,000	8,552	71	3,704	1,192
OH	1,618	1,041	330	1,371	247	3,348	672
OK	329	150	151	301	28	321	531
OR	503	192	219	411	92	1,039	208
PA	2,411	2,066	141	2,226	184	5,439	840
RI	384	230	92	322	42	329	58
SC	622	470	45	515	107	523	629
SD	56	22	32	54	1	187	75
TN	1,108	989	24	1,013	93	715	899
TX	3,255	2,346	272	2,618	637	1,880	2,883
UT	151	47	38	85	66	269	141
VA	659	493	(60)	433	226	354	1,189
VT	118	56	42	98	18	106	36
WA	1,335	947	178	1,125	210	1,601	345
WI	889	259	389	648	241	1,242	415
WV	326	147	63	210	116	434	283
WY	73	17	54	72	1	73	34
		DOLLARS IN BILLIONS					
US (2)	45.6	31.9	7.6	39.5	6.3	56.5	26.9

* "Combined Savings" is the sum of the Medicaid and Community-Based Long-Term Care (CB LTC) Savings and the State's Employee Health Benefits Savings.

** Combined savings in Medicaid expenditures and state-only expenditures for community-based long-term care.

*** Savings on state employee health benefits.

**** Savings for employers and workers in firms that currently offer insurance only.

(1) Assumes all states adopt reform on January 1, 1997.

(2) Assumes implementation as outlined in the Health Security Act. Due to different pr in umptions, state-by-state aggrega may not sum to national totals. Actual state savings will depend on when states adopt reform.

SOURCE: ASPE

FEHB Weighted Average Monthly Premiums – Programwide

Calendar Year	1984	1985	1986	1987	1988	1989
Weighted Avg Monthly Premium	151.40	149.68	132.57	155.74	195.99	235.86
% Change	9.9%	−1.1%	−11.4%	17.5%	25.8%	20.3%
Calendar Year	1990	1991	1992	1993	1994 **	
Weighted Avg Monthly Premium	256.46	268.48	288.25	312.23	323.18	
% Change	8.7%	4.7%	7.4%	8.3%	3.5%	

Premiums represent the total programwide weighted average monthly premiums.
Populations reflect March enrollment figures for each year.

**** 1994 weighted average premium is based on March, 1993 populations.**

Includes Postal

5/5/94 DRAFT

SUMMARY
COMPARISON OF HEALTH SECURITY ACT AND FEHBP BLUE CROSS / BLUE SHIELD STANDARD OPTION

This memo outlines the major differences between the Health Security Act (HSA) benefit package and the Blue Cross / Blue Shield (BC/BS) Standard Option benefit package offered under the Federal Employees Health Benefits Program (FEHBP). The attached table provides a more detailed comparison.

Major Areas of Difference

The major differences between the two benefit packages are in the following areas:

Cost sharing

- Out-of-pocket maximum
  --HSA uses $1,500 for individuals / $3,000 per family
  --BC/BS uses $3,250 for individuals not using preferred providers

- Deductibles
  --HSA uses a $200 for individual / $400 for family comprehensive deductible, with separate deductibles for drugs ($250) and dental ($50)
  --BC/BS uses a $250 deductible for hospital, $200 outpatient services, $50 drugs

- Coinsurance
  --HSA uses 20% for most professional services, with 20% cost sharing on drugs
  --BC/BS uses 25% for most professional services, with 40% cost sharing on drugs

Mental Health and Substance Abuse

- Lifetime maximums
  --HSA has no lifetime maximums
  --BC/BS has $50,000 lifetime maximum for mental illness, and one 28-day substance abuse treatment program per lifetime up to a $3,000 maximum

Other lifetime maximums

- HSA has no lifetime maximums
- BC/BS has $150,000 maximum for each of bone marrow, hear, heart-lung, liver, lung, and pancreas transplants

Extended care (nursing home, rehabilitation facility)

- HSA benefit package includes coverage of 100 days as alternative to hospital care
- BC/BS not covered

Adult dental care

- HSA prior to January 1, 2001 only covers adults for emergency dental treatment.
- BC/BS includes coverage for a specified list of dental procedures paid according to a schedule of allowances.

Vision care

- HSA benefit package includes coverage for routine eye examination and diagnosis and treatment for defects in vision. Also covered are eyeglasses and contact lenses for individuals under 18.
- BC/BS benefit package does not specifically cover, but does exclude eyeglasses, contact lenses, routine eye exams or vision testing for prescribing or fitting of eyeglasses or contact lenses.

Actuarial Comparisons

Actuarial comparisons of the HSA with other insurance policies and BC/BS Standard Option have been done from three perspectives[1]:

- **National Average Context**
  - -- HSA is approximately at 60th percentile
  - -- BC/BS is approximately at 30th percentile
- **Fortune 500 Context**
  - -- HSA is at approximately 50th percentile
  - -- FEHBP BC/BS Standard Option is at approximately 20th percentile

NOTE: Small changes in benefits can result in a comparatively larger change in placement in the percentile range because the benefit ranges that exist in plans between the 35th percentile plan and the 50th percentile are not substantial.

- **Actuarial Value**
  - -- BC/BS Standard Option (Single Premium $1,719) is approximately 11% less than HSA (Administration estimate of single premium $1,932)

---

[1]For purposes of all these comparisons the dental benefit was assumed to be the HSA benefit and the BC/BS plan was assumed to be the out-of-network fee-for-service option.

United States
Office of
Personnel
Management

FAX TRANSMITTAL SHEET

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Remarks

WARNING: Most Fax machines produce copies on mal paper. The image produced is highly unstable and will deteriorate significantly in a few years. It sh d be copied on a plain paper copier prior to filing.

From: Jenny Marion
To: Ira Forman
Date: May 27, 1994
Subject: Minimum Benefits in the FEHBP

Andy Bush who works for the minority Ways & Means Committee asked for a list of minimum benefits that are offered in the FEHBP. Insurance Programs is preparing a comprehensive list to be faxxed today.

From: Jenny Marion
To: Ira Forman
Date: May 27, 1994
Subject; Request for data on number of federal enrollees in Fee For Service Plans by state

Celinda Franco from CRS called the Office of Actuaries to ask for a copy of data on the number of federal enrollees who are in fee for service plans by state. We were able to give her the numbers by plan.

From: Nancy KICHAK (NHKICHAK)
To: CJSMITH
Date: Wednesday, May 25, 1994 8:31 am
Subject: Request from Senator Kennedy's Ofice

Suzanne Calzoncit has requested the actuarial value of Blue Cross High Option. They are thinking of plan ammendments that define the benefit package in terms of acturial value.

ACTUARIAL VALUES OF 1993 FEHBP PLANS

SOURCE: OPM\RIG\Office of Actuaries *25-May-94*

Plan Name	Annual Value of Self Options
Blue Cross / Blue Shield High	$2,048
Blue Cross / Blue Shield High PPO	$2,354
Blue Cross / Blue Shield Standard	$1,924
Blue Cross / Blue Shield Standard PPO	$2,336
B.A.C.E.	$2,037
FEHBP Program Weighted Average	$2,227

Actuarial Value of Reform Proposal As Compared to FEHB for 1993

Proposal	**- High Cost Sharing**	**1.000**
	- Low Cost Sharing	**1.232**
BC/BS Standard	**- Non-PPO**	**1.020**
	- PPO	**1.238**
Mail Handlers		**1.070**
APWU		**1.040**
GEHA		**1.060**
NALC		**1.073**
Kaiser N. California		**1.250**
Kaiser S. California		**1.240**
U.S. HealthCare Pennsylvania		**1.283**
HIP of New York		**1.336**

From: Nancy KICHAK (NHKICHAK)
To: CJSMITH
Date: Friday, May 27, 1994 8:58 am
Subject: Request from Senator Chaffee's Office

Senator Chaffee's office wants actuarial values of BC Standard and largest HMO. I am sending him the standard table. He also wants actuarial value without retiree costs. Since actuarial values are based on a standard inclusive group, he really wants an idea of premium. We will look to see what we have.