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Approximately 40 Health Plans Go Into Effect July 1

GOVERNMENT-WIDE HEALTH PLANS O.K.'D

The Civil Service Commission has approved the first two of about 40 plans which will be available to Federal employees under the Federal Employees Health Benefits Act of 1959. Contracts, scheduled to go into effect in July, have been signed with the Aetna Life Insurance Company for the Government-wide indemnity plan, and with Blue Cross-Blue Shield for the Government-wide benefit plan.

Contracts for health benefit plans offered by 15 Federal employee organizations, and by more than 20 carriers of comprehensive medical plans (pg. 8) will be approved as rapidly as final details can be worked out.

Every eligible employee will receive a copy of the Commission's official brochures describing each of the two Government-wide plans.

With respect to the Service Benefit Plan, agencies and installations will receive directly from their local Blue Cross-Blue Shield plans, a supplemental folder containing information about the Service Benefit Plan which is of local applicability.

Distribution of brochures on employee organization plans to employees will not be made by the Agency. Instead, the Commission will mail direct to each employee-member of an organization the brochure describing the plan of that organization. The employee organization will have the responsibility of distributing employee organization plans.

If you are in an area served by a Comprehensive Medical Plan, your Personnel Office will receive from their headquarters or other designated shipping points

brochures describing the comprehensive plans.

The choice of plans will be yours. The Civil Service Commission, the Agency and FLY-BY won't advise you which of the plans to subscribe to.

What happens if you fail to register? In this case, you will be contacted and urged to do so, even if it is a registration not to enroll. If you decline to file a Registration Form, one will be filed for you and a notation made in the "Remarks" that "employee contacted but declines to register."

By the same token, if for some reason you cannot be contacted, a Registration Form will be filed for you and the remarks will simply state, "unable to contact." But the Group Health Benefits regulations permit the employing office to determine that you were unable, for cause beyond your control, to register to enroll. When this is determined, you will be permitted to enroll within 31 days of your first opportunity to do so.

Effective date of enrollment is the first day of your pay period which begins on or after July 1, 1960, provided you were in a pay status at any time during the preceding pay period. If you were not in a pay status during this preceding pay period, your enrollment becomes effective on the first day of the pay period which begins at least 14 days after your return to pay status.

Medical Certificates--Whether a child over 19 and a husband included in the family enrollment of a female employee is incapable of self-support by reason of mental or physical disability is for final determination by the employing of-

fice, based on the medical certificate which must be obtained by the employee at his own expense and submitted with his Registration Form. The medical certificate must indicate the following:

- The name of the husband or child (and name of enrolling employee)
- The nature of his disability
- The period of time the disability has existed
- The probably future course and duration of the disability
- The doctor's name and address

In the case of a husband, the Health Benefits Act requires the disability which makes him incapable of self-support to be one which can be expected to continue for more than one year. In the case of a child, the disability must have existed before the child reached age 19. In either case, the Civil Service Commission construes the law to intend that only the most serious types of disability should be considered as qualifying the child or husband as incapable of self-support and then only if they can be expected to continue for a period of at least one year and if, in fact, the child or husband is not capable, because of the disability, of working at any job. (The fact that a child or husband may have investment income is not disqualifying because "dependency" is not a requirement.)

If you file a Registration Form and retire, die or are otherwise separated (except by transfer), before the effective date of enrollment, your registration will be void. What happens if, after you file a Registration Form, but before the effective date of enrollment you transfer to another employing office? In this case,

your registration is not void. It will be processed under permanent procedures for transfers between employing offices.

Registration Forms--The distribution of Health Benefits Registration Forms (Standard Form 2809) will be made from the Government Printing Office to Headquarters, each Regional Personnel Office (Health Benefits Officer), NAFEC and the Aeronautical Center and from there, forwarded to each eligible employee. Headquarters' Distribution will take care of the dissemination of forms to Washington headquarters personnel.

When you receive the form, fill it out carefully. Study all of the brochures on all of the Plans that pertain to you, your family and your area. Then, and only then, fill out the form. With the exception of Part D (which you will leave blank) answer all other questions fully giving correct information--and don't worry about Item 7. Your answer to this item has no bearing on the cost of insurance to you or to the benefits you will receive. It is placed there for statistical data only.

You must copy onto your Registration Form an Enrollment Code Number that shows which Plan, which Option, and which type of enrollment you want. This Code number will be supplied to you by the brochure covering each Plan. Be sure you copy both the name of the Plan and the Enrollment Code Number correctly.

When you have completed the Form, follow the instructions given to you by your local supervisor or representative. In general, the Form will be sent by him to the Personnel Office where your eligibility is determined and a copy placed in your file. The remaining two copies are sent to the Payroll Office where deductions are made and a copy retained. The third copy is sent to the carrier of your choice.

Personnel officers may start accepting completed forms on June 1, 1960. It would be wise not to wait until the last day (June 30, 1960) of the enrollment period. Your help in completing Standard

Form 2809 promptly will tend to level out the registration work load in the Agency and will facilitate timely handling of registrations by the carriers.

Regardless of which Option and Plan you decide upon, here are the facts which ALL Plans will contain.

Family Enrollment--A family enrollment must include all eligible members of your family. Eligible family members are your wife or husband and unmarried children under age 19. Unmarried children age 19 or over are also included if they are incapable of self-support because of a disability which began before age 19. A medical certificate for a child over 19 must be attached to the Registration Form and filed with your Personnel office.

Cancellation of Enrollment--Your enrollment cannot be canceled by the Plan because of the status of your health, or that of any member of your family, or because of the amount of benefits you used. But if you want to cancel your enrollment, you may do so at any time. To do this, get Standard Form 2809 from your Personnel Office, fill it out, and file it with that office.

Change in Enrollment--If you want to change type of enrollment from self only to family, or vice versa; if you want to change from one Option or Plan to another; or if you do not enroll now but wish to do so at a later date, consult your Personnel Office to see whether you can make the desired change and, if so, under what conditions.

Transfer--If you transfer to another agency, your coverage continues without change.

Leave Without Pay--If you go on leave without pay, your coverage and that of your family continues for up to a year without charge to you.

Military Service--If you go into the Armed Forces under conditions that entitle you and your family to health services or health benefits sponsored by the Government, your coverage under this Plan ceases while you are entitled to such benefits.

Death--If you die while enrolled for self and family, coverage of your survivor annuitants continues. If there is only one survivor, family coverage will automatically be changed to individual coverage.

Retirement--If you retire, you and covered members of your family may be eligible to continue in the Plan. See your Personnel Officer if you have any questions about your eligibility. You should file your retirement application as soon as possible to make sure that if you are eligible, your coverage under the Plan continues without interruption.

Temporary Extension of Coverage--When enrollment ends for any reason except voluntary cancellation, coverage continues for 31 days at no charge to you. If you or any covered member of your family is confined in a hospital or other institution on the 31st day of this temporary extension, that person's benefits will continue for the rest of the confinement, but not beyond 60 additional days.

Conversion--If your enrollment, or that of any member of your family, ends for any reason other than voluntary cancellation, coverage may be converted to a nongroup contract. This must normally be done during the 31-day "Temporary Extension of Coverage."

Termination of Plan--If for any reason your Plan is terminated, you will be given an opportunity to join another plan without interruption of your coverage.

The following information has been extracted from the brochure prepared by the Bureau of Retirement and Insurance at the Civil Service Commission and covers one of the Government-wide Plans. Each eligible employee will receive a copy of this brochure.

Government-wide Indemnity Benefit Plan (see chart page 4.) This Plan is provided by a large number of insurance companies and administered by Aetna Life Insurance Company. It has two levels of benefits--a high option and a low option. Both options offer the same kinds of benefits but differ in the amount of benefits payable and in cost to you.

This Plan provides benefits for: hospital room and board expenses; other hospital, surgical, and medical expenses; and maternity expenses. Here are the major features of this plan.

Pays for care and service in a hospital, at your doctor's office, at your home, or elsewhere; pays benefits for tuberculosis and for mental and nervous condition, both in and out of the hospital; benefits, including the "Maximum Benefit," apply equally and separately to each covered member of your family; a uniform benefit structure regardless of where you are; the same benefits, regardless of your income; choice of any recognized hospital or doctor; payments made direct to you or to your doctor and hospital.

This Plan does NOT provide benefits for: expenses incurred while not covered by the Plan; illness or injury covered by workmen's compensation; services and supplies not certified by a physician or surgeon as being necessary or for which you have no legal obligation to pay; services and supplies to the extent that they are over-priced; routine

FLY-BY

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physical examinations and eye examinations, and immunizations.

The Plan will pay benefits for semi-private or ward accommodations in a hospital for room, general nursing care, meals and special diets. If for any reason a private room is used, you must pay the difference between the cost of these accommodations and the hospital's average semiprivate accommodations.

The high option pays the first \$1000 of the cost and 80 percent of the remainder. The low option pays the first \$250 and 75 per cent of the remainder. You do not have to pay a deductible for hospital room and board in either option.

For other hospital, surgical and medical benefits, you pay the first \$50 under the high option and the Plan pays 80 percent of the remainder. Under the low option, you pay the first \$50 and the Plan pays 75 per cent of the remainder.

Expenses Covered--The Plan will pay benefits without regard to any fee schedules, for necessary expenses of:

- Professional services of physicians, surgeons, radiologists, internists, and other specialists, both in and out of a hospital. These include all surgery, office visits, home calls, doctor's visits in hospital and consultations.

- All services and supplies furnished by a hospital.

- Services and supplies, both in and out of a hospital. These include: registered graduate nurse (special nurse); drugs and medicines requiring a doctor's prescription; diagnostic X-ray and laboratory test and examinations; ambulance service; blood and blood plasma; electrocardiograms; anesthesia; basal metabolism tests; oxygen; surgical dressings, splints, and casts; intravenous injections and solutions; X-ray, radium, and radioactive isotopes therapy; artificial limbs and artificial eyes.

This Plan LIMITS benefits for: cosmetic surgery and treatment--to that necessary for prompt repair of injuries caused by accident; ambulance service--to that necessary to go to the first hospital where treated; services of a registered graduate nurse--to those of a nurse who is not related to you and does not ordinarily live in your home; physiotherapy--to that administered by a physician or prescribed by him and administered by a qualified physiotherapist who is not related to you and does not ordinarily live in your home; dental work--to that necessary for prompt repair of accidental injury to natural teeth and to oral surgery that does not involve any tooth structure, alveolar process, abscess, periodontal disease, or disease of gingival tissue; drugs and medicines while NOT confined in a hospital--the

first \$30 each calendar year is NOT covered; mental and nervous disorders while NOT confined in a hospital--to 50 per cent of covered expenses.

Maternity Benefits--There is no waiting period for Maternity Benefits. Under the high option, the Plan pays 100 percent of actual charges up to \$15 for each day in the hospital (up to 10 days) plus \$90 for obstetrician and \$18 for anesthetist for a normal delivery; or \$150 for obstetrician and \$30 for anesthetist for Caesarean section; or \$60 for obstetrician and \$12 for anesthetist for other termination of pregnancy. You pay any difference between the above amounts and the total of your actual expenses.

Under the low option, the Plan pays 100 per cent of actual charges up to \$10 for each day in the hospital (up to 10 days) plus \$60 for obstetrician and \$12 for anesthetist for normal delivery; or \$100 for obstetrician and \$20 for anesthetist

for Caesarean section; or \$40 for obstetrician and \$8 for anesthetist for other termination of pregnancy.

Under either option, you do not have to pay the \$50 deductible towards maternity benefits, and maternity benefits do not count against the maximum benefit.

The Deductible--The "Deductible" is the \$50 you pay before this Plan starts paying "Other Hospital, Surgical, and Medical Benefits." There is no deductible for hospital room and board expenses; \$50 deductible for other expenses; and no deductible for maternity expenses.

There is a separate "Deductible" for each member of your family. The "Deductible" is applied once in a calendar year for each person, regardless of how many different illnesses or accidents he may have. However, if you pay the "Deductible" for three members of your family in a calendar year, you do not have to pay any more "Deductibles" that year for other members of the family. The "Deductible" is the same--\$50 for either Option.

You can count toward the "Deductible" only those expenses that are covered under "Other Hospital, Surgical, and Medical" expenses. You cannot, therefore, count the first \$30 spent for drugs and medicines while not confined in a hospital.

Expenses applied against the "Deductible" in the last three months of a calendar year will be credited toward the "Deductible" for the next year.

Maximum Benefit--There is a "Maximum Benefit" for you and for each individual member of your family. Under the high option, this is \$30,000 for each person; under the low option, it is \$10,000 for each person. The "Maximum Benefit" is reduced by the amount of benefits (except Maternity) which are paid.

On January 1 of every year, each person gets an automatic restoration of benefits for future use. The amount of this restoration is whatever amount, UP TO \$1000, is needed to bring the high option "Maximum Benefit" back up to \$30,000. It is whatever amount UP TO \$500 is needed to bring the low option "Maximum Benefit" back up to \$10,000. You do NOT have to apply for this automatic restoration.

Any time your "Maximum Benefit" has been reduced by \$1000 or more, the full maximum amount can be reinstated upon satisfactory evidence of insurability. **Costs and Contributions**--The maximum amounts the Government can contribute toward the cost of employee policies are \$1.30 biweekly for single employees and \$3.12 for family coverage, except that if the covered family of a woman employee

Who is Eligible?

Just who is eligible to be enrolled in the Federal Employees Health Benefits Program? You are UNLESS you fall into one of the following groups:

- Employees serving under appointments limited to one year or less, except (1) employees so appointed for full-time employment without break in service or after a separation of three days or less, following service in which they were enrolled under this part, and (2) acting postmasters.

- Employees whose employment is of uncertain or purely temporary duration, or who are employed for brief periods at intervals, or who are expected to work less than six months in each year.

- Employees in the postal field service under temporary appointments pending establishment of a register.

- Part-time, when-actually employed, or intermittent employees having no regular tour of duty.

- Employees whose salary, pay, or compensation on an annual basis is \$12 a year or less.

- Beneficiary or patient employees in Government hospitals or homes.

- Employees paid on a contract or fee basis.

- Employees paid on a piecework basis, except those whose work schedule provides for regular or full-time service.

The Commission shall make final determinations of the applicability of this section to specific employees or groups of employees.

If you are excluded by law or regulation, you are NOT to file a Registration Form. But all non-excluded employees MUST register either to enroll or not to enroll.

GOVERNMENT-WIDE INDEMNITY BENEFIT PLAN

KINDS OF EXPENSES	HIGH OPTION				LOW OPTION			
Hospital Room and Board	PLAN PAYS				PLAN PAYS			
	First \$1,000 each calendar year 80% of any charge over that amount				First \$250 each calendar year 75% of any charge over that amount			
	YOU PAY				YOU PAY			
	20% of any charge over \$1,000				25% of any charge over \$250			
Other Hospital, Surgical, and Medical	PLAN PAYS				PLAN PAYS			
	80% of charges over first \$50				75% of charges over first \$50			
	YOU PAY				YOU PAY			
	First \$50 each calendar year (the Deductible) 20% of Remainder				First \$50 each calendar year (the Deductible) 25% of Remainder			
Maternity	PLAN PAYS				PLAN PAYS			
	Hospital--up to \$15 a day for 10 days Obstetrician--up to \$90 for normal delivery, \$150 for Caesarean, \$60 for miscarriage Anesthetist--up to \$18 for normal delivery, \$30 for Caesarean, \$12 for miscarriage				Hospital--up to \$10 a day for 10 days Obstetrician--up to \$60 for normal delivery, \$100 for Caesarean, \$40 for miscarriage Anesthetist--up to \$12 for normal delivery, \$20 for Caesarean, \$8 for miscarriage			
	YOU PAY				YOU PAY			
	The Remainder				The Remainder			
Maximum Benefit	\$30,000				\$10,000			
Monthly Rates		Govt.	Emp.	Total		Govt.	Emp.	Total
	Self Only	\$ 2.82	\$ 3.94	\$ 6.76		\$ 2.82	\$ 2.82	\$ 5.64
	Family	6.76	10.70	17.46		6.76	6.76	13.52
	Female with non-dependent husband	3.94	13.52	17.46		3.94	9.58	13.52

includes a nondependent husband the contribution will be \$1.82. Opposite the same set of figures, your contribution under the high option will be \$1.82; \$4.94 and \$6.24. The low option will cost you \$1.30; \$3.12 and \$4.42.

Other Facts--Under this Plan, if you are confined to a hospital or other institution on the effective date of enrollment you will have your "Maximum Benefit" limited to \$1000 under the high option, or to \$500 under the low option. This limitation will be removed after you have been free of confinement for 31 consecutive days.

The Plan covers charges to the extent that they are reasonable and customary. Whether a charge is reasonable and customary is determined by comparing it with charges made for similar services or supplies provided under similar conditions to people under like circumstances. If there is a good reason for a higher charge, the Plan will cover it.

If the hospital makes a flat daily charge, without stating how much is for

room and board and how much for other services, 60 percent of the charge will be considered to be for room and board. If it uses a schedule of charges that gets lower the longer you stay, 90 percent of the lowest daily charge will be considered room and board expenses.

If you change from one option to the other under this Plan, the new option will cover only the expenses incurred after the change is effective. If any member of your family is confined in a hospital or institution on the day the change is effective, benefits for that person will be payable under the provisions of the former option for the rest of the confinement, but not beyond 91 days.

If you change options, expenses applied against your "Deductible" for the calendar year under one option are applied against your "Deductible" for the same calendar year under the new option.

If you change options, all benefits charged against your "Maximum Benefit" under one option and not then re-

stored or reinstated, count as charges against your "Maximum Benefit" under the other option.

If any covered member of your family is confined in a hospital or other institution on the day enrollment is changed to another Federal employees health benefits plan, benefits will be continued under the old enrollment for the rest of the confinement, but not beyond 91 days.

If your enrollment terminates other than by voluntary cancellation, or if your enrollment continues but one of your dependents ceases to qualify as an eligible dependent, you or your dependent has the right to obtain, without any requirement of evidence of insurability, a nongroup contract of accident and health insurance of a kind then being issued by Aetna for group conversion purposes. Renewal of the nongroup contract can be refused only for reasons of fraud, overinsurance, or nonpayment of premiums when due.

Written application for the converted contract normally must be made and

GOVERNMENT-WIDE SERVICE BENEFIT PLAN

KINDS OF EXPENSES	HIGH OPTION				LOW OPTION			
	BASIC BENEFITS		DEDUCTIBLE	SUPPLEMENTAL	BASIC BENEFITS		DEDUCTIBLE	SUPPLEMENTAL
HOSPITAL ROOM AND BOARD	Up to 120 Days Per Admission in				Same as for High Option			
	Member Hospital	Non-Member Hospital			but up to 30 days			
	PLAN PAYS • in full	• \$12.00 a day	YOU	PLAN			YOU	PLAN
OTHER HOSPITAL SERVICES	YOU PAY • nothing	• remainder	PAY	PAYS			PAY	PAYS
	PLAN PAYS • in full	• 90% of actual charges	\$100	80%	Same as for High Option		\$200	75%
	YOU PAY • nothing	• remainder		of	but up to 30 days			of
SURGICAL and MEDICAL	PLAN PAYS • amount set by fee schedule		D	ADDITIONAL ALLOWABLE EXPENSES	PLAN PAYS • amount set by fee schedule		D	ADDITIONAL ALLOWABLE EXPENSES
	YOU PAY • any remainder		E		YOU PAY • the remainder		E	
	PLAN PAYS • up to \$100 hospital expenses plus amounts set by fee schedule for obstetrician & anesthesiologist		U	up to \$20,000 MAXIMUM SUPPLEMENTAL BENEFIT	PLAN PAYS • \$10 a day hospital expenses up to 10 days plus amounts set by fee schedule for doctor & anesthesiologist		U	up to \$5,000 MAXIMUM SUPPLEMENTAL BENEFIT
MATERNITY	YOU PAY • the remainder		T		YOU PAY • the remainder		T	
			I				I	
			B				B	
MONTHLY RATES			L				L	
			E				E	
		Govt.	Emp.	Total		Govt.	Emp.	Total
	Self Only	\$ 2.82	\$ 4.57	\$ 7.39		\$ 2.82	\$ 2.82	\$ 5.64
	Family	6.76	12.61	19.37		6.76	7.45	14.21
	Female with non-dependent husband	3.94	15.43	19.37		3.94	10.27	14.21

the initial premium paid to Aetna within 31 days after the end of the enrollment period in this Plan. Any converted contract issued under the above terms becomes effective at the end of the 31-day period of "Temporary Extension of Coverage."

If, by reason of law or employment, you or any member of your family is covered under any health benefits plan other than this Plan, the amount of any benefit paid under such plan may be deducted from your expenses before you receive any benefits under this Plan.

If another plan provides for the furnishing of services or supplies rather than for payments in cash, then the total cash value of all services and supplies furnished will be taken into account.

This Plan does not cover charges incurred for a member of your family during any period of time while coverage or continuation of benefits is provided under any other Federal employee's health benefits plan.

Coverage under any other plan which pays for loss of income or for time lost from work but not for hospital or medical expenses is not considered to be a double coverage.

How to Claim Benefits--Under this Plan you will be given two Identification Cards and a kit containing claim forms. You can obtain benefits by authorizing direct payment to the doctor or hospital or, by filing a claim so that the Plan can pay you direct. If you wish to authorize direct payment to a hospital, you merely present your Identification Card upon admission and complete a form which will be available at the hospital. You need file no claim.

In order to claim benefits direct you will send to the nearest claim office a completed Employee Statement of Claim; an attending physician's statement; one of your Identification Cards; and any receipts or bills connected with the claim. It will be wise to keep track of small medical expenses accumulating over a period of time. File a claim as soon as the covered expenses of any individual family member go over the \$50 "Deductible."

You will need complete and accurate records for each charge you want to count toward the "Deductible" and for each charge for which you claim benefits. Keep separate records for each member

of your family, since both the "Deductible" and the "Maximum Benefit" apply separately to each person. The kit you receive with your Identification Cards will help you keep track of each person's expenses. Bills and receipts should be itemized and should show:

- The date services or supplies are received
- The name of the family member concerned
- The name of the attending physician
- The prescription number of drugs and medicines

To assure prompt payment always submit claims promptly and always send in one of your Identification Cards. It will be returned with your benefit payment.

The following information has been extracted from the brochure prepared by the Bureau of Retirement and Insurance at the Civil Service Commission and covers one of the Government-wide Plans. Each eligible employee will receive a copy of this brochure.

Government-wide Service Benefit Plan (see chart page 5.) This Plan is provided by Blue Cross and Blue Shield. It provides benefits for hospital room and board ex-

penses; other hospital expenses; surgical-medical expenses; maternity expenses plus supplemental expenses.

Here are the major features of this Plan: pays for care and service in a hospital, doctor's office, your home, or elsewhere; benefits, including the "Maximum Benefit," apply equally and separately to each covered family member; Basic Benefits are generally paid directly to the doctor or hospital; Supplemental Benefits for services not fully covered by Basic Benefits are generally paid directly to you.

This Plan does NOT provide benefits for: Expenses incurred while not covered by the Plan; illness or injury covered by workmen's compensation; services and supplies not prescribed by a physician; services and supplies for which you have no legal obligation to pay; "personal comfort" services, such as radio, telephone, and beauty and barber services; routine physical examinations, immunizations, eye glasses or hearing aids, or examinations for them; travel, even though prescribed; convalescent or custodial care, or rest cures; care required as a result of war, declared or undeclared, or act of war occurring on or after the effective date of coverage.

This Plan LIMITS benefits for: private room accommodations in a hospital; dental work; cosmetic surgery; treatment of pulmonary tuberculosis and of mental and nervous disorders; patients in a hospital on the date of enrollment; certain cases where double coverage exists.

This Plan will pay benefits for semi-private or ward accommodations in a hospital for room, general nursing care, meals and special diets. If for any reason a private room in a Member Hospital is used, you must pay the difference between the charge for the private room and the hospital's average charge for semi-private accommodations (high option) or \$12.00 a day (low option).

Basic Hospital Room and Board Benefits--If you are in a Member Hospital this Plan provides full coverage. The high option takes care of up to 120 days for each admission and you will pay nothing; the low option takes care of up to 30 days per admission and you pay nothing. If you are in a Non-Member hospital the Plan pays the actual charges up to \$12 a day. The high option takes care of up to 120 days for each admission, and you will pay the remainder. Under the low option, up to 30 days per admission and you pay any remainder.

A "Member Hospital" is one that has agreed with Blue Cross to provide paid-in-full basic hospital benefits. A "Non-Member Hospital" is an institution, other than a Member Hospital, which is

engaged primarily in providing bed patients with diagnosis and treatment under the supervision of physicians and which has 24-hour-a-day registered graduate nursing service.

A Member Hospital will give you paid-in-full basic hospital benefits. You will be reimbursed for covered charges made by a Non-Member Hospital.

Overseas Hospitals--Usual and customary room and board charges of overseas hospitals are paid in full, up to the number of days provided by the option selected. Overseas hospitals include all those outside the United States, Puerto Rico, Canada, and Mexico.

Not covered by the Plan is room and board expenses in nursing homes, rest homes, hotels; or places for the aged, drug addicts, alcoholics, or in any other place which is not a "hospital"; hospitalization primarily for diagnostic studies or tests or for physiotherapy.

Basic Benefits for treatment of pulmonary tuberculosis and of nervous or mental disorders are limited to care provided in a hospital (not a sanatorium) and may not, during any 12 consecutive months, exceed 30 days under the high option or 10 days under the low option.

Separate stays in a hospital are considered as One Admission unless separated by at least 90 days. This 90-day requirement does not apply to confinement for normal maternity care or to a first admission for an accidental injury.

This Plan will pay benefits, to the extent mentioned above, for the following hospital services: use of operating, recovery, and treatment rooms and equipment; drugs and medicines for use in the hospital; dressings, ordinary splints, and plaster casts. The following, provided and billed for as a regular hospital service: laboratory examination; X-ray examinations; electrocardiograms; basal metabolism tests; radiation therapy; physical therapy; oxygen and its administration; administration of blood and blood plasma; anesthetics and their administration.

These supplies and services are available if you are a bed patient; if you receive surgical treatment in the out-patient department; or if you receive emergency treatment in the out-patient department within 72 hours after an accident.

Basic Surgical-Medical Benefits--In some areas of the United States, called "Service Areas," a participating physician will accept this Plan's Basic Benefits as full payment for surgery and certain other services, provided your family income is below a prescribed amount. A supplemental folder available from your Personnel Office

or from the Local Blue Shield Plan will show whether yours is a Service Area as far as this Plan and the option you select are concerned. The folder will also contain the Fee Schedules in effect in your area.

Not all areas known as "Service Areas" for usual Blue Shield purposes are "Service Areas" for purposes of this Plan. If you are under the Income Limit, it is essential that you check specifically whether your local Blue Shield physicians have agreed to accept as payment in full the payments made under this Plan and the particular option you select.

This Plan pays benefits for the following services when provided and billed for by a physician: surgery, radiation therapy and anesthesia whether you are in or out of the hospital. Physical therapy, laboratory, and pathological services--for hospitalized bed patients; doctors' visits in a hospital--non-surgical cases (up to 120 days per admission under the High Option, 30 days per admission under the Low Option); diagnostic X-ray (with film) for hospitalized bed patients or, within 72 hours after an accident, for patients in a doctor's office or hospital.

For purposes of this Plan, "Physician," "Doctor," "Surgeon," or "Specialist" means any physician who is legally qualified and licensed to practice medicine and perform surgery at the time and place services are rendered, including a dentist who is legally qualified and licensed to perform oral surgery.

Not covered by the Plan is local infiltration anesthetics; administration of anesthetics by the operating surgeon or his assistant; home and office visits by the physician (except that such visits for surgery and for radiation therapy are covered.)

Basic Maternity Benefits--There is no waiting period for maternity benefits. Under the high option the Plan pays 100 per cent of actual hospital charges, up to \$100. The low option pays \$10 for each day in the hospital, up to 10 days. Both options take care of obstetrician's services and anesthesiologist's services for the fee set by the schedule used locally. The amount will differ with the option. Under either option you pay any difference between the above benefits and the total of your actual expenses.

Maternity Benefits cover, to the extent mentioned above, expenses due to each pregnancy including childbirth, miscarriage, and for other termination of pregnancy; charges made by a hospital for care of the mother (routine nursery care of the infant is considered maternity expense of the mother and not expense of the child); fees of the physician

or surgeon who delivers the child; charges for the administration of anesthesia by a physician or surgeon who is not the attending physician or his assistant.

Maternity Benefits are paid instead of "Basic Hospital Room and Board Benefits," "Other Basic Hospital Benefits," "Basic Surgical-Medical Benefits," and "Supplemental Benefits."

Supplemental Benefits--These benefits supplement Basic Benefits in amount and kind; are available after you pay the deductible for the individual concerned; pay part of certain expenses over the deductible.

This Plan pays Basic Benefits as already described. Allowable expenses not covered by Basic Benefits count toward the Deductible; after it has been met, Supplemental Benefits will be available. If you pay the \$100 deductible the Plan will pay 80 per cent of the remainder and the maximum supplemental benefit will be \$20,000 (\$10,000 per Benefit Period). On the other hand, if you pay the \$200 deductible the Plan will pay 75 per cent of the remainder and the maximum supplemental benefit will be \$5000 (\$2500 per Benefit Period.)

Supplemental Benefits are paid, without regard to any fee schedules, for reasonable and necessary expenses for the following services and supplies, if not fully covered by Basic Benefits: services of physicians, including specialists, in and out of a hospital for surgery, office visits, home calls, consultations and doctor's visits in a hospital.

Hospital room and board; use of operating and treatment rooms; drugs and dressings used in a hospital; nursing services; prescription drugs used outside a hospital; X-ray and diagnostic laboratory procedures; local professional ambulance service related to in-patient care or to out-patient accident care; transfusions, including cost of blood and plasma; anesthesia; oxygen; braces, crutches, and artificial limbs and eyes, when prescribed; rental of durable equipment used for treatment; services of a qualified professional physiotherapist.

Supplemental Benefits are limited for cosmetic surgery and treatment, and dental work--to that required to correct accidental injury occurring while you are covered by this plan; nursing care--to that of a registered professional nurse (and, in a hospital, a registered practical nurse) who is not related to you. Low Option Benefits are limited to 75 per cent of those charges which do not exceed \$500.

Mental or nervous disorders--to in-

patient Care (including care in a mental institution) and 50 per cent of out-patient and out-of-hospital Care under high option; to in-patient Care in a hospital (not a mental institution) under low option; pulmonary tuberculosis--to in-patient Care in a hospital or sanatorium.

Hospital room and board expenses up to \$25 a day (high option) or \$15 a day (low option) may be charged to Supplemental Benefits, to the extent that the expense has not been covered by Basic Benefits. The Supplemental Benefits will pay 80 per cent (high option) or 75 per cent (low option) of such expenses after the Deductible has been met.

Benefit Period--A Benefit Period is the length of time during which Supplemental Benefits are provided. It begins on the first day of care by a physician, on which expenses chargeable to Supplemental Benefits are incurred. It ends 12 months after it began, or after 90 days without medical expenses, whichever occurs first. The first Benefit Period may begin on or after the effective date of coverage under this Plan. There is a separate Benefit Period for each covered member of the family.

Maximum Benefit--There is a Maximum Supplemental Benefit of \$10,000 for a Benefit Period under the high option, and \$2500 for a Benefit Period under the low option. The Maximum for two or more Benefit Periods is \$20,000 under the high option, \$5000 under the low. There is a separate Maximum Benefit for you and each covered member of your family.

Reinstatement of Maximum Benefit--When the \$20,000 or the \$5000 Maximum has been paid for an individual, it can be reinstated upon satisfactory evidence of his insurability.

The Deductible--The Deductible is the amount you pay before this Plan starts paying "Supplemental Benefits." The Deductible is \$100 under the high option, \$200 under the low option. There is no deductible for Basic Hospital Room and Board expenses; Other Basic Hospital expenses; Basic Surgical-Medical expenses; or Basic Maternity expenses. There is a \$100 or \$200 deductible for Supplemental expense.

There is a separate Deductible for each covered member of your family for each Benefit Period. However, if two or more covered members are injured in the same accident, you have to pay only one Deductible for those members. You can count toward the Deductible only those expenses that are reimbursable under Supplemental Benefits.

Costs and Contributions--The maximum amounts the Government can contribute toward the cost of employee policies are \$1.30 biweekly for single employees and

\$3.12 for family coverage, except that if the covered family of a woman employee includes a nondependent husband the contribution will be \$1.82. Opposite the same set of figures, your contribution under the high option will be \$2.11; \$5.82 and \$7.12. The low option will cost you \$1.30; \$3.44 and \$4.74.

Other Facts--A person confined to a hospital on the effective date of his enrollment will be entitled to Basic Surgical-Medical Benefits, except the physician's visits to a non-surgical patient in the hospital. He will also be entitled to Supplemental Benefits. These benefits will be limited to charges for services provided on or after the effective date of enrollment. He will not be entitled to Basic Hospital Room and Board Benefits or to Other Basic Hospital Benefits. These limitations cease to apply when the person leaves the hospital.

Option Changes--If you change from one option to the other under this Plan, the new option will cover the expenses incurred after the change is effective. If any member of your family is confined in a hospital on the day the change is effective, benefits for that person will be payable under provisions of the former option for the rest of the confinement, but not beyond 91 days.

If you change options, the same expenses applied against your Deductible for the Benefit Period under one option are applied against your deductible for the same Benefit Period under the new option.

If you change options, all benefits charged against your Maximum per Benefit Period under one option count as charges against your Maximum Benefit Period under the other option.

Change to Another Plan--If any covered member of your family is confined in a hospital on the day enrollment is changed to another Federal Employees Health Benefits Plan, benefits will be continued under the old enrollment for the rest of the confinement, but not beyond 91 days.

Conversion--If your enrollment terminates other than by voluntary cancellation, or if your enrollment continues but one of your dependents ceases to qualify as an eligible dependent, you or your dependent has the right to obtain from Blue Cross and Blue Shield, without any requirement of evidence of good health, a health benefits agreement of the type then being issued for conversion purposes. This conversion privilege does not, however, apply to Supplemental Benefits. Renewal of the conversion agreement can be refused only for reasons of fraud, overinsurance, or nonpayment of premiums when due.

Written application for the conversion agreement normally must be made and the initial premium paid within 31 days after the end of the enrollment period in this Plan. Any conversion agreement issued under the above terms becomes effective at the end of the 31-day period of Temporary Extension of Coverage.

Double Coverage--If, by reason of law or employment, you or any member of your family is covered under any health benefits plan other than this one, the amount of any benefits paid under such plan may be deducted from your expenses before you receive any Supplemental Benefits.

If another plan provides for the furnishing of services or supplies rather than for payments in cash, then the total cash value of all services and supplies will be taken into account.

Supplemental Benefits do not cover charges incurred for a member of your family during any period of time while coverage or continuation of benefits is provided under any other Federal employees health benefits plan.

Coverage under any other plan which pays for loss of income or for time lost from work but not for hospital or medical expenses is not considered to be double coverage.

How to Obtain Benefits--You will be given an Identification Card. Show it to the doctor or hospital whenever you receive service. To claim Basic Benefits in the United States the hospital or physician will fill out all necessary forms and send them to the local Blue Cross or Blue Shield Plan which, in most cases, will pay the benefit directly to the hospital or physician.

To claim Basic Benefits outside the United States pay the bills yourself and obtain itemized and receipted bills. Send these, along with your Identification Number, to Blue Cross-Blue Shield, 14th and L Streets, N. W., Washington 5, D. C. You will be reimbursed.

To claim Supplemental Benefits anywhere in the world send the following to Blue Cross-Blue Shield (same address):

- Completed Major Medical Claim Form (forms are available from Blue Cross or Blue Shield offices)
- Itemized bills and receipts connected with the claim
- The number from your Identification Card

Keep track of small medical expenses accumulating over a period of time, so that you can file a claim. When expenses

of any individual family member go over the Deductible, in the event of prolonged care, claims should be submitted every 90 days, or when charges incurred are substantial.

Records of Expenses are Important--

You will need complete and accurate claim records for each charge you want to count toward the Deductible and for each charge for which you claim benefits. Keep separate records for each member of your family, since both the Deductible and the Maximum Supplemental Benefit apply separately to each person.

Bills and receipts should be itemized and should show:

- The date(s) services or supplies are received, including date first seen by the physician
- The name of the family member concerned
- The nature of the illness or diagnosis
- The name of the attending physician
- The prescription number of drugs and medicines.

If, after you have registered, you have any problems or run into any trouble with any Plan or Option that you have decided upon and taken, get in touch with the Carrier of the Plan.

GEOGRAPHIC AREAS SERVICED BY THE APPROVED ORGANIZATIONS OFFERING A COMPREHENSIVE PLAN FOR APPROVAL UNDER P. L. 86-382 AS OF MARCH 10, 1960

ORGANIZATION AND NO. OF OPTIONS

Health Insurance Plan of Greater New York New York, New York (1)

Group Health Insurance, Incorporated New York, New York (2)

AF of L Medical Service Plan Philadelphia, Pennsylvania (1)

Group Health St. Paul, Minnesota (2)

The Bridge Clinic Seattle, Washington (1)

Group Health Cooperative of Puget Sound Seattle, Washington (2)

Western Clinic Tacoma, Washington (1)

GEOGRAPHIC AREA

New York City (Boroughs of Manhattan, Brooklyn, Bronx, Queens and Richmond) most of Nassau and a small part of Suffolk Counties, Yonkers and Columbia counties, Mt. Vernon.

New York, Kings, Queens, Bronx, Richmond, Westchester, Putnam, Rockland, Nassau, Suffolk, Orange, Sullivan, Ulster, Dutchess, Columbia, Greene, Delaware, Albany, Rensselaer, and Schenectady counties, in New York State, Bergen, Essex, Hudson, Morris, Passaic, and Union, counties in New Jersey

Metropolitan Philadelphia

Corporate Limits of Minneapolis, St. Paul, St. Anthony, Roseville, Lauderdale, Falcon Heights, Little Canada.

Greater Seattle

King County

Pierce County, Washington

North Idaho District Medical Service Bureau Lewiston, Idaho (1)	Bonner, Boundary, Shoshone, Kootenai, Benewoh, Latah, Nye, Perce, Clearwater, Lewis and Idaho Counties in Idaho; Asotin County in Washington
Seattle Letter Carrier Medical Service, Inc. Seattle, Washington (2)	Seattle, Washington
National Hospital Association Portland, Oregon (1)	King, Thurston, Pierce, Kitsap Snohomish, Pacific, Cowlitz, Clark, Yakima, Chelan, Walla Walla, Benton, Franklin, Spokane, and Skagit Counties in Washington; Multnomah, Marion Linn, Polk, Columbia, Washington, Clatsop, Yamhill, Lane, Hood River, Wasco, Umatilla, Clackamas, Jackson, Coos, Benton, and Douglas Counties in Oregon
Washington Physicians Service Seattle, Washington (1)	Washington State
Kaiser Foundation Health Plan Northern California Region Oakland, California (2)	San Francisco, San Mateo, Santa Clara, Alameda, Contra Costa, Solano, Napa, Sonoma and Marin Counties lying within a radius of thirty miles of the Hospitals or Medical Offices in Oakland, San Francisco, South San Francisco, Richmond, Vallejo, Walnut Creek, Redwood City, Napa, Pittsburgh, Concord, Martinez, San Rafael.
Kaiser Foundation Health Plan Southern California Region Los Angeles, California (2)	Los Angeles, San Bernardino, Riverside and Orange Counties lying within a thirty mile radius of the Hospitals or Medical Offices at Los Angeles, Santa Monica, Compton, Pasadena, San Bernardino, Glendale, Inglewood, North Hollywood, San Pedro, Long Beach, Ontario, Los Angeles Proper, West Central Los Angeles, Downtown Los Angeles and East Los Angeles.
Kaiser Foundation Health Plan of Oregon Portland, Oregon (1)	Within a radius of fifteen miles of any Hospital or Medical Office located in Portland, Oregon and Vancouver, Washington
Kaiser Foundation Health Plan Hawaii Region (1)	Island of Oahu, Hawaii
National Health Plan Los Angeles, California (2)	Los Angeles and Orange Counties
Ray E. Harris, M. D. and Staff San Francisco, California (2)	San Francisco and San Mateo Counties
Pacific Health Plan Los Angeles, California (2)	Within a radius of thirty miles of Main Office at 1901 South Trinity, Los Angeles, California
Ross Loos Medical Group Los Angeles, California (2)	Los Angeles and Orange Counties
Physicians and Surgeons Association San Francisco, California (2)	
Bay Group	San Francisco, San Mateo, Santa Clara, Marin, Contra Costa, Alameda Counties
San Diego Group	San Diego County
Gruber-DePaula Medical Group	Within a radius of fifteen miles of clinics at Santa Monica, West Los Angeles, Venice, Mar Vista, Pacific Palisades, Topanga.
Clinic Medical Center	Within a radius of fifteen miles of clinics at Long Beach, Garden Grove, Laguna Beach.
Hawaii Medical Service Association (1)	State of Hawaii including Oahu and the outlying islands.
San Joaquin Foundation for Medical Care Stockton, California (1)	Sonoma, Santa Clara, Stanislaus, Sacramento, San Joaquin, Tuolumne, Calaveras, Eldorado, Mariposa, Merced, Madera, Fresno, King, Tulare, Kern, San Bernardino, Riverside, San Diego, Orange, and Amador Counties.
Group Health Association, Incorporated, Washington, D. C. (2)	Within a radius of fifteen air miles from the White House, Washington, D. C.

MEET FAA'S FAMILY OF



Region One Manager Lawrence C. Elliott

Lawrence C. Elliott, 58, born in Greenville, Texas, was graduated from the Greenville, Texas high school. He then went to Texas A&M College from 1920 to 1924.

Mr. Elliott, who holds a commercial pilot's license, was awarded the Department of Commerce Exceptional Service Award in 1953. From June 15, 1923 to March 1928, he was in the Army Air Corps stationed at Brooks Field first in Primary Flying where he graduated with a Junior Airplane Pilot Rating and then Advance Flying.

From March 1928 to January 1933 he was Airways Extension Superintendent for the Bureau of Lighthouses Airways Division in Washington, D. C. This position required surveying both by air and on the ground to locate appropriate sites for the erection of beacons and the construction of intermediate fields 30 to 50 miles apart. He remained with the Bureau of Lighthouses until May 1935 but his status changed in January 1933 to Senior Airplane Pilot which required of him flight checking all aids to air navigation, both day and night, throughout the United States.

From May 1935 to May 1938 he was with the Bureau of Air Commerce stationed at Fort Worth, Texas. He managed the over-all program, maintaining aids to air navigation in the Fourth Air Navigation District.

From May 1938 to July 1945 he was with the CAA as Regional Manager with headquarters located at Fort Worth, Texas. Following field reorganization of the FAA, Mr. Elliott, in January 1960, was named Acting Regional Manager of the Second Region with Headquarters in Fort Worth.



Region Two Manager Archie W. League

Archie W. League, 52, a native of Poplar Bluff, Mo., studied Aeronautical Engineering in St. Louis. In the late 1920s he became the nation's first airport traffic controller. By then, he had learned to fly, operated his own flying circus, barnstormed Missouri and southern Illinois, and became one of the nation's first licensed airplane and engine mechanics, holding License Number 356.

After 10 years as a petty officer in Naval Reserve Aviation, Mr. League shifted to the Army Air Corps as a 2nd Lieutenant and served during World War II in the Pacific. He left the Army with the rank of Colonel to return to the CAA as Chief of the Operations Inspection Staff in the old Fifth Region in Kansas City. He was promoted to Chief of Planning and Evaluation Division on August 7, 1949, served as Deputy Regional Administrator in 1952 during the assignment of the regular Deputy to Hawaii, and was appointed Chief of the Airports Division in the Regional Office at Kansas City on May 22, 1955. On August 26, 1956, he was promoted to Assistant Regional Administrator for the Third CAA Region with headquarters in Kansas City. He also served as Chairman of the Civil Service Board of Examiners for the Agency. He is a jet pilot graduate of the Air Force Senior Officers Jet Instrument Course and has flown 52 different types of aircraft.

When CAA became FAA, he assumed duties as Chief of the Agency's Analysis Division in the Office of the Assistant Administrator for Plans and Requirements. On October 18, 1959, he became the Assistant Director of the newly-formed Bureau of National Capital Airports.



Region Three Manager Leonard W. Jurden

Leonard W. Jurden began his aviation career in 1918 when he joined the Army Signal Corps as an aviation cadet.

In 1928 he joined the Bureau of Air Commerce of the Department of Commerce. He was based at Wichita as an inspector of airplanes, engines, and later, aeronautical schools. In 1930 he was based in Kansas City.

In 1938, following the passage of the Civil Aeronautics Act, Mr. Jurden, who had been serving then in New York under the Air Commerce Bureau, was transferred back to Kansas City as Regional Manager of the then new CAA.

During World War II, he served with the Air Training Command.

Following the war, Mr. Jurden returned to the CAA and to Kansas City as Regional Administrator. He has logged more than 4000 hours of flying in some 50 different types of aircraft.

Following field reorganization of the Federal Aviation Agency, Mr. Jurden, in January 1960, was named Acting Regional Manager of the Third Region with Headquarters in Kansas City, Mo.

On April 23, 1960, Administrator Quesada named the six Regional Managers who will head up the Regional Offices under the Agency's field reorganization program. The appointments include two transfers in addition to the redesignations from Acting Regional Manager to Regional Manager. The two transfers involve A.W. League from Washington Headquarters to Region 2, and L.C. Elliott from Region 2 to Region 1.

REGIONAL MANAGERS



Region Four Manager Walter P. Plett

Walter P. Plett, 53, was born in Boston, Mass., and received his early schooling there. He earned his degree in Electrical Engineering at Northeastern University in Boston, graduating in 1927. For the next six years he was employed as a radio engineer with Westinghouse in Springfield, Mass., where he designed and supervised the manufacture of radio equipment.

Mr. Plett's career with the Federal Government started in 1934 when he accepted a position as a radio engineer in the Washington Office of the Federal Airways. In 1939, he was chosen as one of an initial group of 16 engineers assigned to launch the Federal Airways Program in Alaska as a project of the Civil Aeronautics Administration. When Alaska became such an important theater in military operations, he had advanced to the job of Superintendent of Airways.

In October 1945, Mr. Plett was named to the top post in Alaska—Regional Administrator. Between the years 1945-1955, he was responsible for directing all the activities including airway and airport development, traffic control and safety regulation and enforcement. He is a Past President of the Anchorage Kiwanis Club and a Charter Member of the Anchorage Chapter of SPEBSQA.

On March 27, 1955, Mr. Plett was named Deputy Regional Administrator of the Fourth CAA Region. In March of 1956 he was promoted to Regional Administrator of that Region which includes the eleven western states.

Following field reorganization of the Federal Aviation Agency, Mr. Plett, in January 1960, was named Acting Regional Manager of the Fourth Region with Headquarters in Los Angeles.



Region Five Manager Allen D. Hulen

Allen D. Hulen, 54, born in Lathrop, Mo., was graduated from the High School at Lawson, Mo. He enlisted in the Navy in 1924 and began extensive schooling and work in the field of radio operations. In the Navy he served at Bremerton, Wash., and on board various ships. He was honorably discharged in August 1930.

In December 1930 he joined the Air Navigation Division of the Bureau of Air Commerce in the Department of Commerce. He was radio and communications operator and instructed in these subjects at various CAA stations in Salt Lake City, Reno, Rock Springs, Wyoming, and Seattle.

In 1939 he was transferred to Anchorage where he became Communications Supervisor, Chief of the Communications Branch, Assistant Superintendent of Airways, Superintendent of the Airways Operation Branch and, in 1948, Assistant Regional Administrator.

During the war he was kept at his important post in Alaska where building, operation and maintenance of the airways assumed tremendous military importance. In 1955 he became Regional Administrator. In January 1960 he was named acting Regional Manager for the Fifth Region with Headquarters in Anchorage, Alaska.

Mr. Hulen, a flying, communicating Regional Manager and a veteran of 28 years of government service to civil aviation, flies all types of planes, having obtained his pilot's license in 1946. He travels over the whole of his vast region at least once a year on an annual inspection, and in many other trips involving supervision of airways aids and the routine administration of the 36 stations and 8000 miles of airways in Alaska.



Region Six Manager John M. Beardslee

John M. Beardslee, 52, was born in Washington, D. C. He was graduated from Tawas City High School, Tawas City, Mich. He attended Bay City (Michigan) Jr. College from 1924 to 1926 then went to Michigan State University until 1928 when he was graduated and received his B.S. degree. He started out in State Forestry working for the Michigan State Department of Conservation.

From August 1928 to July 1930 he worked in survey, design and supervision of contract construction of intermediate fields for the Airways Division of the Department of Commerce in Washington, D. C. From July 1930 to December 1935 he was Assistant Airways Engineer for the Lighthouse Service-Aeronautics Branch at Oakland, Calif., and Washington, D. C.

From February 1936 to June 1939 he was with the Bureau of Air Commerce as Assistant/Associate Civil Engineer in Oakland, Calif., then as Associate Civil Engineer at Santa Monica, Calif.

From June 1939 to February 1941 he was with the CAA in Anchorage, Alaska. From February 1941 to December 1942 he was transferred by the CAA to Santa Monica, Calif. as supervisor of engineers in site selection. From December 1942 to January 1950 he was with the CAA in Honolulu, T.H. as Manager of the Pacific Islands Office and then as Regional Administrator.

He became Deputy Director in the Office of Federal Airways from January 1950 to March 1954 in Washington, D. C., and later Director. From March 1954 to October 1956 he became Assistant Administrator for Operations. He has been Regional Administrator and Acting Regional Manager of the Sixth Region in Honolulu since October 1956.

Name Change Affects 336 Domestic and 11 International Stations

Air Traffic Communications Stations (ATCS) and International Air Traffic Communications Stations (IATCS) of the FAA now go under the name of Flight Service Station (FSS) and International Flight Service Station (IFSS) respectively. This re-naming properly identifies the primary functions these stations perform in the Agency's air traffic management responsibilities.

The name changes apply to 336 domestic and 11 international stations. The services provided by these stations are principally for aircraft in the general, business, and non-tactical military categories, as well as for air carriers in many cases. Air-ground communications pertaining to flight services are provided on airways and in all areas where control of airspace is conducted, and along regularly traveled VFR (visual flight rules) routes at the most used altitudes.

Domestic and international Flight Service Stations accept and close flight plans, and provide pre-flight pilot briefing, point-to-point communications, weather information, assistance to aircraft in trouble, initiate search and rescue actions, and other flight assistance services.

CAA Pin Found in Alaska

A CAA pin with a diamond inset has been found in Anchorage, Alaska. Sixth Region Headquarters has conducted a search of its Region but couldn't find the owner. If you have been in Anchorage lately and lost this pin, get in touch with the finder, Mrs. Alice Brown, 230 East Third St., Anchorage, Alaska.



Organizational Structure Established for Regions

A new organizational structure has been established for the Agency's six Regional offices, but does not include the Aeronautical Center and NAFEC.

The new organization will streamline procedures and assure greater efficiency and more uniform application of Agency programs and policies. The organization centralizes responsibility for the field activities of the major offices and bureaus (except Alaska and Hawaii) in the appropriate Washington Bureau or Office.

Each Regional Headquarters in the organization consists of a Regional Manager, an Assistant Regional Manager, a Public Affairs Officer, a Management Analysis Officer and the following staff and service elements:

An Audit Service Staff, Emergency Readiness Staff, Security Staff, an Accounting Division, Administrative Services Division, Budget Division, Legal Division and a Personnel and Training Division.

In addition, the Agency's program activities in each region will be conducted through these four field divisions:

- Air Traffic Management Field Division.
- Facilities and Materiel Field Division.
- Flight Standards Field Division.
- Aviation Medicine Field Division.

Regional Managers continue to have the authority formerly vested in Regional Administrators to direct all staff and supporting services which constitute the Office of the Regional Manager. In exercising this authority, the Regional Manager is subject to policy and technical guidance from the appropriate Washington Offices (and Bureaus).

In Regions 5 and 6, all components of the Regional Office are under the supervision of the Regional Manager. In Regions 1 through 4, the Regional Manager promotes coordination and the exchange of information among all field divisions and has direct supervision over the elements of the Office of the Regional Manager. The other Divisions in Regions 1 through 4 are under the direct supervision of their respective Washington Bureaus or Office.

In all Regions, the Regional Manager reports to the Administrator on all matters within his area of responsibility.

The heads of Washington Bureaus and Offices are authorized to establish the structure of their field counterparts.

New Computer Lab Opened at NAFEC

A new computer laboratory--with a UNIVAC File-1 computer and auxiliary devices similar to those being installed at air traffic controls in various parts of the country--has been opened at NAFEC.

The new laboratory will carry out experimentation on new operational concepts and improvements to the automatic computers already installed at Indianapolis, New York, Washington, Pittsburgh, Cleveland, and Boston.

These computers are currently used to relieve the human air traffic controllers of the tremendous work load involved in preparing the flight strips used to keep track of the aircraft under their control.

The new laboratory will, over the next two years, carry out the experiments necessary to "prove out" additional new functions of and improvement to the newly automated control centers. The experimentation will be done largely by simulator techniques or computers themselves. By thus eliminating the use of actual aircraft, greater freedom of experimentation in seeking improvements will be attained.

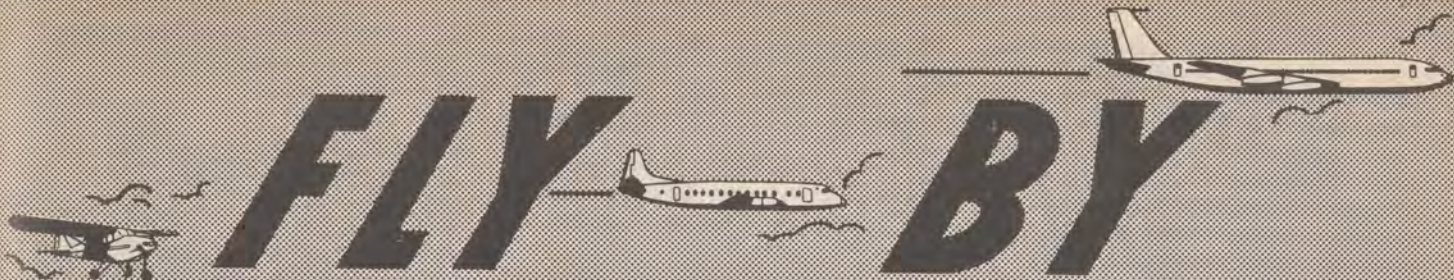
What is FLY-BY?

You have been seeing (and, it is hoped, reading) FLY-BY for more than a year. Yet information received from many sources reveal the fact that some of you still don't know exactly what it is and what it seeks to accomplish.

FLY-BY is the official Agency-wide house organ. It is published by the Agency at the middle management level, the Office of Personnel and Training, and is beamed in three directions--upward to top management, laterally to middle management, and outward to all employees. It is the middle-ground for collecting and disseminating information that may be of Agencywide interest and usefulness. It is distributed to FAAers around the world on the average of one copy for each two employees.

FLY-BY seeks only to inform--not entertain. Its columns are open to anyone with a legitimate story, article, or any item that might be of Agencywide interest. If you come across such an item for possible publication, by all means write it out and send it in.

Any and all correspondence is invited whether it be a story idea, a finished article, a photograph, a kindly nod, or even your strongest criticism.



OFFICIAL EMPLOYEE PUBLICATION OF THE FEDERAL AVIATION AGENCY

Volume 2 No. 6

SPECIAL ISSUE

May 1960

Proposed Draft of Agency Practice on Appeals and Grievances

WANTED--COMMENTS

The draft proposal of the Agency Practice governing the subject of Employee Appeals and Grievances is printed in full in this issue of FLY-BY. Remember, it is only a draft at the present time. If you have any comments to make about it, now's the time. Management desires that all employees participate in the development of this Agency Practice.

You, therefore, have this opportunity to review and comment on the matter of handling employee appeals and grievances in the Agency before approval of the final system. How do you do this? Just submit your comments.

After you have reviewed the draft of this Agency Practice, you are encouraged to submit your comments or reactions—whether favorable or unfavorable—with respect to this proposal. These should be sent to the Personnel Relations Branch, PT-26, FAA Headquarters, Washington 25, D.C. They should be received by July 1.

No particular form is necessary when you submit these comments. While your signature would be desired following the comments, you do not have to sign if you don't want to. All comments, suggestions and reactions will be carefully reviewed and considered in the development of the final Agency Practice.

EMPLOYEE APPEALS AND GRIEVANCES

- Section 1. Purpose
- Section 2. Scope
- Section 3. Policy
- Section 4. Definitions
- Section 5. Procedure
- Section 6. Appointment of Boards
- Section 7. Conduct of Board Proceedings
- Section 8. Leave and Travel
- Section 9. Appeals to Civil Service Commission
- Section 10. Safeguards
- Section 11. Assistance of Personnel Office

- Section 12. Information to Employees
- Section 13. Time Limits
- Section 14. Records and Reports
- Section 15. Responsibility

1. **PURPOSE:** This practice establishes Federal Aviation Agency policy, procedure and responsibility governing employee appeals and grievances in the FAA.

2. **SCOPE:** It applies to employee grievances and complaints generally, and to appeals concerning personnel actions such as promotions, reassignments, demotions, suspensions or disciplinary actions. It does not apply to appeals based on petitions or proposals from employee groups, position classification, performance ratings, restoration after military service, reduction-in-force, discrimination under EO 10590, adverse action under PL 733, or separations during probationary or trial periods. Information concerning appeals with respect to such matters are covered by Agency Practices dealing with the specific subject.

3. **POLICY:** It is the policy of the FAA that all of its personnel have free access to supervisors at all levels for discussion of grievances, complaints and personnel actions as they arise and that opportunity for fair and impartial resolutions of those matters be provided.

4. DEFINITIONS:

a. **Grievance** - An employee's expressed dissatisfaction with the aspects of his working conditions and relationships which are outside his control.

b. **Appeal** - A request for change of an administrative decision or an official personnel action. It may also be a

request for redress in a grievance matter or a request for change in working conditions.

c. **Review**--An examination of the decision and record of an appeal handled in accordance with this practice.

d. **Field Board of Grievance Appeal**--An appeal board appointed by a regional manager or head of other major field organization, for field personnel to investigate, consider, find and recommend action or disposition of matters referred to it in accordance with this practice.

e. **FAA Board of Grievance Appeal and Review**--A review board appointed by the Administrator, FAA, to review on the record and recommend to him action or disposition of matters referred to it after such matters have been handled at the field level in accordance with this practice. It is also an appeal board in the case of FAA headquarters personnel performing functions assigned, in those cases, to the Field Board of Grievance Appeal.

5. PROCEDURES:

a. Employee-Supervisory Level:

(1) **Discussions:** Employees and their supervisors should feel free to discuss informally any problem, complaint or grievance and seek to settle at the work level any matter in connection with their working conditions or relationships. They should explore every avenue to resolve, amicably and harmoniously, problems as they arise without resort to formal procedures. Informal channels of discussion normally should be, but not necessarily, limited to the employee's immediate supervisor, proceeding then through each succeeding line of supervision in an effort to resolve the matter.

For good reason, employees may present their grievances orally and/or in writing directly to higher level supervisors. All facts relating to the grievance should be presented orally and/or in writing by the employee and by any individual against whom the grievance may be directed. The presentation should indicate clearly who is aggrieved and the specific nature of the grievance. In cases where the grievance is submitted in writing, a written decision will be made to the employee concerned.

(2) Consideration and Decision by Supervisors: The supervisor or official at each level to whom the grievance is submitted shall carefully examine and consider the grievance and make every effort to see that the issues underlying it are promptly and fairly resolved without undue delay.

Employees may designate a representative or representatives of their own choosing to present their grievance at any or all levels of the procedure.

While a grievance is being considered, employees concerned are expected to perform their assigned duties and responsibilities to the best of their ability and not disturb others concerning their grievance. If decisions are reached which are not satisfactory, the employees concerned are expected to accept the decision and perform their work assignments to the best of their ability, availing themselves if they so desire, of the further procedures or action on their own part which may be open to them. Employees shall be assured that if they are not satisfied with the decision in their case, they may carry the matter in accordance with this procedure, to the Administrator, FAA, for review and final decision.

b. Field Level:

(1) Submission of Grievance-- Field employees who are dissatisfied with the result of previous consideration of their grievance at the employee-supervisory level, may submit their grievance or appeal in writing to the

regional manager or head of other major field organization. FAA headquarters personnel submit their grievance or appeal directly to the Administrator, FAA.

(2) Contents of Written Request-- Each request for resolution of a grievance or appeal will contain the following:

(a) A clear, specific, detailed statement of the grievance or matter appealed.

(b) Reasons, evidence and information supporting the grievance or other appeal.

(c) A clear statement of the specific remedy or relief sought.

(d) Reasons and information why the remedy or relief sought should be granted.

(e) A brief summary as appropriate of previous discussion of the grievance at each supervisory level along with information each supervisor provided concerning the reason the grievance was not resolved or settled.

(3) Appointment of Field Board-- On receipt of the matter, the regional manager or head of other major field organization, in the case of FAA field personnel, will appoint forthwith a Field Board of Grievance Appeal to consider the matter and refer to it all pertinent information. FAA headquarters personnel cases are referred by the Administrator, FAA, to the FAA Board of Grievance Appeal and Review which will perform the function of the Field Board of Grievance Appeal.

(4) Action of Field Board-- The Board shall make investigation, review pertinent records and correspondence, arrange for interview of employees and supervisors, hear the employee, witnesses and counsel personally, if requested, and take such other action as necessary to obtain the facts upon which to predicate an equitable and impartial recommendation in each case.

(5) Report of Field Board-- The Board will submit a written report of its findings of fact, conclusions and recommendation to the regional manager or head of other major field organization, in the case of FAA field personnel. FAA headquarters personnel cases will be submitted to the Administrator, FAA, by the FAA Board of Grievance Appeal and Review. Minority reports will be submitted in writing immediately following the majority report. Full information upon which the dissenting opinion is based will be outlined along with the name of the individual Board member dissenting.

(a) Consideration of Grievance-- The Board shall carefully consider all material before it including



the record of the grievance, the prior decisions made in the matter by supervision, the investigation made into the matter, and the information and testimony of individuals and witnesses.

(b) Field Board Findings-- The Board shall make specific findings with respect to each item of concern to the employee outlined in his grievance. These findings shall be supported fully by a statement of reasons which constitute the basis for such findings.

(c) Field Board Recommendation-- The recommendation of the Board shall be predicated upon its findings and shall outline the specific action recommended with respect to the grievance. The findings and recommendations shall be submitted to the Administrator in the case of FAA headquarters personnel or the regional manager or head of other major field organization in the case of FAA field personnel together with the entire record of the case. The Board's findings and recommendation will be confidential and will not be made available to the employee concerned.

(6) Decision of Administrator, Headquarters Personnel Cases-- In cases involving FAA headquarters personnel, the Administrator, FAA, will review the entire matter, consider the Board's findings and recommendation, and advise the employee concerned of his decision and that it is final, in writing.

(7) Decision of Regional Manager or Head of Other Major Field Organization, Field Personnel Cases-- In cases involving FAA field personnel, the regional manager or head of other major field organization will review the entire matter, consider the Board's findings and recommendation, and advise the employee concerned of his decision in writing.

(8) Advice to Field Employees in Unfavorable Decision Cases-- In those field personnel cases where the decision

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is unfavorable, the employee will be advised of his right to request a review, on the record, by the Administrator, FAA, of the decision.

c. FAA Administrator Level:

(1) Request for Review--Where the field employee requests a review of the decision in his case, the entire record, including the Field Board of Grievance Appeal proceedings, along with all findings and recommendations will be submitted to the Administrator.

(2) Consideration by FAA Board of Grievance Appeal and Review--Upon receipt of field employees appeal to the Administrator, the FAA Board of Grievance Appeal and Review shall make its deliberations upon the entire record and initiate such other investigation or action it determines advisable, and shall submit its recommendation to the Administrator, FAA.

(3) Administrator, FAA, Final Decision--The Administrator, FAA, shall make final determination concerning the employee grievance and inform the employee concerned of his decision, and that it is final, in writing.

6. APPOINTMENT OF BOARDS:

a. The Administrator, FAA, at the time of request for review of decision in a grievance matter in the case of field employees or in the case of an appeal or grievance from a headquarters employee, shall appoint an FAA Board of Grievance Appeal and Review, consisting of three members, one to be designated as the chairman.

b. The regional manager or head of other major field organization, in the case of field personnel, shall appoint at the time of appeal or grievance, a Field Board of Grievance Appeal consisting of three members, one to be designated as the chairman.

c. Personnel to sit on these boards shall be composed of FAA employees and be selected from a panel of at least ten individuals possessing the highest degree of integrity, ability, and good judgment.

d. All persons serving as members of these boards shall occupy a position designated as sensitive.

e. No person shall serve as a member of the board who has prejudged the case, who may be biased or who possess information that would make it embarrassing to render an impartial recommendation.

f. The employee shall be advised of the composition of the board that will consider his grievance and that he may file an objection to any member named.

7. CONDUCT OF BOARD PROCEEDINGS:

a. All boards have full authority



pertaining to board procedure unless otherwise indicated herein.

b. The proceedings of all boards shall be held during working hours insofar as practicable and shall be informal, presided over by the chairman, and conducted in an orderly and decorous manner.

c. The FAA Board of Grievance Appeal and Review shall review all pertinent information, request additional information or additional or further hearings by Field Boards of Grievance Appeal, if appropriate, to extend and clarify the record to obtain information sufficient to arrive at a recommendation to the Administrator, FAA. This board shall also perform functions outlined for field boards in the case of Washington headquarters personnel.

d. The Field Board of Grievance Appeal shall make such investigation, review pertinent records and correspondence, interview employees and supervisors, and take such other steps as to assure the fullest possible disclosure of relevant and material facts. Any pertinent information received or considered by one member must be made available to all members of the board.

e. Field Boards of Grievance Appeal will conduct hearings, examine witnesses, and at its discretion, permit the employee concerned to examine witnesses, in arriving at a fair and impartial recommendation.

f. Field Boards of Grievance Appeal will assure that an official record of the hearing is made, and will determine whether a verbatim transcript or summary of the proceedings is made.

g. Field Boards of Grievance Appeal will determine whether a copy of the proceedings will be given the employee concerned in the matter.

8. LEAVE AND TRAVEL: Employees, employee witnesses and representatives will be granted authorized absence without charge to leave when called by Field Boards of Grievance Appeal to present grievances in person or to attend hearings in connection therewith. Travel may be authorized for FAA employees where required to travel in connection with grievance cases, provided they are requested to do so by the Board. These requests will be made only when, in the opinion of the Board, travel is absolutely essential and after all other feasible means of adjudicating the case have been exhausted. Except as noted, all time spent during working hours will be charged to leave and all travel will be at the personal expense of the employee or witness involved.

9. APPEALS TO THE CIVIL SERVICE COMMISSION: An employee may appeal an adverse personnel action to the Civil Service Commission not later than ten (10) days after the effective date of an adverse action. If, however, the Civil Service Commission accepts the appeal under Part 22, Civil Service Regulations, no further appeal will be entertained by the Federal Aviation Agency since the Civil Service Commission will review the merits of the case as well as its procedural aspects. However, in the case of appeals under Part 9, Civil Service Regulations, appeals action will be processed by the FAA to a conclusion since the Civil Service Commission will review only the procedures.

10. SAFEGUARDS: An employee exercising his right to use this procedure shall be unimpeded and free from restraint, interference, coercion, discrimination, or reprisal and shall be allowed reasonable official time to prepare and

present his grievance. These safeguards also apply to all others concerned who provide or otherwise assist in the equitable settlement of grievances.

11. ASSISTANCE OF PERSONNEL OFFICE: To assist in the attempt to resolve employee grievances, the services of the Personnel Office are available for consultation freely and informally with, and impartial aid to, supervisors and employees alike. An open door policy will be maintained. Assistance is also available to all those concerned with the preparation, consideration, and the disposition of grievances submitted to the Administrator, FAA, regional managers, or heads of other major field organizations.

12. INFORMATION TO EMPLOYEES: Each new employee of FAA is provided information concerning the appeal and review of employee grievance in the employee handbook; additionally, copies of this Agency Practice are available to all employees. This is provided in order that all employees may be fully informed of their rights as to the presentation and consideration of grievances and appeals and the procedure through which these rights may be exercised.

13. TIME LIMITS: Generally, grievances should be submitted within 30 days after their occurrence. While time limits cannot be rigidly adhered to in the filing of grievances, boards will consider whether the employee presented the grievance within a reasonable time after the grievance took place. Appeals of adverse personnel actions are required, however, to be made within ten days after the effective date of the action. The effective date of personnel actions ordinarily will be deferred pending outcome of an appeal. Exceptions may be made when approved by the appropriate Personnel Office.

14. RECORDS AND REPORTS: Documentation of grievance and appeals matters is necessary for administrative, reference and record purposes.

a. Records--The following records should be maintained: At the employee-supervisory level if the grievance is not resolved to the satisfaction of the employee, each supervisor who considers the matter should prepare a summary of the grievance outlining the problem, the action taken, the reasons therefore, and information given to the employee of the further procedures available to him. At the field level and FAA Administrator level, appropriate records and files concerning grievances and appeals will be maintained.

b. Reports--Statistical data with respect to grievances and appeals will

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be incorporated into the monthly report of personnel operations.

15. RESPONSIBILITY:

a. The Administrator, FAA, is responsible for making final determination in grievance matters submitted to the Administrator level.

b. Regional Manager and Heads of Other Major Field Organizations are responsible for administering the appropriate provisions of this Agency Practice and making determination in grievance matters at the field level in the case of FAA field employees.

c. Chief, Personnel Programs Division, FAA, is responsible for development of policies, standards and procedures with respect to the appeal and review of employee grievances in the FAA, for overall administration of this Agency grievance procedure, for guidance and assistance to regional managers and head of other major field organiza-

tions in the implementation of this Agency Practice, for providing administrative support in the implementation of this Agency Practice at the Administrator level, and for information to employees concerning their rights with respect to the presentation of grievances and the procedure through which these rights may be exercised.

d. Chief, Personnel Operations Division, FAA, is responsible for providing administrative support in the implementation of this Agency Practice in cases involving FAA headquarters personnel handled at the employee-supervisory level and guidance and assistance to FAA office and bureau heads, Washington.

e. All Supervisors and Employees of FAA are responsible for carrying out the pertinent provisions of this Agency Practice in good faith, attempting to clarify misunderstandings, and making reasonable adjustments of grievances and complaints which arise in day-to-day relationships. Supervisors are also responsible for acting promptly and fairly upon grievances submitted to them in accordance with this Agency Practice.

