LAW 1

Spouse Equity

2011 CLEARANCE

# IMPORTANT

## DPRS OPEN SEASON INFORMATION

**PLEASE READ ALL INFORMATION AND INSTRUCTIONS.**

**RETURN PAGE 2 OF THIS FORM ONLY IF YOU WISH TO MAKE A CHANGE.**

## TABLE OF CONTENTS



**Privacy Act Statement.** The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 8, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan (2) verify your and /or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB program. Executive Order 9397 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

Agencies other than the OPM may have further routine uses for disclosure of information for the records system in which the file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

**Public Burden Statement.** We estimate, this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415-3430. The OMB number, 3206-0202 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
**FEHB**
OPEN SEASON
DPRS-2809
OMB 3206-0202
(Revised 7/11)

# REQUEST TO CHANGE FEHB ENROLLMENT FOR 2012 PLAN YEAR

Read the enclosed instructions before completing this form. Return this form to:
USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161
You may fax your form to 888-212-8734.
Do not take any action to maintain your present coverage.

Form redesigned by NFC

## COMPLETE THIS FORM *ONLY* IF YOU ARE MAKING CHANGES.

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at **www.opm.gov/insure.health**.

## SECTION I - Enrollee and Family Member Information *(For additional family members use a separate sheet and attach.)*

| 1. ENROLLEE NAME *(last, first, middle initial)* | 2. SOCIAL SECURITY NUMBER | 3. DATE OF BIRTH *(mm/dd/yyyy)* | 4. SEX ☐ M ☐ F | 5. ARE YOU MARRIED? ☐ YES ☐ NO |
|---|---|---|---|---|
| | | | | |

| 6. HOME MAILING ADDRESS *(including ZIP Code)* | I need to correct my address. The changes are indicated in item 6 ☐ | 7. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | 8. MEDICARE CLAIM NUMBER |
|---|---|---|---|
| | | | |

| 9. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 10 below. ☐ NO | |
|---|---|
| 10. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | NAME OF OTHER INSURANCE / POLICY NUMBER |

Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. Child under age 26; 09. Adopted child; 17. Step child; 10. Eligible foster child; 99. Disabled child age 26 or older who is incapable of self-support because of a physical or mental disability that began before his/her 26th birthday.

| 11. NAME OF FAMILY MEMBER *(last, first, middle initial)* | 12. SOCIAL SECURITY NUMBER | 13. DATE OF BIRTH *(mm/dd/yyyy)* | 14. SEX ☐ M ☐ F | 15. RELATIONSHIP CODE |
|---|---|---|---|---|
| | | | | |

| 16. ADDRESS *(if different from enrollee)* | 17. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | 18. MEDICARE CLAIM NUMBER |
|---|---|---|
| | | |

| 19. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 20 below. ☐ NO | |
|---|---|
| 20. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | NAME OF OTHER INSURANCE / POLICY NUMBER |

| 21. EMAIL ADDRESS *(if home address is different from enrollee's)* | 22. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)* |
|---|---|
| | |

| 23. NAME OF FAMILY MEMBER *(last, first, middle initial)* | 24. SOCIAL SECURITY NUMBER | 25. DATE OF BIRTH *(mm/dd/yyyy)* | 26. SEX ☐ M ☐ F | 27. RELATIONSHIP CODE |
|---|---|---|---|---|
| | | | | |

| 28. ADDRESS *(if different from enrollee)* | 29. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | 30. MEDICARE CLAIM NUMBER |
|---|---|---|
| | | |

| 31. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 32 below. ☐ NO | |
|---|---|
| 32. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | NAME OF OTHER INSURANCE / POLICY NUMBER |

| 33. EMAIL ADDRESS *(if home address is different from enrollee's)* | 34. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)* |
|---|---|
| | |

## SECTION II - FEHB Plan You Are Currently Enrolled In

| 1. PLAN NAME | 2. ENROLLMENT CODE |
|---|---|
| | |

## Section III - FEHB Plan You Are Changing to

| 1. PLAN NAME | 2. ENROLLMENT CODE |
|---|---|
| | |

## SECTION IV - Signature

*WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)*

| 1. YOUR SIGNATURE *(do not print)* | 2. DATE *(mm/dd/yyyy)* |
|---|---|
| | |

| 3. EMAIL ADDRESS | 4. PREFERRED TELEPHONE NUMBER |
|---|---|
| | ( ) |

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

**FEHB**

**OPEN SEASON**

# INFORMATION AND INSTRUCTION SHEET FOR COMPLETING FORM DPRS-2809

**Carefully read the following instructions before completing your request form.**

**You must make all changes through the National Finance Center.**

The enclosed Direct Premium Remittance System (DPRS) form, DPRS-2809, should not be used by anyone other than the addressee and must be signed by the addressee.

DPRS-2809 allows you to change your current health benefits plan, if your account is current.

**If you decide not to make an enrollment change this year, it is not necessary to complete the form, DPRS-2809.** Please read both the form and the accompanying plan comparison charts to make sure your current health benefits plan and option of coverage, especially Health Maintenance Organization (HMO) plans, will still be available to you in 2012. If your plan is not listed, you must select another plan during this Open Season period (November 14 through December 12, 2010) to be assured of continued health benefits coverage. 2011

**Important.** You should also carefully review the 2011 premium cost shown in the plan comparison charts for your plan and option of coverage. There are only limited opportunities, which permit you to change your enrollment outside of the Open Season. If you do not change your enrollment during the Open Season, you may not be eligible to change later, even if you do not wish to pay an increased premium cost for your enrollment.

**Note: Procedures for Brochure Request.** All brochure plan requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at www.opm.gov/insure/health. To contact the carrier for a plan brochure, call the phone number provided in this package. NFC will not stock any brochures.

**Section I, Action.** Mark the Change Enrollment block to change your FEHB enrollment.

**Section II, Enrollment Codes and Plan Names.** Mark one block only in the Nationwide Plans section, or enter the enrollment code and name of plan in the HMO Plan or HDHP or CDHP block. A list of high deductible health plans is included on pages 10-11. A list of the Health Maintenance Organization and Points of Service Plans is included on the state comparison chart on page 12 if any are available in your state of residence.

If you are changing your enrollment from self only to self and family, see Section III.

**Section III, Dependents Information.** If you are enrolling as self and family, list your eligible dependents and provide the requested information. List additional dependents on a separate page.

**Section IV, Address Correction.** If your address is incorrect on the enclosed form, enter the changes in the space provided. Mark a line through the erroneous information of your preprinted address. The address you provide here will be used by DPRS to mail all future correspondence, including health benefits information.

**Acknowledgment Letters.** If you made a change in your enrollment coverage during the Open Season, a letter acknowledging your change will be mailed to you. Keep the acknowledgment letter to use as verification of your new enrollment coverage effective January 1, 2011.

**Section V, Authorization.** You must sign and date the form. No changes will be made unless the enrollee signs and dates the form. Enter the daytime area code and phone number where you can be contacted to answer questions concerning the information on this form.

**Effective Date of Open Season Changes.** All enrollment changes will be effective January 1, 2012. If your change is processed before January 1, 2012, the coupons received in January will reflect the new premium. Otherwise, the new premium will be reflected in the coupons sent to you after the change is processed, retroactive to January 1, 2012.

**Identification Cards. These cards are issued by the health plans, not DPRS.** You should direct questions about identification (ID) cards to your plan. Cards are usually issued within 30 days from the date the plan receives notice of your enrollment change. Should you or your family require medical attention after the January 1, 2012 effective date, but before you receive your new ID card, you may use the letter we send you, acknowledging your open season change, as proof of your new coverage.

The FEHB web site at www.opm.gov/insure/health can help you choose your health plan. In addition to the info contained in this guide you will find information on:

- Who is Eligible
- How to Choose a Plan
- FEHB Handbook
- Frequently Asked Questions
- Medicare and FEHB
- Medicare Information for Caregiver
- Making Sure You Get Quality Healthcare
- Consumer Protection

**Additional Help.** If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit at 504-426-6420 from 7:45 a.m. to 4:00 p.m., CST, weekdays or write to: **DPRS, P.O. Box 61760, New Orleans, LA 70161-1760.** Visit our web site at www.nfc.usda.gov select "DPRS" from the Related Websites drop-down menu. You will be able to view the full RI 70-5 FEHB Guide under "FEHB Guides" as well as the DPRS-2809 Open Season change form under "DPRS Open Season Information".

DIRECT PREMIUM REMITTANCE SYSTEM

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## Nationwide Fee-For-Service Plans (Pages 8 & 9)

Always consult plan brochures before making your final decision. The chart does not show all of your possible out-of-pocket expenses.

**Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO)** A FFS plan provides flexibility in using medical providers of your choice. You may choose medical providers who have contracted with the health plan to offer discounted charges. You may choose medical providers who are not contacted with the plan, but you will pay more of the cost. Medical providers who have contracts with the health plan (Preferred Provider Organization or PPO) have agreed to accept the health plan9s reimbursement. You usually pay a copayment or a coinsurance charge and do not file claims or other paperwork. Going to a PPO hospital does not guarantee PPO benefits for all services received in the hospital, however. Lab work, radiology services, and other services from independent practitioners within the hospital are frequently not covered by the hospital9s PPO agreement. If you receive treatment for medical providers who are not contracted with the health plan, you either pay them directly and submit a claim for reimbursement to the health plan, or the health plan pays the provider directly according to plan coverage and you pay a deductible, coinsurance or the balance of the billed charge. In any case, you pay a greater amount of out-of-pocket cost.

**PPO only** A PPO-only plan provides medical services only through medical providers that have contracts with the plan. With few exceptions, there is no medical coverage if you or your family members receive care from providers not contracted with the plan.

**Fee-for-Service plans open only to specific groups** Several Fee-for-Service plans that are sponsored or underwritten by an employee organization strictly limit enrollment to persons who are members of that organization. If you are not certain if you are eligible, check with your human resources office first.

<u>How to read the Fee-for-Service Chart:</u>

**Deductibles** are the amount of covered expenses that you pay before your health plan begins to pay.

**Calendar Year** deductibles for families are two or more times the per person amount shown.

In some plans your combined **Prescription Drug** purchases from Mail Order and local pharmacies count toward the deductible. In other plans, only purchases from local pharmacies count. Some plans require each family member to meet a per person deductible.

The **Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

**Copay/Coinsurance** are the dollar amounts or percentages of covered expenses that you pay before your health plan begins to pay.

**Doctors** is what you must pay for office visits and inpatient Surgical Procedures.

**Hospital Inpatient Room and Board** is your portion of the covered charges for inpatient room and board expenses.

**Prescription Drug Payment Levels**

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier 1, Tier 11, Level 1, etc. The 2 to 3 payment levels that plans use follow:

Level I includes most generic drugs, but may include some preferred brands.

Level II may include generics and preferred brands not included in Level I.

Level III includes all other covered drugs, with some exceptions for specialty drugs.

The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

**YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.**

## Health Maintenance Organization Plans and Plans Offering a Point-of-Service Product (Page 12)

Always consult plan brochures before making your final decision. The chart does not show all of your possible out-of-pocket expenses.

**Health Maintenance Organization (HMO)** An HMO provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service you receive and free you from completing paperwork or being billed for covered services. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work.

-The HMO provides a comprehensive set of services as long as you use the doctors and hospital affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and sometimes a copayment of in-hospital care.

-Most HMOs ask you to choose a doctor or medical group as your primary care physician (PCP). Your PCP provides your general medical care. In many HMOs, you must get authorization or a "referral" from your PCP to see other providers. The referral is a recommendation by your physician for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures that you see the right provider for the care appropriate to your condition.

-Medical Care from a provider not in the plan's network is covered unless it's emergency care or your plan has an arrangement with another provider.

**Plans Offering a Point-of-Service (POS) Product**-A POS plan is like having two plans in one - an HMO and a FFS plan. A POS allows you and your family members to choose between using, (1) a network or providers in a designated service area (like an HMO), or (2) out-of-network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non-HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

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# DIRECT PREMIUM REMITTANCE SYSTEM

## Nationwide and Regional High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) and Consumer-Driven Health Plans (Pages 10 & 11)

**Always consult plan brochures before making your final decision. The chart is not a complete statement of your out-of-pocket obligations in every individual circumstance.**

A **High Deductible Health Plan (HDHP)** provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The HDHP gives you flexibility and discretion over how you use your health care benefits.

A **Consumer-Driven Health Plan (CDHP)** provides you with freedom in spending health care dollars the way you want. The typical plan has common components: Member responsibility for certain up-front costs, an account that you may use to pay these up-front costs and catastrophic coverage with a high deductible. You and your family members receive full coverage for in-network preventive care.

### How to Read the HDHP/CDHP Charts:

**Premium Contribution (pass through) to HSA/HRA** (or personal care account) – shows the amount your health plan automatically deposits or credits into your account on a monthly basis for Self Only/Self and Family enrollments. (Consumer-Driven Health Plans credit accounts annually.) The amount credited under Premium Contribution™ is shown as a monthly amount for comparison purposes only.

**Calendar Year (CY) Deductible Self/Family** is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles, coinsurance and copayments, before the plan pays catastrophic benefits.

**Catastrophic (Cat.) Limit Self/Family** is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance and copayments, before the Plan pays catastrophic benefits.

**Office Visit** shows what you pay for a visit to a primary care physician after the deductible is met for other than preventative care.

**Hospital Inpatient** shows what you pay after the deductible is met for hospital services when an inpatient. The amount could be a daily copayment up to a specified amount (e.g. $50 a day up to three days), a coinsurance amount such as 20%, or a flat deductible amount (e.g. $200 per admission). This amount does not include charges from physicians or for services that may not be charged by the hospital such as lab work or radiology services.

**Outpatient Surgery** shows what you pay the doctor for surgery performed on an outpatient basis.

**Preventative Services** are often covered in full, usually with no or only a small deductible or copayment. Preventative services may also be payable up to an annual maximum dollar amount (e.g. up to $300 per person per year).

### Prescription Drug Payment Levels

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier 1, Tier11, Level 1, etc. The 2 to 3 payment levels that plans use follow:

**Level I** includes most generic drugs, but may include some preferred brands.
**Level II** may include generics and preferred brands not included in Level I.
**Level III** includes all other covered drugs, with some exceptions for specialty drugs.

The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

**YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.**

**A Health Savings Account (HSA)** allows individuals to pay for current health expenses and save for future qualified medical expenses on a tax-free basis. Funds deposited into an HSA account are not taxed, the balance in the HSA grows tax-free, and that amount is available on a tax-free basis to pay medical costs. To open up an HSA a person must be covered under a High Deductible Health Plan (HDHP) and cannot be eligible for Medicare.

Features of an HSA include:
- Tax-deductible deposits you make to the HSA.
- Tax-deferred interest earned on the account.
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused funds and interest from year to year.
- Portability; the account is owned by you and yours to keep-even when you retire, leave government service or change plans.

**Health Reimbursement Arrangements (HRAs)** are a common feature of Consumer-Driven Health Plans. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA because they have Medicare. HRAs are similar to HSAs except an enrollee cannot make deposits into an HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

Features of an HRA include:
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused credits from year to year.
- Credits in an HRA do not earn interest.
- Credits in the HRA are forfeited if you leave federal employment or switch health insurance plans.

DIRECT PREMIUM REMITTANCE SYSTEM

New page not included in 07

## Affordable Care Act (ACA) of 2010

The following information is a condensed version of information regarding the Affordable Care Act (ACA). For more details and the most up-to-date information, please visit www.opm.gov/insure.

**What are the changes to FEHB Program Dependent Eligibility Rules under the ACA?**

**Children Between ages of 22 and 26** – Children between the ages of 22 and 26 are covered under their parents Self and Family enrollment up to age 26.
**Married Children** – Married children (but NOT their spouse or their own children) are covered up to age 26.
**Children with or eligible for employer-provided health insurance** – Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
**Step Children** – Step children do not need to live with the enrollee in a parent-child relationship to be eligible for coverage up to age 26.
**Children Incapable of Self Support** – Children who are incapable of self support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
**Foster Children** – Foster children are eligible for coverage up to age 26 provided the foster parent certifies that the child meets the eligibility requirements specified on the foster child certification. See www.opm.gov/insure/health.

Children do not have to live with their parent, be financially dependent upon their parent or be students to be covered up to age 26. There is also no requirement that the child have prior or current insurance coverage. FEHB program plans will send notices to their enrollees of the coverage eligibility changes as part of that plan's Open Season communications.

**How Does This Affect Eligibility For Temporary Continuation of Coverage (TCC)?**

Children who lose coverage due to reaching age 26 are eligible for TCC for up to 36 months even if they previously had TCC.

If you are a child of an FEHB enrollee and you are now enrolled under Temporary Continuation of Coverage (TCC), you may no longer need your TCC enrollment since you will be covered under your parent's Self and Family enrollment. Once you are assured of coverage under your parent's Self and Family enrollment, you may want to cancel your TCC enrollment. To cancel your TCC, you must send a written, signed request to the National Finance Center at:

USDA, National Finance Center
DPRS Billing Unit
PO Box 61760
New Orleans, LA 70161-1760

You must include the date you wish to have your TCC account cancelled.

**Please note that your parent must take action with his/her Human Resources and/or OWCP office for you to be covered under their FEHB plan. **Please do not request to have your TCC coverage cancelled until you have proof of the begin date of coverage from your parent's Human Resources and/or OWCP office.**

If you have additional questions, please contact the National Finance Center at 800-242-9630 or nfc.dprs@usda.gov.

**What is a Grandfathered Health Plan Under ACA?**
The Affordable Care Act requires that health plans include certain consumer protections and benefits coverage that affect some FEHB plan benefits beginning in 2011 and beyond. All plans in the FEHB Program have complied with all required provisions. However, certain protections and coverage terms depend upon whether the plan is considered a "grandfathered health plan" under the Act. A grandfathered health plan may preserve basic health coverage that was in effect when the law was enacted. If an FEHB plan indicates that it is a grandfathered plan that means certain benefit features including cost sharing, premium payments and covered services have not significantly changed from last year. While grandfathered health plans must comply with certain benefit requirements under the ACA, being a grandfathered plan also means that plan may not have included all benefit protections and coverage terms that apply to other plans. Information on a plan's specific benefit changes under the ACA will be available in the plan's brochure.

**How Does the ACA Affect Benefits for High Deductible Health Plans?**
Beginning January 1, 2011, currently eligible over-the-counter (OTC) products that are medicines or drugs will not be eligible for reimbursement from your Health Savings Account (HSA) or your Health Reimbursement Arrangement (HRA) – unless – you have a prescription for that item written by your physician. The only exception is insulin – you will not need a prescription from January 1, 2011 forward. Other currently eligible OTC items that are not medicines or drugs will not require a prescription. Effective January 1, 2011, the 10% penalty for non-eligible medical expenses paid from an HSA will increase to 20%.

**Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families**

- If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

- If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

- Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

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## DIRECT PREMIUM REMITTANCE SYSTEM

## OPEN SEASON INFORMATION

The 2011 Open Season for Spouse Equity/Temporary Continuation of Coverage Enrollees/Direct Pay Annuitants under the Federal Employees Health Benefits (FEHB) Program will be from November 14 through December 12, 2011. During Open Season you may change from one plan to another, from one option to another in the same plan, or from self only to self and family. Certain former spouses are excluded from self and family. Refer to our office for eligibility. Coverage under your current enrollment will continue **automatically** unless you request a change or unless your current plan will no longer be participating in the FEHB Program after December 31, 2011.

This Open Season package contains information tailored especially for you. The plan comparison chart on the following pages shows the benefits and premiums effective as of January 1, 2012 for Nationwide Fee-for-Service Plans (Pages 8 & 9), the Nationwide High Deductible and Consumer Driven Health Plans, (Pages 10 & 11) and the Health Maintenance Organizations (HMOs) and Point of Service (POS) Plans available in your state (Page 12). When comparing HMOs please note that, generally, you may only enroll in an HMO that services the area you live in. In some cases, the HMO may allow you to enroll if you work within its service area even though you live outside of the service area. Check with the HMO for questions concerning your specific eligibility to enroll. If no HMO or POS plans are available in your area, page 12 is omitted from your package.

Before you make a final decision about changing your enrollment, you should carefully review the official brochure(s) for the plan or plans in which you are interested.

Please use the following letter codes to determine the benefit explanations for plans on page 9 and page 11:

A - NONE
B - N/A
C - +35%
D - DAY x 5
E - NOTHING
F - +DIFF.
G - MAX $200
H - NOT COVERED
I - OR 50%
J - MAX $150
L - $55 MAX
M - $70 MAX
N - $100 MAX
O - $90 MAX
P - OR $45
Q - $50 MIN
R - NOTHING UP TO $1,200
S - DED/25%
T - $75 DAY-$750
U - MAX $150+
V - MAX $200+

### Important

You should carefully review the 2012 premiums shown in the following plan comparison chart for your plan and option of coverage. Do not rely on the chart alone for benefit data. If you do not change your enrollment during open season, you may not be eligible to change until the next open season. You may also make changes to the name, address, or telephone number information on the form, or add eligible new dependents if you already have a family plan. To avoid delays, make sure you sign and date the form if you request any changes. No changes will be made unless the enrollee signs the form.

### Benefit Changes

Your current plan will send you a copy of its new brochure and rate sheet. Be sure to read your plan's brochure to see how benefits change in 2012. Other plan brochures you request directly from the carrier may not have premiums in them, so be sure to save the enclosed comparison chart for 2012 premium rates.

### Plans Not Participating in the FEHB Program in 2012

Some plans will withdraw from the FEHB Program after December 31, 2011. You should check the enclosed comparison chart and, if your plan is not listed in the comparison chart, contact your plan to verify their participation in the FEHB Program. If the plan will not be in the FEHB Program in 2012, you must elect new coverage during this open season. If you do not pick a new insurance plan by the end of Open Season, you will not have health coverage in 2012 unless you are a Federal retiree or survivor annuitant. If you are a Federal retiree or survivor annuitant and you don't select another plan, we will enroll you in the Blue Cross and Blue Shield Service Benefit Plan option that is most similar to your current plan's cost and benefits. The effective date of your enrollment will be January 1, 2012. If Blue Cross and Blue Shield is the plan you want, don't wait for us to enroll you. If you elect them now, you will receive your plan card sooner.

### Effective Dates of Open Season Changes

All changes to new plans will be effective January 1, 2012.

### 2012 Payment Coupons

Note: If you are enrolled under Automatic Preauthorized Debit from your bank account, coupons will be mailed to you for informational purposes only.

For those enrollees who either stay with their current plan or whose changes are received before December 31, 2011, your new 2012 payment coupons will be mailed to you during the first two weeks of January, 2012. Your payment coupon for the month of January 2012 will be the first coupon to reflect the 2012 premium. If you do not receive your new coupons by January 22, call the Direct Premium Remittance System (DPRS) at 1-800-242-9630, weekdays, between the hours of 7:45 a.m. and 4:00 p.m. CST, for your new premium rate.

## 2011 DPRS OPEN SEASON INFORMATION SPOUSE EQUITY ENROLLEES (100% PREMIUM)
## FEE FOR SERVICE PLANS - ENROLLMENT CODES AND RATES

| PLAN NAME | Telephone Number | Plan Option | Enrollment Code | | Your Monthly Premium | |
|---|---|---|---|---|---|---|
| | | | Self Only | Self & Family | Self Only | Self & Family |
| **PLANS OPEN TO ALL** | | | | | | |
| APWU HEALTH PLAN | 800/222-2798 | HIGH | 471 | 472 | 477.08 | 1078.72 |
| BLUE CROSS AND BLUE SHIELD | LOCAL | STANDARD | 104 | 105 | 378.81 | 1306.89 |
| BLUE CROSS AND BLUE SHIELD | LOCAL | BASIC | 111 | 112 | 453.48 | 1081.97 |
| GEHA HEALTH BENEFIT PLAN | 800/821-6136 | HIGH | 311 | 312 | 567.62 | 1290.97 |
| GEHA HEALTH BENEFIT PLAN | 800/821-8136 | STANDARD | 314 | 315 | 346.62 | 788.28 |
| MAIL HANDLERS BENEFIT PLAN | 800/410-7778 | STANDARD | 454 | 455 | 611.20 | 1398.76 |
| MAIL HANDLERS BENEFIT VALUE OPTION | 800/410-7778 | VALUE OPTION | 414 | 415 | 285.81 | 681.63 |
| NALC HEALTH BENEFIT PLAN | 888/639-8252 | HIGH | 321 | 322 | 552.07 | 1202.61 |
| SAMBA HEALTH BENEFIT PLAN | 800/638-8589 | HIGH | 441 | 442 | 661.68 | 1558.25 |
| SAMBA HEALTH BENEFIT PLAN | 800/638-6589 | STANDARD | 444 | 445 | 501.78 | 1145.95 |

| PLAN NAME | Telephone Number | Plan Option | Enrollment Code | | Your Monthly Premium | |
|---|---|---|---|---|---|---|
| | | | Self Only | Self & Family | Self Only | Self & Family |
| **PLANS OPEN ONLY TO SPECIFIC GROUPS** | | | | | | |
| COMPASS ROSE HEALTH PLAN | 800/634-0069 | HIGH | 421 | 422 | 510.49 | 1184.93 |
| FOREIGN SERVICE BENEFIT PLAN | 202/833-4910 | HIGH | 401 | 402 | 493.96 | 1181.46 |
| PANAMA CANAL AREA BENEFIT PLAN | 800/424-3196 | HIGH | 431 | 432 | 408.24 | 854.21 |
| RURAL CARRIERS BENEFIT PLAN | 800/638-8432 | HIGH | 381 | 382 | 585.83 | 1155.79 |

# 2011 DPRS OPEN SEASON INFORMATION SPOUSE EQUITY ENROLLEES (100% PREMIUM)
## FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

### PLANS OPEN TO ALL

| Enrollment Code | | Benefit Type | Medical-Surgical - You Pay | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Deductible | | | Copay ($)/Coinsurance (%) | | | | | | | | | | |
| | | | Per Person | | Hospital Inpatient | Doctors | | Hospital Inpatient | Prescription Drugs | | | Mail Order Discounts |
| Self Only | Self & Family | | Calendar Year | Prescription Drug | | Office Visits | Inpatient Surgical Procedures | R&B | Level I | Level II | Level III | |
| 471 | 472 | PPO | $275 | A | A | $18 | 10% | 10% | $8 | 25% | 25% | YES |
| | | NON PPO | $500 | A | $300 | 30%F | 30%F | 30% | 50% | 50% | 50% | YES |
| 104 | 105 | PPO | $350 | A | $250 | $20 | 15% | E | 20% | 30% | 30% | YES |
| | | NON PPO | $350 | A | $350 | 35% | 35% | 35% | 45%+ | 45%+ | 45%+ | YES |
| 111 | 112 | PPO | A | A | $150 D | $25 | $150 | E | $10 | $40 | $50 I | N/A |
| 311 | 312 | PPO | $350 | A | $100 | $20 | 10% | E | $5 | 25% J | B | YES |
| | | NON PPO | $350 | A | $300 | 25% | 25% | E | $5 | 25% U | B | YES |
| 314 | 315 | PPO | $350 | A | A | $10 | 15% | 15% | $5 | 50% G | B | YES |
| | | NON PPO | $350 | A | A | 35% | 35% | 35% | $5 | 50% V | B | YES |
| 454 | 455 | PPO | $400 | A | $200 | $20 | 10% | E | $10 | 30% G | 50% G | YES |
| | | NON PPO | $600 | A | $500 | 30% | 30% | 30% | 50% | 50% | 50% | YES |
| 414 | 415 | PPO | $600 | A | A | $30 | 20% | 20% | $10 | 50% | 50% | YES |
| | | NON PPO | $800 | H | A | 40% | 40% | 40% | H | H | H | YES |
| 321 | 322 | PPO | $300 | A | $200 | $20 | 15% | E | 20% | 30% | 30% | YES |
| | | NON PPO | $300 | A | $250 | 30% | 30% | 30% | 45% | 45%+ | 45%+ | YES |
| 441 | 442 | PPO | $300 | A | $200 | $20 | 10% | E | $10 | 15% L | 30% O | YES |
| | | NON PPO | $300 | A | $300 | 30% | 30% | 30% | $10 | 15% L | 30% O | YES |
| 444 | 445 | PPO | $350 | A | $200 | $20 | 15% | E | $10 | 25% M | 25% N | YES |
| | | NON PPO | $350 | A | $300 | 30% | 30% | 30% | $10 | 25% M | 25% N | YES |

### PLANS OPEN ONLY TO SPECIFIC GROUPS

| Enrollment Code | | Benefit Type | Medical-Surgical - You Pay | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Deductible | | | Copay ($)/Coinsurance (%) | | | | | | | | | | |
| | | | Per Person | | Hospital Inpatient | Doctors | | Hospital Inpatient | Prescription Drugs | | | Mail Order Discounts |
| Self Only | Self & Family | | Calendar Year | Prescription Drug | | Office Visits | Inpatient Surgical Procedures | R&B | Level I | Level II | Level III | |
| 421 | 422 | PPO | $300 | A | $150 | $10 | 10% | E | $5 | $30 | 30% P | YES |
| | | NON PPO | $300 | A | $350 | 30% | 30% | 30% | $5 | $30 | 30% P | YES |
| 401 | 402 | PPO | $300 | A | E | 10% | 10% | E | $10 | 25% | 30%+Q | YES |
| | | NON PPO | $300 | A | $200 | 30% | 30% | 20% | $10 | 25% | 30%+Q | YES |
| 431 | 432 | POS | A | A | $25 | $5 | E | E | 20% | 20% | 20% | NO |
| | | FFS | A | A | $100 | 50% | 50% | 50% | 20% | 20% | 20% | NO |
| 381 | 382 | PPO | $350 | $200 | $100 | $20 | 10% | E | 30% | 30% | 30% | YES |
| | | NON PPO | $400 | $200 | $300 | 25% | 20% | 20% | 30% | 30% | 30% | YES |

## Nationwide High Deductible and Consumer Driven Health Plans

| Plan Name | Telephone Number | Enrollment Code | | Premium | |
|---|---|---|---|---|---|
| | | Self | Self & Family | Self | Self & Family |
| APWU HEALTH PLAN-(CDHP) | 888/833-3463 | 474 | 475 | 336.70 | 757.47 |
| GEHA-(HDHP) | 800/821-8136 | 341 | 342 | 380.81 | 868.79 |
| MAILHANDLERS-(HDHP) | 800/894-9901 | 481 | 482 | 394.77 | 894.51 |

## High Deductible and Consumer Driven Health Plans for Your State

| Plan Name | Telephone Number | Enrollment Code | | Premium | |
|---|---|---|---|---|---|
| | | Self | Self & Family | Self | Self & Family |
| AETNA HEALTH FUND-(CDHP) | 877/459-6604 | 221 | 222 | 500.48 | 1,175.42 |
| AETNA HEALTH FUND-(HDHP) | 877/459-6604 | 224 | 225 | 341.38 | 747.63 |
| HUMANA COVERAGEFIRST-(CDHP) | 888/393-6765 | AD1 | AD2 | 459.10 | 1,032.98 |
| HUMANA COVERAGEFIRST-(CDHP) | 888/393-6765 | LM1 | LM2 | 467.31 | 1,051.44 |
| KAISER FOUNDATION HP-(HDHP) | 888/865-5813 | GW1 | GW2 | 329.57 | 740.94 |

## Nationwide High Deductible and Consumer Driven Health Plan (cont'd)

| Enrollment Code | | Benefit Type | Premium Contribution | | CY Deductible | | Catastrophic Limit | | Office Visit | In-patient surgery | Out-patient surgery | Pre-ventive Serv-ices | Prescription Drugs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Self | Self & Family | | HSA | HRA | Self | Self & Family | Self | Self & Family | | | | | Level I | Level II | Level III |
| 474 | 475 | IN-NET | $100 | $200 | $600 | $1,200 | $3,000 | $4,500 | 15% | A | 15% | E | 25% | 25% | 25% |
| | | OUT-NET | $100 | $200 | $600 | $1,200 | $4,000 | $9,000 | 40% F | A | 40% F | R | B | B | B |
| 341 | 342 | IN-NET | $62.50 | $125 | $1,500 | $3,000 | $5,000 | $10,000 | 5% | 5% | 5% | E | 25% | 25% | 25% |
| | | OUT-NET | $62.50 | $125 | $1,500 | $3,000 | $5,000 | $10,000 | 25% | 25% | 25% | S | 25%+ | 25%+ | 25%+ |
| 481 | 482 | IN-NET | $70 | $140 | $2,000 | $4,000 | $5,000 | $10,000 | $15 | T | E | E | $10 | $25 | $40 |
| | | OUT-NET | $70 | $140 | $2,000 | $4,000 | $7,500 | $15,000 | 40% | 40% | 40% | H | H | H | H |

## High Deductible and Consumer Driven Health Plan for Your State (cont'd)

| Enrollment Code | | Location |
|---|---|---|
| Self | Self & Family | |
| 221 | 222 | MOST OF GEORGIA |
| 224 | 225 | MOST OF GEORGIA |
| AD1 | AD2 | ATLANTA AREA |
| LM1 | LM2 | MACON AREA |
| GW1 | GW2 | ATL/ATHENS/COLUMBUS/MACON/SAVAN |

SEE PLAN BROCHURES FOR BENEFIT INFORMATION

## 2011 OPRS OPEN SEASON INFORMATION SPOUSE EQUITY ENROLLEES (100% PREMIUM)
## HMO AND POS PLANS FOR GEORGIA

| PLAN NAME | Premium | | PLAN LOCATION | Enrollment Code | | Telephone Number |
|---|---|---|---|---|---|---|
| | Self Only | Self & Family | | Self Only | Self & Family | |
| AETNA OPEN ACCESS- HIGH | 622.85 | 1429.18 | ATLANTA AND ATHENS AREAS | 2U1 | 2U2 | 877/458-6604 |
| HUMANA EMPLOYERS HEALTH PLAN | 517.57 | 1184.52 | COLUMBUS | CB1 | CB2 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN | 465.81 | 1048.08 | COLUMBUS | CB4 | CB5 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN | 513.13 | 1154.51 | MACON | DN1 | DN2 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN | 487.46 | 1096.79 | MACON | DN4 | DN5 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN- HIGH | 540.17 | 1215.37 | ATLANTA | DG1 | DG2 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN- STD | 517.57 | 1164.54 | ATLANTA | DG4 | DG5 | 888/393-6765 |
| KAISER FOUNDATION HP- HIGH | 523.38 | 1195.98 | ATL/ATHEN/COLUMBUS/MACON/SAVANNAH | F81 | F82 | 888/865-5813 |
| KAISER FOUNDATION HP- STD | 357.80 | 817.57 | ATL/ATHEN/COLUMBUS/MACON/SAVANNAH | F84 | F85 | 888/865-5813 |

LAW 2 TCC
2011 Clearance

# IMPORTANT

## DPRS OPEN SEASON INFORMATION

**PLEASE READ ALL INFORMATION AND INSTRUCTIONS.**

**RETURN PAGE 2 OF THIS FORM ONLY IF YOU WISH TO MAKE A CHANGE.**

## TABLE OF CONTENTS



**Privacy Act Statement.** The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 8, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan (2) verify your and /or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.
While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.
We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB program. Executive Order 9397 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.
Agencies other than the OPM may have further routine uses for disclosure of information for the records system in which the file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

**Public Burden Statement.** We estimate this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415-3430. The OMB number, 3206-0202 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

**FEHB**

OPEN SEASON
DPRS-2809
OMB 3206-0202
(Revised 7/11)

# REQUEST TO CHANGE FEHB ENROLLMENT FOR 2012 PLAN YEAR



Read the enclosed instructions before completing this form. Return this form to:
USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161
You may fax your form to 888-212-8734.
Do not take any action to maintain your present coverage.

Form redesigned by NFC

## COMPLETE THIS FORM *ONLY* IF YOU ARE MAKING CHANGES.

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at **www.opm.gov/insure.health**.

### SECTION I - Enrollee and Family Member Information *(For additional family members use a separate sheet and attach.)*

| 1. ENROLLEE NAME *(last, first, middle initial)* | 2. SOCIAL SECURITY NUMBER | 3. DATE OF BIRTH *(mm/dd/yyyy)* | 4. SEX ☐ M ☐ F | 5. ARE YOU MARRIED? ☐ YES ☐ NO |
|---|---|---|---|---|
| 6. HOME MAILING ADDRESS *(including ZIP Code)* | ☐ I need to correct my address. The changes are indicated in item 6 | 7. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | | 8. MEDICARE CLAIM NUMBER |
| | | 9. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 10 below. | | ☐ NO |
| 10. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | | NAME OF OTHER INSURANCE | | POLICY NUMBER |

Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. Child under age 26; 09. Adopted child; 17. Step child; 10. Eligible foster child; 99. Disabled child age 26 or older who is incapable of self-support because of a physical or mental disability that began before his/her 26th birthday.

| 11. NAME OF FAMILY MEMBER *(last, first, middle initial)* | 12. SOCIAL SECURITY NUMBER | 13. DATE OF BIRTH *(mm/dd/yyyy)* | 14. SEX ☐ M ☐ F | 15. RELATIONSHIP CODE |
|---|---|---|---|---|
| 16. ADDRESS *(if different from enrollee)* | | 17. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | | 18. MEDICARE CLAIM NUMBER |
| | | 19. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 20 below. | | ☐ NO |
| 20. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | | NAME OF OTHER INSURANCE | | POLICY NUMBER |
| 21. EMAIL ADDRESS *(if home address is different from enrollee's)* | 22. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)* | | | |

| 23. NAME OF FAMILY MEMBER *(last, first, middle initial)* | 24. SOCIAL SECURITY NUMBER | 25. DATE OF BIRTH *(mm/dd/yyyy)* | 26. SEX ☐ M ☐ F | 27. RELATIONSHIP CODE |
|---|---|---|---|---|
| 28. ADDRESS *(if different from enrollee)* | | 29. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | | 30. MEDICARE CLAIM NUMBER |
| | | 31. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 32 below. | | ☐ NO |
| 32. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | | NAME OF OTHER INSURANCE | | POLICY NUMBER |
| 33. EMAIL ADDRESS *(if home address is different from enrollee's)* | 34. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)* | | | |

### SECTION II - FEHB Plan You Are Currently Enrolled In

| 1. PLAN NAME | 2. ENROLLMENT CODE |
|---|---|
| | |

### Section III - FEHB Plan You Are Changing to

| 1. PLAN NAME | 2. ENROLLMENT CODE |
|---|---|
| | |

### SECTION IV - Signature

*WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)*

| 1. YOUR SIGNATURE *(do not print)* | 2. DATE *(mm/dd/yyyy)* |
|---|---|
| 3. EMAIL ADDRESS | 4. PREFERRED TELEPHONE NUMBER ( ) |

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
**FEHB**
OPEN SEASON

# INFORMATION AND INSTRUCTION SHEET FOR COMPLETING FORM DPRS-2809

**Carefully read the following instructions before completing your request form.**

**You must make all changes through the National Finance Center.**

The enclosed Direct Premium Remittance System (DPRS) form, DPRS-2809, should not be used by anyone other than the addressee and must be signed by the addressee.

DPRS-2809 allows you to change your current health benefits plan, if your account is current.

**If you decide not to make an enrollment change this year, it is not necessary to complete the form, DPRS-2809.** Please read both the form and the accompanying plan comparison charts to make sure your current health benefits plan and option of coverage, especially Health Maintenance Organization (HMO) plans, will still be available to you in 2012. If your plan is not listed, you must select another plan during this Open Season period (November 14 through December 12, 2010) to be assured of continued health benefits coverage. 2011

**Important.** You should also carefully review the 2011 premium cost shown in the plan comparison charts for your plan and option of coverage. There are only limited opportunities, which permit you to change your enrollment outside of the Open Season. If you do not change your enrollment during the Open Season, you may not be eligible to change later, even if you do not wish to pay an increased premium cost for your enrollment.

**Note: Procedures for Brochure Request.** All brochure plan requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at www.opm.gov/insure/health. To contact the carrier for a plan brochure, call the phone number provided in this package. NFC will not stock any brochures.

**Section I, Action.** Mark the Change Enrollment block to change your FEHB enrollment.

**Section II, Enrollment Codes and Plan Names.** Mark one block only in the Nationwide Plans section, or enter the enrollment code and name of plan in the HMO Plan or HDHP or CDHP block. A list of high deductible health plans is included on pages 10-11. A list of the Health Maintenance Organization and Points of Service Plans is included on the state comparison chart on page 12 if any are available in your state of residence.

If you are changing your enrollment from self only to self and family, see Section III.

**Section III, Dependents Information.** If you are enrolling as self and family, list your eligible dependents and provide the requested information. List additional dependents on a separate page.

**Section IV, Address Correction.** If your address is incorrect on the enclosed form, enter the changes in the space provided. Mark a line through the erroneous information of your preprinted address. The address you provide here will be used by DPRS to mail all future correspondence, including health benefits information.

**Acknowledgment Letters.** If you made a change in your enrollment coverage during the Open Season, a letter acknowledging your change will be mailed to you. Keep the acknowledgment letter to use as verification of your new enrollment coverage effective January 1, 2011.

**Section V, Authorization.** You must sign and date the form. No changes will be made unless the enrollee signs and dates the form. Enter the daytime area code and phone number where you can be contacted to answer questions concerning the information on this form.

**Effective Date of Open Season Changes.** All enrollment changes will be effective January 1, 2012. If your change is processed before January 1, 2012, the coupons received in January will reflect the new premium. Otherwise, the new premium will be reflected in the coupons sent to you after the change is processed, retroactive to January 1, 2012.

**Identification Cards.** These cards are issued by the health plans, not DPRS. You should direct questions about identification (ID) cards to your plan. Cards are usually issued within 30 days from the date the plan receives notice of your enrollment change. Should you or your family require medical attention after the January 1, 2012 effective date, but before you receive your new ID card, you may use the letter we send you, acknowledging your open season change, as proof of your new coverage.

The FEHB web site at www.opm.gov/insure/health can help you choose your health plan. In addition to the info contained in this guide you will find information on:

- Who is Eligible
- How to Choose a Plan
- FEHB Handbook
- Frequently Asked Questions
- Medicare and FEHB
- Medicare Information for Caregiver
- Making Sure You Get Quality Healthcare
- Consumer Protection

**Additional Help.** If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit at 504-426-6420 from 7:45 a.m. to 4:00 p.m., CST, weekdays or write to: DPRS, P.O. Box 61760, New Orleans, LA. 70161-1760. Visit our web site at www.nfc.usda.gov select "DPRS" from the Related Websites drop-down menu. You will be able to view the full RI 70-5 FEHB Guide under "FEHB Guides" as well as the DPRS-2809 Open Season change form under "DPRS Open Season Information".

DIRECT PREMIUM REMITTANCE SYSTEM

pg 5 of 2008 pkg

## Nationwide Fee-For-Service Plans (Pages 8 & 9)

Always consult plan brochures before making your final decision. The chart does not show all of your possible out-of-pocket expenses.

**Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO)** A FFS plan provides flexibility in using medical providers of your choice. You may choose medical providers who have contracted with the health plan to offer discounted charges. You may choose medical providers who are not contacted with the plan, but you will pay more of the cost. Medical providers who have contracts with the health plan (Preferred Provider Organization or PPO) have agreed to accept the health plan9s reimbursement. You usually pay a copayment or a coinsurance charge and do not file claims or other paperwork. Going to a PPO hospital does not guarantee PPO benefits for all services received in the hospital, however. Lab work, radiology services, and other services from independent practitioners within the hospital are frequently not covered by the hospital9s PPO agreement. If you receive treatment for medical providers who are not contracted with the health plan, you either pay them directly and submit a claim for reimbursement to the health plan, or the health plan pays the provider directly according to plan coverage and you pay a deductible, coinsurance or the balance of the billed charge. In any case, you pay a greater amount of out-of-pocket cost.

**PPO only** A PPO-only plan provides medical services only through medical providers that have contracts with the plan. With few exceptions, there is no medical coverage if you or your family members receive care from providers not contracted with the plan.

**Fee-for-Service plans open only to specific groups** Several Fee-for-Service plans that are sponsored or underwritten by an employee organization strictly limit enrollment to persons who are members of that organization. If you are not certain if you are eligible, check with your human resources office first.

**How to read the Fee-for-Service Chart:**

**Deductibles** are the amount of covered expenses that you pay before your health plan begins to pay.

**Calendar Year** deductibles for families are two or more times the per person amount shown.

In some plans your combined **Prescription Drug** purchases from Mail Order and local pharmacies count toward the deductible. In other plans, only purchases from local pharmacies count. Some plans require each family member to meet a per person deductible.

The **Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

**Copay/Coinsurance** are the dollar amounts or percentages of covered expenses that you pay before your health plan begins to pay.

**Doctors** is what you must pay for office visits and inpatient Surgical Procedures.

**Hospital Inpatient Room and Board** is your portion of the covered charges for inpatient room and board expenses.

**Prescription Drug Payment Levels**

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier 1, Tier11, Level 1, etc. The 2 to 3 payment levels that plans use follow:

Level I includes most generic drugs, but may include some preferred brands.

Level II may include generics and preferred brands not included in Level I.

Level III includes all other covered drugs, with some exceptions for specialty drugs.

The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

**YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.**

**Health Maintenance Organization Plans and Plans Offering a Point-of-Service Product (Page 12)**

Always consult plan brochures before making your final decision. The chart does not show all of your possible out-of-pocket expenses.

**Health Maintenance Organization (HMO)** An HMO provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service you receive and free you from completing paperwork or being billed for covered services. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work.

-The HMO provides a comprehensive set of services as long as you use the doctors and hospital affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and sometimes a copayment of in-hospital care.

-Most HMOs ask you to choose a doctor or medical group as your primary care physician (PCP). Your PCP provides your general medical care. In many HMOs, you must get authorization or a "referral" from your PCP to see other providers. The referral is a recommendation by your physician for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures that you see the right provider for the care appropriate to your condition.

-Medical Care from a provider not in the plan's network is covered unless it's emergency care or your plan has an arrangement with another provider.

**Plans Offering a Point-of-Service (POS) Product**-A POS plan is like having two plans in one - an HMO and a FFS plan. A POS allows you and your family members to choose between using, (1) a network or providers in a designated service area (like an HMO), or (2) out-of-network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non-HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

→ on pg 11 of 2008 pkg

## DIRECT PREMIUM REMITTANCE SYSTEM

Bottom of 2008 HDP

**Nationwide and Regional High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) and Consumer-Driven Health Plans (Pages 10 & 11)**

**Always consult plan brochures before making your final decision. The chart is not a complete statement of your out-of-pocket obligations in every individual circumstance.**

A High Deductible Health Plan (HDHP) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The HDHP gives you flexibility and discretion over how you use your health care benefits.

Bottom - 2nd Column of 2008 HDP

A Consumer-Driven Health Plan (CDHP) provides you with freedom in spending health care dollars the way you want. The typical plan has common components: Member responsibility for certain up-front costs, an account that you may use to pay these up-front costs and catastrophic coverage with a high deductible. You and your family members receive full coverage for in-network preventive care.

**How to Read the HDHP/CDHP Charts:**

**Premium Contribution (pass through) to HSA/HRA (or personal care account)** - shows the amount your health plan automatically deposits or credits into your account on a monthly basis for Self Only/Self and Family enrollments. (Consumer-Driven Health Plans credit accounts annually.) The amount credited under Premium Contribution= is shown as a monthly amount for comparison purposes only.

**Calendar Year (CY) Deductible Self/Family** is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles, coinsurance and copayments, before the plan pays catastrophic benefits.

**Catastrophic (Cat.) Limit Self/Family** is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance and copayments, before the Plan pays catastrophic benefits.

**Office Visit** shows what you pay for a visit to a primary care physician after the deductible is met for other than preventative care.

**Hospital Inpatient** shows what you pay after the deductible is met for hospital services when an inpatient. The amount could be a daily copayment up to a specified amount (e.g. $50 a day up to three days), a coinsurance amount such as 20%, or a flat deductible amount (e.g. $200 per admission). This amount does not include charges from physicians or for services that may not be charged by the hospital such as lab work or radiology services.

**Outpatient Surgery** shows what you pay the doctor for surgery performed on an outpatient basis.

**Preventative Services** are often covered in full, usually with no or only a small deductible or copayment. Preventative services may also be payable up to an annual maximum dollar amount (e.g. up to $300 per person per year).

**Prescription Drug Payment Levels**

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier 1, Tier11, Level 1, etc. The 2 to 3 payment levels that plans use follow:

Level I includes most generic drugs, but may include some preferred brands.
Level II may include generics and preferred brands not included in Level I.
Level III includes all other covered drugs, with some exceptions for specialty drugs.

The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

**YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.**

A Health Savings Account (HSA) allows individuals to pay for current health expenses and save for future qualified medical expenses on a tax-free basis. Funds deposited into an HSA account are not taxed, the balance in the HSA grows tax-free, and that amount is available on a tax-free basis to pay medical costs. To open up an HSA a person must be covered under a High Deductible Health Plan (HDHP) and cannot be eligible for Medicare.

Features of an HSA include:
- Tax-deductible deposits you make to the HSA.
- Tax-deferred interest earned on the account.
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused funds and interest from year to year.
- Portability; the account is owned by you and yours to keep-even when you retire, leave government service or change plans.

Health Reimbursement Arrangements (HRAs) are a common feature of Consumer-Driven Health Plans. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA because they have Medicare. HRAs are similar to HSAs except an enrollee cannot make deposits into an HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

Features of an HRA include:
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused credits from year to year.
- Credits in an HRA do not earn interest.
- Credits in the HRA are forfeited if you leave federal employment or switch health insurance plans.

## DIRECT PREMIUM REMITTANCE SYSTEM

New info not in 2008

### Affordable Care Act (ACA) of 2010

The following information is a condensed version of information regarding the Affordable Care Act (ACA). For more details and the most up-to-date information, please visit www.opm.gov/insure.

**What are the changes to FEHB Program Dependent Eligibility Rules under the ACA?**

**Children Between ages of 22 and 26** – Children between the ages of 22 and 26 are covered under their parents Self and Family enrollment up to age 26.
**Married Children** – Married children (but NOT their spouse or their own children) are covered up to age 26.
**Children with or eligible for employer-provided health insurance** – Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
**Step Children** – Step children do not need to live with the enrollee in a parent-child relationship to be eligible for coverage up to age 26.
**Children Incapable of Self Support** – Children who are incapable of self support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
**Foster Children** – Foster children are eligible for coverage up to age 26 provided the foster parent certifies that the child meets the eligibility requirements specified on the foster child certification. See www.opm.gov/insure/health.

Children do not have to live with their parent, be financially dependent upon their parent or be students to be covered up to age 26. There is also no requirement that the child have prior or current insurance coverage. FEHB program plans will send notices to their enrollees of the coverage eligibility changes as part of that plan's Open Season communications.

**How Does This Affect Eligibility For Temporary Continuation of Coverage (TCC)?**

Children who lose coverage due to reaching age 26 are eligible for TCC for up to 36 months even if they previously had TCC.

If you are a child of an FEHB enrollee and you are now enrolled under Temporary Continuation of Coverage (TCC), you may no longer need your TCC enrollment since you will be covered under your parent's Self and Family enrollment. Once you are assured of coverage under your parent's Self and Family enrollment, you may want to cancel your TCC enrollment. To cancel your TCC, you must send a written, signed request to the National Finance Center at:

USDA, National Finance Center
DPRS Billing Unit
PO Box 61760
New Orleans, LA 70161-1760

You must include the date you wish to have your TCC account cancelled.

**Please note that your parent must take action with his/her Human Resources and/or OWCP office for you to be covered under their FEHB plan. Please do not request to have your TCC coverage cancelled until you have proof of the begin date of coverage from your parent's Human Resources and/or OWCP office.**

If you have additional questions, please contact the National Finance Center at 800-242-9630 or nfc.dprs@usda.gov.

**What is a Grandfathered Health Plan Under ACA?**
The Affordable Care Act requires that health plans include certain consumer protections and benefits coverage that affect some FEHB plan benefits beginning in 2011 and beyond. All plans in the FEHB Program have complied with all required provisions. However, certain protections and coverage terms depend upon whether the plan is considered a "grandfathered health plan" under the Act. A grandfathered health plan may preserve basic health coverage that was in effect when the law was enacted. If an FEHB plan indicates that it is a grandfathered plan that means certain benefit features including cost sharing, premium payments and covered services have not significantly changed from last year. While grandfathered health plans must comply with certain benefit requirements under the ACA, being a grandfathered plan also means that plan may not have included all benefit protections and coverage terms that apply to other plans. Information on a plan's specific benefit changes under the ACA will be available in the plan's brochure.

**How Does the ACA Affect Benefits for High Deductible Health Plans?**
Beginning January 1, 2011, currently eligible over-the-counter (OTC) products that are medicines or drugs will not be eligible for reimbursement from your Health Savings Account (HSA) or your Health Reimbursement Arrangement (HRA) – unless – you have a prescription for that item written by your physician. The only exception is insulin – you will not need a prescription from January 1, 2011 forward. Other currently eligible OTC items that are not medicines or drugs will not require a prescription. Effective January 1, 2011, the 10% penalty for non-eligible medical expenses paid from an HSA will increase to 20%.

**Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families**

- If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

- If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

- Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

page 4 in the 2008 pkg.

## DIRECT PREMIUM REMITTANCE SYSTEM

## OPEN SEASON INFORMATION

The 2011 Open Season for Spouse Equity/Temporary Continuation of Coverage Enrollees/Direct Pay Annuitants under the Federal Employees Health Benefits (FEHB) Program will be from November 14 through December 12, 2011. During Open Season you may change from one plan to another, from one option to another in the same plan, or from self only to self and family. Certain former spouses are excluded from self and family. Refer to our office for eligibility. Coverage under your current enrollment will continue automatically unless you request a change or unless your current plan will no longer be participating in the FEHB Program after December 31, 2011.

This Open Season package contains information tailored especially for you. The plan comparison chart on the following pages shows the benefits and premiums effective as of January 1, 2012 for Nationwide Fee-for-Service Plans (Pages 8 & 9), the Nationwide High Deductible and Consumer Driven Health Plans, (Pages 10 & 11) and the Health Maintenance Organizations (HMOs) and Point of Service (POS) Plans available in your state (Page 12). When comparing HMOs please note that, generally, you may only enroll in an HMO that services the area you live in. In some cases, the HMO may allow you to enroll if you work within its service area even though you live outside of the service area. Check with the HMO for questions concerning your specific eligibility to enroll. If no HMO or POS plans are available in your area, page 12 is omitted from your package.

Before you make a final decision about changing your enrollment, you should carefully review the official brochure(s) for the plan or plans in which you are interested.

Please use the following letter codes to determine the benefit explanations for plans on page 9 and page 11:

A - NONE
B - N/A
C - +35%
D - DAY x 5
E - NOTHING
F - +DIFF.
G - MAX $200
H - NOT COVERED
I - OR 50%
J - MAX $150
L - $55 MAX
M - $70 MAX
N - $100 MAX
O - $90 MAX
P - OR $45
Q - $50 MIN
R - NOTHING UP TO $1,200
S - DED/25%
T - $75 DAY-$750
U - MAX $150+
V - MAX $200+

### Important

You should carefully review the 2012 premiums shown in the following plan comparison chart for your plan and option of coverage. Do not rely on the chart alone for benefit data. If you do not change your enrollment during open season, you may not be eligible to change until the next open season. You may also make changes to the name, address, or telephone number information on the form, or add eligible new dependents if you already have a family plan. To avoid delays, make sure you sign and date the form if you request any changes. No changes will be made unless the enrollee signs the form.

### Benefit Changes

Your current plan will send you a copy of its new brochure and rate sheet. Be sure to read your plan's brochure to see how benefits change in 2012. Other plan brochures you request directly from the carrier may not have premiums in them, so be sure to save the enclosed comparison chart for 2012 premium rates.

### Plans Not Participating in the FEHB Program in 2012

Some plans will withdraw from the FEHB Program after December 31, 2011. You should check the enclosed comparison chart and, if your plan is not listed in the comparison chart, contact your plan to verify their participation in the FEHB Program. If the plan will not be in the FEHB Program in 2012, you must elect new coverage during this open season. If you do not pick a new insurance plan by the end of Open Season, you will not have health coverage in 2012 unless you are a Federal retiree or survivor annuitant. If you are a Federal retiree or survivor annuitant and you don't select another plan, we will enroll you in the Blue Cross and Blue Shield Service Benefit Plan option that is most similar to your current plan's cost and benefits. The effective date of your enrollment will be January 1, 2012. If Blue Cross and Blue Shield is the plan you want, don't wait for us to enroll you. If you elect them now, you will receive your plan card sooner.

### Effective Dates of Open Season Changes

All changes to new plans will be effective January 1, 2012.

### 2012 Payment Coupons

Note: If you are enrolled under Automatic Preauthorized Debit from your bank account, coupons will be mailed to you for informational purposes only.

For those enrollees who either stay with their current plan or whose changes are received before December 31, 2011, your new 2012 payment coupons will be mailed to you during the first two weeks of January, 2012. Your payment coupon for the month of January 2012 will be the first coupon to reflect the 2012 premium. If you do not receive your new coupons by January 22, call the Direct Premium Remittance System (DPRS) at 1-800-242-9630, weekdays, between the hours of 7:45 a.m. and 4:00 p.m. CST, for your new premium rate.

2011 DPRS OPEN SEASON INFORMATION TCC ENROLLEES (102% PREMIUM)
FEE FOR SERVICE PLANS - ENROLLMENT CODES AND RATES

| PLAN NAME | Telephone Number | Plan Option | Enrollment Code | | Your Monthly Premium | |
|---|---|---|---|---|---|---|
| | | | Self Only | Self & Family | Self Only | Self & Family |
| **PLANS OPEN TO ALL** | | | | | | |
| APWU HEALTH PLAN | 800/222-2728 | HIGH | 471 | 472 | 466.62 | 1100.29 |
| BLUE CROSS AND BLUE SHIELD | LOCAL | STANDARD | 104 | 105 | 590.18 | 1333.03 |
| BLUE CROSS AND BLUE SHIELD | LOCAL | BASIC | 111 | 112 | 462.55 | 1083.21 |
| GEHA HEALTH BENEFIT PLAN | 800/821-8336 | HIGH | 311 | 312 | 578.97 | 1316.79 |
| GEHA HEALTH BENEFIT PLAN | 800/821-8336 | STANDARD | 314 | 315 | 359.65 | 804.05 |
| MAIL HANDLERS BENEFIT PLAN | 800/410-7778 | STANDARD | 454 | 455 | 623.42 | 1426.74 |
| MAIL HANDLERS BENEFIT VALUE OPTION | 800/410-7778 | VALUE OPTION | 414 | 415 | 291.63 | 695.26 |
| NALC HEALTH BENEFIT PLAN | 888/838-8252 | HIGH | 321 | 322 | 583.11 | 1226.66 |
| SAMBA HEALTH BENEFIT PLAN | 800/838-8589 | HIGH | 431 | 442 | 674.81 | 1589.42 |
| SAMBA HEALTH BENEFIT PLAN | 800/838-8589 | STANDARD | 444 | 445 | 511.82 | 1168.87 |

| PLAN NAME | Telephone Number | Plan Option | Enrollment Code | | Your Monthly Premium | |
|---|---|---|---|---|---|---|
| | | | Self Only | Self & Family | Self Only | Self & Family |
| **PLANS OPEN ONLY TO SPECIFIC GROUPS** | | | | | | |
| COMPASS ROSE HEALTH PLAN | 800/838-0069 | HIGH | 421 | 422 | 520.70 | 1208.63 |
| FOREIGN SERVICE BENEFIT PLAN | 202/833-4910 | HIGH | 401 | 402 | 503.84 | 1205.09 |
| PANAMA CANAL AREA BENEFIT PLAN | 800/424-8196 | HIGH | 431 | 432 | 412.42 | 871.29 |
| RURAL CARRIERS BENEFIT PLAN | 800/838-8432 | HIGH | 381 | 382 | 577.15 | 1178.91 |

# 2011 DPRS OPEN SEASON INFORMATION TCC ENROLLEES (102% PREMIUM)
## FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

| Enrollment Code | | Benefit Type | Medical-Surgical - You Pay | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Deductible | | | Copay ($)/Coinsurance (%) | | | | | | | | |
| | | | Per Person | | Hospital Inpatient | Doctors | | Hospital Inpatient | Prescription Drugs | | | | | |
| Self Only | Self & Family | | Calendar Year | Prescription Drug | | Office Visits | Inpatient Surgical Procedures | R&B | Level I | Level II | Level III | Mail Order Discounts | | |
| **PLANS OPEN TO ALL** | | | | | | | | | | | | | | |
| 471 | 472 | PPO | $475 | | A A | $18 | 10% | 10% | | $5 | 25% | 25% | YES | |
| | | NON PPO | $500 | | A A | 30%F | 30%F | 30% | | 50% | 50% | 50% | YES | |
| 104 | 105 | PPO | $350 | | A A | $20 | 15% | | E | 20% | 30% | 30% | YES | |
| | | NON PPO | $350 | | A A | 35% | 35% | 35% | | 45%+ | 45%+ | 45%+ | YES | |
| 111 | 112 | PPO | A | | A A | $150 D | $25 | $150 | E | $10 | $40 | $50 I | N/A | |
| 311 | 312 | PPO | $350 | | A A | $100 $300 | $20 | 10% | E | $5 | 25% J | B | YES | |
| | | NON PPO | $350 | | A A | | 25% | 25% | E | $5 | 25% U | B | YES | |
| 314 | 315 | PPO | $350 | | A A | A A | $10 | 15% | 15% | 15 | 50% G | B | YES | |
| | | NON PPO | $350 | | A A | A A | 35% | 35% | 35% | $5 | 50% V | B | YES | |
| 454 | 455 | PPO | $400 | | A A | $200 $500 | $20 | 10% | E | $10 | 30% G | 50% G | YES | |
| | | NON PPO | $500 | | A A | | 30% | 30% | 30% | 50% | 50% | 50% | YES | |
| 414 | 415 | PPO | $600 | | A H | A A | $30 | 20% | 20% | $10 | 50% | 50% | YES | |
| | | NON PPO | $900 | | A H | A A | 40% | 40% | 40% | H | H | H | YES | |
| 321 | 322 | PPO | $300 | | A A | $200 $350 | $20 | 15% | E | 20% | 30% | 30% | YES | |
| | | NON PPO | $300 | | A A | | 30% | 30% | 30% | 45% | 45%+ | 45%+ | YES | |
| 441 | 442 | PPO | $350 | | A A | $200 $300 | $20 | 10% | E | $10 | 15% L | 30% O | YES | |
| | | NON PPO | $300 | | A A | | 30% | 30% | 30% | $10 | 15% L | 30% O | YES | |
| 444 | 445 | PPO | $350 | | A A | $200 $300 | $20 | 10% | E | $10 | 25% M | 35% N | YES | |
| | | NON PPO | $350 | | A A | | 30% | 30% | 30% | $10 | 25% M | 35% N | YES | |

| Enrollment Code | | Benefit Type | Medical-Surgical - You Pay | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Deductible | | | Copay ($)/Coinsurance (%) | | | | | | | | |
| | | | Per Person | | Hospital Inpatient | Doctors | | Hospital Inpatient | Prescription Drugs | | | | | |
| Self Only | Self & Family | | Calendar Year | Prescription Drug | | Office Visits | Inpatient Surgical Procedures | R&B | Level I | Level II | Level III | Mail Order Discounts | | |
| **PLANS OPEN ONLY TO SPECIFIC GROUPS** | | | | | | | | | | | | | | |
| 421 | 422 | PPO | $300 | | A A | $150 | $10 | 10% | E | $5 | $30 | 30% P | YES | |
| | | NON PPO | $300 | | A A | | 30% | 30% | 30% | $5 | $30 | 30% P | YES | |
| 401 | 402 | PPO | $300 | | A A | E | 10% | 10% | E | $10 | 25% | 30%+Q | YES | |
| | | NON PPO | $300 | | A A | $200 | 30% | 30% | 20% | $10 | 25% | 30%+Q | YES | |
| 431 | 432 | POS | A | | A A | $25 | $5 | B | E | 20% | 20% | 20% | NO | |
| | | FFS | A | | A A | $100 | 50% | 50% | 50% | 20% | 20% | 20% | NO | |
| 381 | 382 | PPO | $350 | $200 | $100 | | $20 | 10% | E | 30% | 30% | 30% | YES | |
| | | NON PPO | $400 | $200 | $300 | | 25% | 20% | 20% | 30% | 30% | 30% | YES | |

## Nationwide High Deductible and Consumer Driven Health Plans

| Plan Name | Telephone Number | Enrollment Code | | Premium | |
|---|---|---|---|---|---|
| | | Self | Self & Family | Self | Self & Family |
| APWU HEALTH PLAN-(CDHP) | 888/823-2483 | 474 | 475 | 343.43 | 772.62 |
| GEHA-(HDHP) | 800/821-8336 | 341 | 342 | 388.43 | 867.10 |
| MAILHANDLERS-(HDHP) | 800/604-9901 | 481 | 482 | 402.67 | 912.40 |

## High Deductible and Consumer Driven Health Plans for Your State

| Plan Name | Telephone Number | Enrollment Code | | Premium | |
|---|---|---|---|---|---|
| | | Self | Self & Family | Self | Self & Family |
| AETNA HEALTH FUND-(CDHP) | 877/459-6604 | 221 | 222 | 510.49 | 1,188.93 |
| AETNA HEALTH FUND-(HDHP) | 877/459-6604 | 224 | 225 | 348.21 | 752.58 |
| HUMANA COVERAGEFIRST-(CDHP) | 888/393-8765 | AD1 | AD2 | 468.28 | 1,063.64 |
| HUMANA COVERAGEFIRST-(CDHP) | 888/393-8765 | LM1 | LM2 | 476.66 | 1,072.47 |
| KAISER FOUNDATION HP-(HDHP) | 888/865-5813 | GW1 | GW2 | 336.16 | 755.76 |

## Nationwide High Deductible and Consumer Driven Health Plan (cont'd)

| Enrollment Code | | Benefit Type | Premium Contribution | | CY Deductible | | Catastrophic Limit | | Office Visit | In-patient surgery | Out-patient surgery | Preventive Services | Prescription Drugs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Self | Self & Family | | HSA | HRA | Self | Self & Family | Self | Self & Family | | | | | Level I | Level II | Level III |
| 474 | 475 | IN-NET | $100 | $200 | $600 | $1,200 | $3,000 | $4,500 | 15% | A | 15% | E | 25% | 25% | 25% |
| | | OUT-NET | $100 | $200 | $600 | $1,200 | $6,000 | $9,000 | 40% F | A | 40% F | R | B | B | B |
| 341 | 342 | IN-NET | $62.50 | $125 | $1,500 | $3,000 | $5,000 | $10,000 | 5% | 5% | 5% | E | 25% | 25% | 25% |
| | | OUT-NET | $62.50 | $125 | $1,500 | $3,000 | $5,000 | $10,000 | 25% | 25% | 25% | S | 25%+ | 25%+ | 25%+ |
| 481 | 482 | IN-NET | $70 | $140 | $2,000 | $4,000 | $5,000 | $10,000 | $15 | T | F | E | $10 | $25 | $40 |
| | | OUT-NET | $70 | $140 | $2,000 | $4,000 | $7,500 | $15,000 | 40% | 40% | 40% | H | H | H | H |

## High Deductible and Consumer Driven Health Plan for Your State (cont'd)

| Enrollment Code | | Location | SEE PLAN BROCHURES FOR BENEFIT INFORMATION |
|---|---|---|---|
| Self | Self & Family | | |
| 221 | 222 | MOST OF GEORGIA | |
| 224 | 225 | MOST OF GEORGIA | |
| AD1 | AD2 | ATLANTA AREA | |
| LM1 | LM2 | MACON AREA | |
| GW1 | GW2 | ATL/ATHENS/COLUMBUS/MACON/SAVAN | |

2011 DPRS OPEN SEASON INFORMATION TCC ENROLLEES (102% PREMIUM)
HMO AND POS PLANS FOR GEORGIA

| PLAN NAME | Premium | | PLAN LOCATION | Enrollment Code | | Telephone Number |
|---|---|---|---|---|---|---|
| | Self Only | Self & Family | | Self Only | Self & Family | |
| AETNA OPEN ACCESS- HIGH | 635.31 | 1457.76 | ATLANTA AND ATHENS AREAS | 2U1 | 2U2 | 877/459-8804 |
| HUMANA EMPLOYERS HEALTH PLAN | 527.92 | 1187.81 | COLUMBUS | CB1 | CB2 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN | 475.13 | 1069.02 | COLUMBUS | CB4 | CB5 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN | 523.58 | 1177.60 | MACON | DN1 | DN2 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN | 497.21 | 1118.73 | MACON | DN4 | DN5 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN- HIGH | 550.87 | 1239.68 | ATLANTA | DQ1 | DQ2 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN- STD | 527.92 | 1187.83 | ATLANTA | DG4 | DG5 | 888/393-6765 |
| KAISER FOUNDATION HP- HIGH | 533.05 | 1219.88 | ATL/ATHEN/COLUMBUS/MACON/SAVANNAH | F81 | F82 | 888/865-5813 |
| KAISER FOUNDATION HP- STD | 364.05 | 833.92 | ATL/ATHEN/COLUMBUS/MACON/SAVANNAH | F84 | F85 | 888/865-5813 |

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# IMPORTANT

## DPRS OPEN SEASON INFORMATION

**PLEASE READ ALL INFORMATION AND INSTRUCTIONS.**

**RETURN PAGE 2 OF THIS FORM ONLY IF YOU WISH TO MAKE A CHANGE.**

## TABLE OF CONTENTS



**Privacy Act Statement.** The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 8, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan (2) verify your and /or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB program. Executive Order 9397 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

Agencies other than the OPM may have further routine uses for disclosure of information for the records system in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

**Public Burden Statement.** We estimate, this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415-3430. The OMB number, 3206-0202 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

**FEHB**

OPEN SEASON
DPRS-2809
OMB 3206-0202
(Revised 7/11)

# REQUEST TO CHANGE FEHB ENROLLMENT FOR 2012 PLAN YEAR



Read the enclosed instructions before completing this form. Return this form to:
USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161
You may fax your form to 888-212-8734.
Do not take any action to maintain your present coverage.

Form redesigned by NFC

## COMPLETE THIS FORM *ONLY* IF YOU ARE MAKING CHANGES.

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at **www.opm.gov/insure.health**.

### SECTION I - Enrollee and Family Member Information *(For additional family members use a separate sheet and attach.)*

| 1. ENROLLEE NAME *(last, first, middle initial)* | 2. SOCIAL SECURITY NUMBER | 3. DATE OF BIRTH *(mm/dd/yyyy)* | 4. SEX ☐ M ☐ F | 5. ARE YOU MARRIED? ☐ YES ☐ NO |
|---|---|---|---|---|
| 6. HOME MAILING ADDRESS *(including ZIP Code)* | ☐ I need to correct my address. The changes are indicated in item 6 | 7. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | | 8. MEDICARE CLAIM NUMBER |
| | | 9. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 10 below. | | ☐ NO |
| 10. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | | NAME OF OTHER INSURANCE | | POLICY NUMBER |

Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. Child under age 26; 09. Adopted child; 17. Step child; 10. Eligible foster child; 99. Disabled child age 26 or older who is incapable of self-support because of a physical or mental disability that began before his/her 26th birthday.

| 11. NAME OF FAMILY MEMBER *(last, first, middle initial)* | 12. SOCIAL SECURITY NUMBER | 13. DATE OF BIRTH *(mm/dd/yyyy)* | 14. SEX ☐ M ☐ F | 15. RELATIONSHIP CODE |
|---|---|---|---|---|
| 16. ADDRESS *(if different from enrollee)* | | 17. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | | 18. MEDICARE CLAIM NUMBER |
| | | 19. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 20 below. | | ☐ NO |
| 20. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | | NAME OF OTHER INSURANCE | | POLICY NUMBER |
| 21. EMAIL ADDRESS *(if home address is different from enrollee's)* | 22. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)* | | | |

| 23. NAME OF FAMILY MEMBER *(last, first, middle initial)* | 24. SOCIAL SECURITY NUMBER | 25. DATE OF BIRTH *(mm/dd/yyyy)* | 26. SEX ☐ M ☐ F | 27. RELATIONSHIP CODE |
|---|---|---|---|---|
| 28. ADDRESS *(if different from enrollee)* | | 29. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | | 30. MEDICARE CLAIM NUMBER |
| | | 31. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 32 below. | | ☐ NO |
| 32. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | | NAME OF OTHER INSURANCE | | POLICY NUMBER |
| 33. EMAIL ADDRESS *(if home address is different from enrollee's)* | 34. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)* | | | |

### SECTION II - FEHB Plan You Are Currently Enrolled In

| 1. PLAN NAME | 2. ENROLLMENT CODE |
|---|---|
| | |

### Section III - FEHB Plan You Are Changing to

| 1. PLAN NAME | 2. ENROLLMENT CODE |
|---|---|
| | |

### SECTION IV - Signature

*WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)*

| 1. YOUR SIGNATURE *(do not print)* | 2. DATE *(mm/dd/yyyy)* |
|---|---|
| 3. EMAIL ADDRESS | 4. PREFERRED TELEPHONE NUMBER ( ) |

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
**FEHB**
OPEN SEASON

# INFORMATION AND INSTRUCTION SHEET FOR COMPLETING FORM DPRS-2809

**Carefully read the following instructions before completing your request form.**

**You must make all changes through the National Finance Center.**

The enclosed Direct Premium Remittance System (DPRS) form, DPRS-2809, should not be used by anyone other than the addressee and must be signed by the addressee.

DPRS-2809 allows you to change your current health benefits plan, if your account is current.

**If you decide not to make an enrollment change this year, it is not necessary to complete the form, DPRS-2809.** Please read both the form and the accompanying plan comparison charts to make sure your current health benefits plan and option of coverage, especially Health Maintenance Organization (HMO) plans, will still be available to you in 2012. If your plan is not listed, you must select another plan during this Open Season period (November 14 through December 12, 2011) to be assured of continued health benefits coverage.

**Important.** You should also carefully review the 2011 premium cost shown in the plan comparison charts for your plan and option of coverage. There are only limited opportunities, which permit you to change your enrollment outside of the Open Season. If you do not change your enrollment during the Open Season, you may not be eligible to change later, even if you do not wish to pay an increased premium cost for your enrollment.

**Note: Procedures for Brochure Request.** All brochure plan requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at www.opm.gov/insure/health. To contact the carrier for a plan brochure, call the phone number provided in this package. NFC will not stock any brochures.

**Section I, Action.** Mark the Change Enrollment block to change your FEHB enrollment.

**Section II, Enrollment Codes and Plan Names.** Mark one block only in the Nationwide Plans section, or enter the enrollment code and name of plan in the HMO Plan or HDHP or CDHP block. A list of high deductible health plans is included on pages 10-11. A list of the Health Maintenance Organization and Points of Service Plans is included on the state comparison chart on page 12 if any are available in your state of residence.

If you are changing your enrollment from self only to self and family, see Section III.

**Section III, Dependents Information.** If you are enrolling as self and family, list your eligible dependents and provide the requested information. List additional dependents on a separate page.

**Section IV, Address Correction.** If your address is incorrect on the enclosed form, enter the changes in the space provided. Mark a line through the erroneous information of your preprinted address. The address you provide here will be used by DPRS to mail all future correspondence, including health benefits information.

**Acknowledgment Letters.** If you made a change in your enrollment coverage during the Open Season, a letter acknowledging your change will be mailed to you. Keep the acknowledgment letter to use as verification of your new enrollment coverage effective January 1, 2011.

**Section V, Authorization.** You must sign and date the form. No changes will be made unless the enrollee signs and dates the form. Enter the daytime area code and phone number where you can be contacted to answer questions concerning the information on this form.

**Effective Date of Open Season Changes.** All enrollment changes will be effective January 1, 2012. If your change is processed before January 1, 2012, the coupons received in January will reflect the new premium. Otherwise, the new premium will be reflected in the coupons sent to you after the change is processed, retroactive to January 1, 2012.

**Identification Cards. These cards are issued by the health plans, not DPRS.** You should direct questions about identification (ID) cards to your plan. Cards are usually issued within 30 days from the date the plan receives notice of your enrollment change. Should you or your family require medical attention after the January 1, 2012 effective date, but before you receive your new ID card, you may use the letter we send you, acknowledging your open season change, as proof of your new coverage.

The FEHB web site at www.opm.gov/insure/health can help you choose your health plan. In addition to the info contained in this guide you will find information on:

- Who is Eligible
- How to Choose a Plan
- FEHB Handbook
- Frequently Asked Questions
- Medicare and FEHB
- Medicare Information for Caregiver
- Making Sure You Get Quality Healthcare
- Consumer Protection

**Additional Help.** If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit at 504-426-6420 from 7:45 a.m. to 4:00 p.m., CST, weekdays or write to: DPRS, P.O. Box 61760, New Orleans, LA. 70161-1760. Visit our web site at www.nfc.usda.gov select "DPRS" from the Related Websites drop-down menu. You will be able to view the full RI 70-5 FEHB Guide under "FEHB Guides" as well as the DPRS-2809 Open Season change form under "DPRS Open Season Information".

DIRECT PREMIUM REMITTANCE SYSTEM

pg 5 & 2008 pkg

## Nationwide Fee-For-Service Plans (Pages 8 & 9)

Always consult plan brochures before making your final decision. The chart does not show all of your possible out-of-pocket expenses.

**Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO)** A FFS plan provides flexibility in using medical providers of your choice. You may choose medical providers who have contracted with the health plan to offer discounted charges. You may choose medical providers who are not contacted with the plan, but you will pay more of the cost. Medical providers who have contracts with the health plan (Preferred Provider Organization or PPO) have agreed to accept the health plan9s reimbursement. You usually pay a copayment or a coinsurance charge and do not file claims or other paperwork. Going to a PPO hospital does not guarantee PPO benefits for all services received in the hospital, however. Lab work, radiology services, and other services from independent practitioners within the hospital are frequently not covered by the hospital9s PPO agreement. If you receive treatment for medical providers who are not contracted with the health plan, you either pay them directly and submit a claim for reimbursement to the health plan, or the health plan pays the provider directly according to plan coverage and you pay a deductible, coinsurance or the balance of the billed charge. In any case, you pay a greater amount of out-of-pocket cost.

**PPO only** A PPO-only plan provides medical services only through medical providers that have contracts with the plan. With few exceptions, there is no medical coverage if you or your family members receive care from providers not contracted with the plan.

**Fee-for-Service plans open only to specific groups** Several Fee-for-Service plans that are sponsored or underwritten by an employee organization strictly limit enrollment to persons who are members of that organization. If you are not certain if you are eligible, check with your human resources office first.

How to read the Fee-for-Service Chart:

**Deductibles** are the amount of covered expenses that you pay before your health plan begins to pay.

**Calendar Year** deductibles for families are two or more times the per person amount shown.

In some plans your combined **Prescription Drug** purchases from Mail Order and local pharmacies count toward the deductible. In other plans, only purchases from local pharmacies count. Some plans require each family member to meet a per person deductible.

The **Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

**Copay/Coinsurance** are the dollar amounts or percentages of covered expenses that you pay before your health plan begins to pay.

**Doctors** is what you must pay for office visits and inpatient Surgical Procedures.

**Hospital Inpatient Room and Board** is your portion of the covered charges for inpatient room and board expenses.

**Prescription Drug Payment Levels**

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier 1, Tier 11, Level 1, etc. The 2 to 3 payment levels that plans use follow:

Level I includes most generic drugs, but may include some preferred brands.

Level II may include generics and preferred brands not included in Level I.

Level III includes all other covered drugs, with some exceptions for specialty drugs.

The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

**YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.**

## Health Maintenance Organization Plans and Plans Offering a Point-of-Service Product (Page 12)

Always consult plan brochures before making your final decision. The chart does not show all of your possible out-of-pocket expenses.

**Health Maintenance Organization (HMO)** An HMO provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service you receive and free you from completing paperwork or being billed for covered services. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work.

-The HMO provides a comprehensive set of services as long as you use the doctors and hospital affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and sometimes a copayment of in-hospital care.

-Most HMOs ask you to choose a doctor or medical group as your primary care physician (PCP). Your PCP provides your general medical care. In many HMOs, you must get authorization or a "referral" from your PCP to see other providers. The referral is a recommendation by your physician for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures that you see the right provider for the care appropriate to your condition.

-Medical Care from a provider not in the plan's network is covered unless it's emergency care or your plan has an arrangement with another provider.

**Plans Offering a Point-of-Service (POS) Product**-A POS plan is like having two plans in one - an HMO and a FFS plan. A POS allows you and your family members to choose between using, (1) a network or providers in a designated service area (like an HMO), or (2) out-of-network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non-HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

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## DIRECT PREMIUM REMITTANCE SYSTEM

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**Nationwide and Regional High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) and Consumer-Driven Health Plans (Pages 10 & 11)**

**Always consult plan brochures before making your final decision. The chart is not a complete statement of your out-of-pocket obligations in every individual circumstance.**

A **High Deductible Health Plan (HDHP)** provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The HDHP gives you flexibility and discretion over how you use your health care benefits.

A **Consumer-Driven Health Plan (CDHP)** provides you with freedom in spending health care dollars the way you want. The typical plan has common components: Member responsibility for certain up-front costs, an account that you may use to pay these up-front costs and catastrophic coverage with a high deductible. You and your family members receive full coverage for in-network preventive care.

**How to Read the HDHP/CDHP Charts:**

**Premium Contribution (pass through) to HSA/HRA** (or personal care account) - shows the amount your health plan automatically deposits or credits into your account on a monthly basis for Self Only/Self and Family enrollments. (Consumer-Driven Health Plans credit accounts annually.) The amount credited under Premium Contribution= is shown as a monthly amount for comparison purposes only.

**Calendar Year (CY) Deductible Self/Family** is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles, coinsurance and copayments, before the plan pays catastrophic benefits.

**Catastrophic (Cat.) Limit Self/Family** is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance and copayments, before the Plan pays catastrophic benefits.

**Office Visit** shows what you pay for a visit to a primary care physician after the deductible is met for other than preventative care.

**Hospital Inpatient** shows what you pay after the deductible is met for hospital services when an inpatient. The amount could be a daily copayment up to a specified amount (e.g. $50 a day up to three days), a coinsurance amount such as 20%, or a flat deductible amount (e.g. $200 per admission). This amount does not include charges from physicians or for services that may not be charged by the hospital such as lab work or radiology services.

**Outpatient Surgery** shows what you pay the doctor for surgery performed on an outpatient basis.

**Preventative Services** are often covered in full, usually with no or only a small deductible or copayment. Preventative services may also be payable up to an annual maximum dollar amount (e.g. up to $300 per person per year).

**Prescription Drug Payment Levels**

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier 1, Tier11, Level 1, etc. The 2 to 3 payment levels that plans use follow:

Level I includes most generic drugs, but may include some preferred brands.
Level II may include generics and preferred brands not included in Level I.
Level III includes all other covered drugs, with some exceptions for specialty drugs.

The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

**YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.**

**A Health Savings Account (HSA)** allows individuals to pay for current health expenses and save for future qualified medical expenses on a tax-free basis. Funds deposited into an HSA account are not taxed, the balance in the HSA grows tax-free, and that amount is available on a tax-free basis to pay medical costs. To open up an HSA a person must be covered under a High Deductible Health Plan (HDHP) and cannot be eligible for Medicare.

Features of an HSA include:
- Tax-deductible deposits you make to the HSA.
- Tax-deferred interest earned on the account.
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused funds and interest from year to year.
- Portability; the account is owned by you and yours to keep-even when you retire, leave government service or change plans.

**Health Reimbursement Arrangements (HRAs)** are a common feature of Consumer-Driven Health Plans. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA because they have Medicare. HRAs are similar to HSAs except an enrollee cannot make deposits into an HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

Features of an HRA include:
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused credits from year to year.
- Credits in an HRA do not earn interest.
- Credits in the HRA are forfeited if you leave federal employment or switch health insurance plans.

DIRECT PREMIUM REMITTANCE SYSTEM

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## Affordable Care Act (ACA) of 2010

The following information is a condensed version of information regarding the Affordable Care Act (ACA). For more details and the most up-to-date information, please visit www.opm.gov/insure.

**What are the changes to FEHB Program Dependent Eligibility Rules under the ACA?**

**Children Between ages of 22 and 26** – Children between the ages of 22 and 26 are covered under their parents Self and Family enrollment up to age 26.
**Married Children** – Married children (but NOT their spouse or their own children) are covered up to age 26.
**Children with or eligible for employer-provided health insurance** – Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
**Step Children** – Step children do not need to live with the enrollee in a parent-child relationship to be eligible for coverage up to age 26.
**Children Incapable of Self Support** – Children who are incapable of self support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
**Foster Children** – Foster children are eligible for coverage up to age 26 provided the foster parent certifies that the child meets the eligibility requirements specified on the foster child certification. See www.opm.gov/insure/health.

Children do not have to live with their parent, be financially dependent upon their parent or be students to be covered up to age 26. There is also no requirement that the child have prior or current insurance coverage. FEHB program plans will send notices to their enrollees of the coverage eligibility changes as part of that plan's Open Season communications.

**How Does This Affect Eligibility For Temporary Continuation of Coverage (TCC)?**

Children who lose coverage due to reaching age 26 are eligible for TCC for up to 36 months even if they previously had TCC.

If you are a child of an FEHB enrollee and you are now enrolled under Temporary Continuation of Coverage (TCC), you may no longer need your TCC enrollment since you will be covered under your parent's Self and Family enrollment. Once you are assured of coverage under your parent's Self and Family enrollment, you may want to cancel your TCC enrollment. To cancel your TCC, you must send a written, signed request to the National Finance Center at:

USDA, National Finance Center
DPRS Billing Unit
PO Box 61760
New Orleans, LA 70161-1760

You must include the date you wish to have your TCC account cancelled.

**Please note that your parent must take action with his/her Human Resources and/or OWCP office for you to be covered under their FEHB plan. Please do not request to have your TCC coverage cancelled until you have proof of the begin date of coverage from your parent's Human Resources and/or OWCP office.**

If you have additional questions, please contact the National Finance Center at 800-242-9630 or nfc.dprs@usda.gov.

**What is a Grandfathered Health Plan Under ACA?**
The Affordable Care Act requires that health plans include certain consumer protections and benefits coverage that affect some FEHB plan benefits beginning in 2011 and beyond. All plans in the FEHB Program have complied with all required provisions. However, certain protections and coverage terms depend upon whether the plan is considered a "grandfathered health plan" under the Act. A grandfathered health plan may preserve basic health coverage that was in effect when the law was enacted. If an FEHB plan indicates that it is a grandfathered plan that means certain benefit features including cost sharing, premium payments and covered services have not significantly changed from last year. While grandfathered health plans must comply with certain benefit requirements under the ACA, being a grandfathered plan also means that plan may not have included all benefit protections and coverage terms that apply to other plans. Information on a plan's specific benefit changes under the ACA will be available in the plan's brochure.

**How Does the ACA Affect Benefits for High Deductible Health Plans?**
Beginning January 1, 2011, currently eligible over-the-counter (OTC) products that are medicines or drugs will not be eligible for reimbursement from your Health Savings Account (HSA) or your Health Reimbursement Arrangement (HRA) – unless – you have a prescription for that item written by your physician. The only exception is insulin – you will not need a prescription from January 1, 2011 forward. Other currently eligible OTC items that are not medicines or drugs will not require a prescription. Effective January 1, 2011, the 10% penalty for non-eligible medical expenses paid from an HSA will increase to 20%.

**Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families**

- If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

- If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-**KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

- Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

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## DIRECT PREMIUM REMITTANCE SYSTEM

# OPEN SEASON INFORMATION

The 2011 Open Season for Spouse Equity/Temporary Continuation of Coverage Enrollees/Direct Pay Annuitants under the Federal Employees Health Benefits (FEHB) Program will be from November 14 through December 12, 2011. During Open Season you may change from one plan to another, from one option to another in the same plan, or from self only to self and family. Certain former spouses are excluded from self and family. Refer to our office for eligibility. Coverage under your current enrollment will continue automatically unless you request a change or unless your current plan will no longer be participating in the FEHB Program after December 31, 2011.

This Open Season package contains information tailored especially for you. The plan comparison chart on the following pages shows the benefits and premiums effective as of January 1, 2012 for Nationwide Fee-for-Service Plans (Pages 8 & 9), the Nationwide High Deductible and Consumer Driven Health Plans, (Pages 10 & 11) and the Health Maintenance Organizations (HMOs) and Point of Service (POS) Plans available in your state (Page 12). When comparing HMOs please note that, generally, you may only enroll in an HMO that services the area you live in. In some cases, the HMO may allow you to enroll if you work within its service area even though you live outside of the service area. Check with the HMO for questions concerning your specific eligibility to enroll. If no HMO or POS plans are available in your area, page 12 is omitted from your package.

Before you make a final decision about changing your enrollment, you should carefully review the official brochure(s) for the plan or plans in which you are interested.

Please use the following letter codes to determine the benefit explanations for plans on page 9 and page 11:

A - NONE
B - N/A
C - +35%
D - DAY x 5
E - NOTHING
F - +DIFF.
G - MAX $200
H - NOT COVERED
I - OR 50%
J - MAX $150
L - $55 MAX
M - $70 MAX
N - $100 MAX
O - $90 MAX
P - OR $45
Q - $50 MIN
R - NOTHING UP TO $1,200
S - DED/25%
T - $75 DAY-$750
U - MAX $150+
V - MAX $200+

### Important

You should carefully review the 2012 premiums shown in the following plan comparison chart for your plan and option of coverage. Do not rely on the chart alone for benefit data. If you do not change your enrollment during open season, you may not be eligible to change until the next open season. You may also make changes to the name, address, or telephone number information on the form, or add eligible new dependents if you already have a family plan. To avoid delays, make sure you sign and date the form if you request any changes. No changes will be made unless the enrollee signs the form.

### Benefit Changes

Your current plan will send you a copy of its new brochure and rate sheet. Be sure to read your plan's brochure to see how benefits change in 2012. Other plan brochures you request directly from the carrier may not have premiums in them, so be sure to save the enclosed comparison chart for 2012 premium rates.

### Plans Not Participating in the FEHB Program in 2012

Some plans will withdraw from the FEHB Program after December 31, 2011. You should check the enclosed comparison chart and, if your plan is not listed in the comparison chart, contact your plan to verify their participation in the FEHB Program. If the plan will not be in the FEHB Program in 2012, you must elect new coverage during this open season. If you do not pick a new insurance plan by the end of Open Season, you will not have health coverage in 2012 unless you are a Federal retiree or survivor annuitant. If you are a Federal retiree or survivor annuitant and you don't select another plan, we will enroll you in the Blue Cross and Blue Shield Service Benefit Plan option that is most similar to your current plan's cost and benefits. The effective date of your enrollment will be January 1, 2012. If Blue Cross and Blue Shield is the plan you want, don't wait for us to enroll you. If you elect them now, you will receive your plan card sooner.

### Effective Dates of Open Season Changes

All changes to new plans will be effective January 1, 2012.

### 2012 Payment Coupons

Note: If you are enrolled under Automatic Preauthorized Debit from your bank account, coupons will be mailed to you for informational purposes only.

For those enrollees who either stay with their current plan or whose changes are received before December 31, 2011, your new 2012 payment coupons will be mailed to you during the first two weeks of January, 2012. Your payment coupon for the month of January 2012 will be the first coupon to reflect the 2012 premium. If you do not receive your new coupons by January 22, call the Direct Premium Remittance System (DPRS) at 1-800-242-9630, weekdays, between the hours of 7:45 a.m. and 4:00 p.m. CST, for your new premium rate.

2011 DPRS OPEN SEASON INFORMATION DOD-RIF ENROLLEES
FEE FOR SERVICE PLANS - ENROLLMENT CODES AND RATES

| PLAN NAME | Telephone Number | Plan Option | Enrollment Code | | Your Monthly Premium | |
|---|---|---|---|---|---|---|
| | | | Self Only | Self & Family | Self Only | Self & Family |
| **PLANS OPEN TO ALL** | | | | | | |
| APWU HEALTH PLAN | 800/222-2798 | HIGH | 471 | 472 | 119.27 | 269.68 |
| BLUE CROSS AND BLUE SHIELD | LOCAL | STANDARD | 104 | 105 | 187.10 | 431.60 |
| BLUE CROSS AND BLUE SHIELD | LOCAL | BASIC | 111 | 112 | 113.37 | 265.49 |
| GEHA HEALTH BENEFIT PLAN | 800/821-6136 | HIGH | 311 | 312 | 175.19 | 415.68 |
| GEHA HEALTH BENEFIT PLAN | 800/821-8136 | STANDARD | 314 | 315 | 86.65 | 197.07 |
| MAIL HANDLERS BENEFIT PLAN | 800/410-7774 | STANDARD | 454 | 455 | 219.27 | 523.47 |
| MAIL HANDLERS BENEFIT VALUE OPTION | 800/410-7774 | VALUE OPTION | 414 | 415 | 71.45 | 170.41 |
| NALC HEALTH BENEFIT PLAN | 888/836-6252 | HIGH | 321 | 322 | 150.54 | 327.32 |
| SAMBA HEALTH BENEFIT PLAN | 800/638-6580 | HIGH | 441 | 442 | 270.25 | 682.96 |
| SAMBA HEALTH BENEFIT PLAN | 800/638-6580 | STANDARD | 444 | 445 | 125.14 | 286.49 |

| PLAN NAME | Telephone Number | Plan Option | Enrollment Code | | Your Monthly Premium | |
|---|---|---|---|---|---|---|
| | | | Self Only | Self & Family | Self Only | Self & Family |
| **PLANS OPEN ONLY TO SPECIFIC GROUPS** | | | | | | |
| COMPASS ROSE HEALTH PLAN | 800/634-0069 | HIGH | 421 | 422 | 122.52 | 309.64 |
| FOREIGN SERVICE BENEFIT PLAN | 202/833-4910 | HIGH | 401 | 402 | 123.45 | 309.17 |
| PANAMA CANAL AREA BENEFIT PLAN | 800/424-8196 | HIGH | 431 | 432 | 102.31 | 213.55 |
| RURAL CARRIERS BENEFIT PLAN | 800/638-3432 | HIGH | 381 | 382 | 174.40 | 288.95 |

# 2011 DPRS OPEN SEASON INFORMATION DOD-RIF ENROLLEES
## FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

### PLANS OPEN TO ALL

| Enrollment Code | | Benefit Type | Medical-Surgical - You Pay | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Deductible | | | Copay ($)/Coinsurance (%) | | | | | | | |
| | | | Per Person | | Hospital Inpatient | Doctors | | Hospital Inpatient | Prescription Drugs | | | | |
| Self Only | Self & Family | | Calendar Year | Prescription Drug | | Office Visits | Inpatient Surgical Procedures | R&B | Level I | Level II | Level III | Mail Order Discounts |
| 471 | 472 | PPO | $275 | | A | $18 | 10% | 10% | $5 | 25% | 25% | YES |
| | | NON PPO | $500 | | A | $300 30%F | 30%F | 30% | 50% | 50% | 50% | YES |
| 104 | 105 | PPO | $350 | | A | $250 | $20 | 15% | E | 20% | 30% | 30% | YES |
| | | NON PPO | $350 | | A | $350 | 35% | 35% | 35% | 45%+ | 45%+ | 45%+ | YES |
| 111 | 112 | PPO | | A | A | $150 D | $25 | $150 | E | $10 | $40 | $50 I | N/A |
| 311 | 312 | PPO | $350 | | A | $100 | $20 | 10% | E | $5 | 25% J | B | YES |
| | | NON PPO | $350 | | A | $300 | 25% | 25% | E | $5 | 25% U | B | YES |
| 314 | 315 | PPO | $350 | | A | A | $10 | 15% | 15% | $5 | 50% G | B | YES |
| | | NON PPO | $350 | | A | A | 35% | 35% | 35% | $5 | 50% V | B | YES |
| 454 | 455 | PPO | $400 | | A | $200 | $20 | 10% | E | $10 | 30% G | 50% G | YES |
| | | NON PPO | $600 | | A | $500 | 30% | 30% | 30% | 50% | 50% | 50% | YES |
| 414 | 415 | PPO | $500 | | A | A | $30 | 20% | 20% | $10 | 50% | 50% | YES |
| | | NON PPO | $900 | | H | A | 40% | 40% | 40% | H | H | H | YES |
| 321 | 322 | PPO | $300 | | A | $200 | $20 | 15% | E | 20% | 30% | 30% | YES |
| | | NON PPO | $300 | | A | $250 | 30% | 30% | 30% | 45% | 45%+ | 45%+ | YES |
| 441 | 442 | PPO | $300 | | A | $200 | $20 | 10% | E | $10 | 15% L | 30% O | YES |
| | | NON PPO | $300 | | A | $300 | 30% | 30% | 30% | $10 | 15% L | 30% N | YES |
| 444 | 445 | PPO | $350 | | A | $200 | $20 | 15% | E | $10 | 25% M | 35% N | YES |
| | | NON PPO | $350 | | A | $300 | 30% | 30% | 30% | $10 | 25% M | 35% N | YES |

### PLANS OPEN ONLY TO SPECIFIC GROUPS

| Enrollment Code | | Benefit Type | Medical-Surgical - You Pay | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Deductible | | | Copay ($)/Coinsurance (%) | | | | | | | |
| | | | Per Person | | Hospital Inpatient | Doctors | | Hospital Inpatient | Prescription Drugs | | | | |
| Self Only | Self & Family | | Calendar Year | Prescription Drug | | Office Visits | Inpatient Surgical Procedures | R&B | Level I | Level II | Level III | Mail Order Discounts |
| 421 | 422 | PPO | $300 | | A | $150 | $10 | 10% | E | $5 | $30 | 30% P | YES |
| | | NON PPO | $300 | | A | $150 | 30% | 30% | 30% | $5 | $30 | 30% P | YES |
| 401 | 402 | PPO | $300 | | A | E | 10% | 10% | E | $10 | 25% | 30%+Q | YES |
| | | NON PPO | $300 | | A | $400 | 30% | 30% | 20% | $10 | 25% | 30%+Q | YES |
| 431 | 432 | POS | | A | A | $25 | $5 | E | E | 20% | 20% | 20% | NO |
| | | FFS | | A | A | $100 | 50% | 50% | 50% | 20% | 20% | 20% | NO |
| 381 | 382 | PPO | $350 | $200 | | $100 | $20 | 10% | E | 30% | 30% | 30% | YES |
| | | NON PPO | $400 | $200 | | $300 | 25% | 20% | 20% | 30% | 30% | 30% | YES |

## Nationwide High Deductible and Consumer Driven Health Plans

| Plan Name | Telephone Number | Enrollment Code | | Premium | |
|---|---|---|---|---|---|
| | | Self | Self & Family | Self | Self & Family |
| APWU HEALTH PLAN-(CDHP) | 866/633-9483 | 474 | 475 | 84.17 | 169.37 |
| GEHA-(HDHP) | 800/821-8138 | 341 | 342 | 85.20 | 217.45 |
| MAILHANDLERS-(HDHP) | 800/894-9901 | 481 | 482 | 98.68 | 225.63 |

## High Deductible and Consumer Driven Health Plans for Your State

| Plan Name | Telephone Number | Enrollment Code | | Premium | |
|---|---|---|---|---|---|
| | | Self | Self & Family | Self | Self & Family |
| AETNA HEALTH FUND-(CDHP) | 877/459-8804 | 221 | 222 | 125.12 | 300.13 |
| AETNA HEALTH FUND-(HDHP) | 877/459-8804 | 224 | 225 | 85.34 | 188.91 |

## Nationwide High Deductible and Consumer Driven Health Plan (cont'd)

| Enrollment Code | | Benefit Type | Premium Contribution | | CY Deductible | | Catastrophic Limit | | Office Visit | In-patient surgery | Out-patient surgery | Preventive Services | Prescription Drugs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Self | Self & Family | | HSA | HRA | Self | Self & Family | Self | Self & Family | | | | | Level I | Level II | Level III |
| 474 | 475 | IN-NET | $100 | $200 | $600 | $1,200 | $3,000 | $4,500 | 15% | A | 15% | E | 25% | 25% | 25% |
| | | OUT-NET | $100 | $200 | $600 | $1,200 | $9,000 | $9,000 | 40% F | A | 40% F | R | B | B | B |
| 341 | 342 | IN-NET | $62.50 | $125 | $1,500 | $3,000 | $5,000 | $10,000 | 5% | 5% | 5% | E | 25% | 25% | 25% |
| | | OUT-NET | $62.50 | $125 | $1,500 | $3,000 | $5,000 | $10,000 | 25% | 25% | 25% | S | 25%+ | 25%+ | 25%+ |
| 481 | 482 | IN-NET | $70 | $140 | $2,000 | $4,000 | $5,000 | $10,000 | $15 | T | E | E | $10 | $25 | $40 |
| | | OUT-NET | $70 | $140 | $2,000 | $4,000 | $7,500 | $15,000 | 40% | 40% | 40% | H | H | H | H |

## High Deductible and Consumer Driven Health Plan for Your State (cont'd)

| Enrollment Code | | Location | SEE PLAN BROCHURES FOR BENEFIT INFORMATION |
|---|---|---|---|
| Self | Self & Family | | |
| 221 | 222 | MOST OF CALIFORNIA | |
| 224 | 225 | MOST OF CALIFORNIA | |

2011 DPRS OPEN SEASON INFORMATION DOD-RIF ENROLLEES
HMO AND POS PLANS FOR CALIFORNIA

| PLAN NAME | Premium | | PLAN LOCATION | Enrollment Code | | Telephone Number |
|---|---|---|---|---|---|---|
| | Self Only | Self & Family | | Self Only | Self & Family | |
| AETNA HMO | 108.57 | 269.90 | LOS ANGELES AND SAN DIEGO AREAS | 2X1 | 2X2 | 877/459-6804 |
| ANTHEM BLUE CROSS- HIGH | 196.80 | 560.13 | MOST OF CALIFORNIA | M51 | M52 | 800/235-8631 |
| BLUE SHIELD CALIF ACCESS & HMO | 132.04 | 307.75 | SOUTHERN REGION | SI1 | SI2 | 800/880-8086 |
| HEALTH NET OF CA NORTH- HIGH | 422.81 | 1008.87 | NORTHERN REGION | LB1 | LB2 | 800/522-0088 |
| HEALTH NET OF CA NORTH- STD | 383.85 | 917.24 | NORTHERN REGION | LB4 | LB5 | 800/522-0088 |
| HEALTH NET OF CA SOUTH- HIGH | 160.57 | 400.98 | SOUTHERN REGION | LP1 | LP2 | 800/522-0088 |
| HEALTH NET OF CA SOUTH- STD | 129.58 | 323.05 | SOUTHERN REGION | LP4 | LP5 | 800/522-0088 |
| KAISER FOUNDATION HP NORTH- HIGH | 230.40 | 609.09 | NORTHERN CALIFORNIA | 591 | 592 | 800/464-4000 |
| KAISER FOUNDATION HP NORTH- STD | 130.13 | 342.72 | NORTHERN CALIFORNIA | 594 | 595 | 800/464-4000 |
| KAISER FOUNDATION HP SOUTH- HIGH | 119.73 | 278.72 | SOUTHERN CALIFORNIA | 621 | 622 | 800/464-4000 |
| KAISER FOUNDATION HP SOUTH- STD | 78.72 | 177.31 | SOUTHERN CALIFORNIA | 624 | 625 | 800/464-4000 |
| PACIFICARE OF CALIFORNIA- HIGH | 118.50 | 270.51 | MOST OF CALIFORNIA | CY1 | CY2 | 800/546-0510 |

DRSCB (Revised 10/08)

LAW 4
Direct Pay
2011 Clearance

# IMPORTANT

## DPRS OPEN SEASON INFORMATION

**PLEASE READ ALL INFORMATION AND INSTRUCTIONS.**

**RETURN PAGE 2 OF THIS FORM ONLY IF YOU WISH TO MAKE A CHANGE.**

## TABLE OF CONTENTS



**Privacy Act Statement.** The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 8, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan (2) verify your and /or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB program. Executive Order 9397 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

Agencies other than the OPM may have further routine uses for disclosure of information for the records system in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

**Public Burden Statement.** We estimate, this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415-3430. The OMB number, 3206-0202 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM
**FEHB**
OPEN SEASON
DPRS-2809
OMB 3206-0202
(Revised 7/11)

# REQUEST TO CHANGE FEHB ENROLLMENT FOR 2012 PLAN YEAR



Read the enclosed instructions before completing this form. Return this form to:
USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161
You may fax your form to 888-212-8734.
Do not take any action to maintain your present coverage.

Form redesigned by NFC

## COMPLETE THIS FORM *ONLY* IF YOU ARE MAKING CHANGES.

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at **www.opm.gov/insure.health**.

### SECTION I - Enrollee and Family Member Information *(For additional family members use a separate sheet and attach.)*

1. ENROLLEE NAME *(last, first, middle initial)* | 2. SOCIAL SECURITY NUMBER | 3. DATE OF BIRTH *(mm/dd/yyyy)* | 4. SEX ☐ M ☐ F | 5. ARE YOU MARRIED? ☐ YES ☐ NO

6. HOME MAILING ADDRESS *(including ZIP Code)* | ☐ I need to correct my address. The changes are indicated in item 6 | 7. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | 8. MEDICARE CLAIM NUMBER

9. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 10 below. ☐ NO

10. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB — *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | NAME OF OTHER INSURANCE | POLICY NUMBER

Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. Child under age 26; 09. Adopted child; 17. Step child; 10. Eligible foster child; 99. Disabled child age 26 or older who is incapable of self-support because of a physical or mental disability that began before his/her 26th birthday.

11. NAME OF FAMILY MEMBER *(last, first, middle initial)* | 12. SOCIAL SECURITY NUMBER | 13. DATE OF BIRTH *(mm/dd/yyyy)* | 14. SEX ☐ M ☐ F | 15. RELATIONSHIP CODE

16. ADDRESS *(if different from enrollee)* | 17. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | 18. MEDICARE CLAIM NUMBER

19. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 20 below. ☐ NO

20. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB — *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | NAME OF OTHER INSURANCE | POLICY NUMBER

21. EMAIL ADDRESS *(if home address is different from enrollee's)* | 22. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)*

23. NAME OF FAMILY MEMBER *(last, first, middle initial)* | 24. SOCIAL SECURITY NUMBER | 25. DATE OF BIRTH *(mm/dd/yyyy)* | 26. SEX ☐ M ☐ F | 27. RELATIONSHIP CODE

28. ADDRESS *(if different from enrollee)* | 29. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY ☐ A ☐ B ☐ D | 30. MEDICARE CLAIM NUMBER

31. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? ☐ YES, indicate in item 32 below. ☐ NO

32. INDICATE THE TYPE(S) OF OTHER INSURANCE ☐ TRICARE ☐ OTHER ☐ FEHB — *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.* | NAME OF OTHER INSURANCE | POLICY NUMBER

33. EMAIL ADDRESS *(if home address is different from enrollee's)* | 34. PREFERRED TELEPHONE NUMBER *(if home address is different from enrollee's)*

### SECTION II - FEHB Plan You Are Currently Enrolled In

1. PLAN NAME | 2. ENROLLMENT CODE

### Section III - FEHB Plan You Are Changing to

1. PLAN NAME | 2. ENROLLMENT CODE

### SECTION IV - Signature

*WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)*

1. YOUR SIGNATURE *(do not print)* | 2. DATE *(mm/dd/yyyy)*

3. EMAIL ADDRESS | 4. PREFERRED TELEPHONE NUMBER ( )

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

**FEHB**

**OPEN SEASON**

# INFORMATION AND INSTRUCTION SHEET FOR COMPLETING FORM DPRS-2809

**Carefully read the following instructions before completing your request form.**

**You must make all changes through the National Finance Center.**

The enclosed Direct Premium Remittance System (DPRS) form, DPRS-2809, should not be used by anyone other than the addressee and must be signed by the addressee.

DPRS-2809 allows you to change your current health benefits plan, if your account is current.

**If you decide not to make an enrollment change this year, it is not necessary to complete the form, DPRS-2809.** Please read both the form and the accompanying plan comparison charts to make sure your current health benefits plan and option of coverage, especially Health Maintenance Organization (HMO) plans, will still be available to you in 2012. If your plan is not listed, you must select another plan during this Open Season period (November 14 through December 12, ~~2010~~ 2011) to be assured of continued health benefits coverage.

**Important.** You should also carefully review the 2011 premium cost shown in the plan comparison charts for your plan and option of coverage. There are only limited opportunities, which permit you to change your enrollment outside of the Open Season. If you do not change your enrollment during the Open Season, you may not be eligible to change later, even if you do not wish to pay an increased premium cost for your enrollment.

**Note: Procedures for Brochure Request.** All brochure plan requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site at www.opm.gov/insure/health. To contact the carrier for a plan brochure, call the phone number provided in this package. NFC will not stock any brochures.

**Section I, Action.** Mark the Change Enrollment block to change your FEHB enrollment.

**Section II, Enrollment Codes and Plan Names.** Mark one block only in the Nationwide Plans section, or enter the enrollment code and name of plan in the HMO Plan or HDHP or CDHP block. A list of high deductible health plans is included on pages 10-11. A list of the Health Maintenance Organization and Points of Service Plans is included on the state comparison chart on page 12 if any are available in your state of residence.

If you are changing your enrollment from self only to self and family, see Section III.

**Section III, Dependents Information.** If you are enrolling as self and family, list your eligible dependents and provide the requested information. List additional dependents on a separate page.

**Section IV, Address Correction.** If your address is incorrect on the enclosed form, enter the changes in the space provided. Mark a line through the erroneous information of your preprinted address. The address you provide here will be used by DPRS to mail all future correspondence, including health benefits information.

**Acknowledgment Letters.** If you made a change in your enrollment coverage during the Open Season, a letter acknowledging your change will be mailed to you. Keep the acknowledgment letter to use as verification of your new enrollment coverage effective January 1, 2011.

**Section V, Authorization.** You must sign and date the form. No changes will be made unless the enrollee signs and dates the form. Enter the daytime area code and phone number where you can be contacted to answer questions concerning the information on this form.

**Effective Date of Open Season Changes.** All enrollment changes will be effective January 1, 2012. If your change is processed before January 1, 2012, the coupons received in January will reflect the new premium. Otherwise, the new premium will be reflected in the coupons sent to you after the change is processed, retroactive to January 1, 2012.

**Identification Cards.** These cards are issued by the health plans, not DPRS. You should direct questions about identification (ID) cards to your plan. Cards are usually issued within 30 days from the date the plan receives notice of your enrollment change. Should you or your family require medical attention after the January 1, 2012 effective date, but before you receive your new ID card, you may use the letter we send you, acknowledging your open season change, as proof of your new coverage.

The FEHB web site at www.opm.gov/insure/health can help you choose your health plan. In addition to the info contained in this guide you will find information on:

- Who is Eligible
- How to Choose a Plan
- FEHB Handbook
- Frequently Asked Questions
- Medicare and FEHB
- Medicare Information for Caregiver
- Making Sure You Get Quality Healthcare
- Consumer Protection

**Additional Help.** If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit at 504-426-6420 from 7:45 a.m. to 4:00 p.m., CST, weekdays or write to: DPRS, P.O. Box 61760, New Orleans, LA. 70161-1760. Visit our web site at www.nfc.usda.gov select "DPRS" from the Related Websites drop-down menu. You will be able to view the full RI 70-5 FEHB Guide under "FEHB Guides" as well as the DPRS-2809 Open Season change form under "DPRS Open Season Information".

DIRECT PREMIUM REMITTANCE SYSTEM

pg 5 of 2008 PKG

## Nationwide Fee-For-Service Plans (Pages 8 & 9)

Always consult plan brochures before making your final decision. The chart does not show all of your possible out-of-pocket expenses.

**Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO)** A FFS plan provides flexibility in using medical providers of your choice. You may choose medical providers who have contracted with the health plan to offer discounted charges. You may choose medical providers who are not contacted with the plan, but you will pay more of the cost. Medical providers who have contracts with the health plan (Preferred Provider Organization or PPO) have agreed to accept the health plan9s reimbursement. You usually pay a copayment or a coinsurance charge and do not file claims or other paperwork. Going to a PPO hospital does not guarantee PPO benefits for all services received in the hospital, however. Lab work, radiology services, and other services from independent practitioners within the hospital are frequently not covered by the hospital9s PPO agreement. If you receive treatment for medical providers who are not contracted with the health plan, you either pay them directly and submit a claim for reimbursement to the health plan, or the health plan pays the provider directly according to plan coverage and you pay a deductible, coinsurance or the balance of the billed charge. In any case, you pay a greater amount of out-of-pocket cost.

**PPO only** A PPO-only plan provides medical services only through medical providers that have contracts with the plan. With few exceptions, there is no medical coverage if you or your family members receive care from providers not contracted with the plan.

**Fee-for-Service plans open only to specific groups** Several Fee-for-Service plans that are sponsored or underwritten by an employee organization strictly limit enrollment to persons who are members of that organization. If you are not certain if you are eligible, check with your human resources office first.

**How to read the Fee-for-Service Chart:**

**Deductibles** are the amount of covered expenses that you pay before your health plan begins to pay.

**Calendar Year** deductibles for families are two or more times the per person amount shown.

In some plans your combined **Prescription Drug** purchases from Mail Order and local pharmacies count toward the deductible. In other plans, only purchases from local pharmacies count. Some plans require each family member to meet a per person deductible.

The **Hospital Inpatient** deductible is what you pay each time you are admitted to a hospital.

**Copay/Coinsurance** are the dollar amounts or percentages of covered expenses that you pay before your health plan begins to pay.

**Doctors** is what you must pay for office visits and inpatient Surgical Procedures.

**Hospital Inpatient Room and Board** is your portion of the covered charges for inpatient room and board expenses.

**Prescription Drug Payment Levels**

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier 1, Tier11, Level 1, etc. The 2 to 3 payment levels that plans use follow:

**Level I** includes most generic drugs, but may include some preferred brands.

**Level II** may include generics and preferred brands not included in Level I.

**Level III** includes all other covered drugs, with some exceptions for specialty drugs.

The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

**YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.**

## Health Maintenance Organization Plans and Plans Offering a Point-of-Service Product (Page 12)

Always consult plan brochures before making your final decision. The chart does not show all of your possible out-of-pocket expenses.

**Health Maintenance Organization (HMO)** An HMO provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service you receive and free you from completing paperwork or being billed for covered services. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work.

-The HMO provides a comprehensive set of services as long as you use the doctors and hospital affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and sometimes a copayment of in-hospital care.

-Most HMOs ask you to choose a doctor or medical group as your primary care physician (PCP). Your PCP provides your general medical care. In many HMOs, you must get authorization or a "referral" from your PCP to see other providers. The referral is a recommendation by your physician for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures that you see the right provider for the care appropriate to your condition.

-Medical Care from a provider not in the plan's network is covered unless it's emergency care or your plan has an arrangement with another provider.

**Plans Offering a Point-of-Service (POS) Product**-A POS plan is like having two plans in one - an HMO and a FFS plan. A POS allows you and your family members to choose between using, (1) a network or providers in a designated service area (like an HMO), or (2) out-of-network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non-HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

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# DIRECT PREMIUM REMITTANCE SYSTEM

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**Nationwide and Regional High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) and Consumer-Driven Health Plans (Pages 10 & 11)**

**Always consult plan brochures before making your final decision. The chart is not a complete statement of your out-of-pocket obligations in every individual circumstance.**

**A High Deductible Health Plan (HDHP)** provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The HDHP gives you flexibility and discretion over how you use your health care benefits.

**A Consumer-Driven Health Plan (CDHP)** provides you with freedom in spending health care dollars the way you want. The typical plan has common components: Member responsibility for certain up-front costs, an account that you may use to pay these up-front costs and catastrophic coverage with a high deductible. You and your family members receive full coverage for in-network preventive care.

**How to Read the HDHP/CDHP Charts:**

**Premium Contribution (pass through) to HSA/HRA (or personal care account)** – shows the amount your health plan automatically deposits or credits into your account on a monthly basis for Self Only/Self and Family enrollments. (Consumer-Driven Health Plans credit accounts annually.) The amount credited under Premium Contribution= is shown as a monthly amount for comparison purposes only.

**Calendar Year (CY) Deductible Self/Family** is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles, coinsurance and copayments, before the plan pays catastrophic benefits.

**Catastrophic (Cat.) Limit Self/Family** is the maximum amount of covered expenses an individual or family must pay out-of-pocket, including deductibles and coinsurance and copayments, before the Plan pays catastrophic benefits.

**Office Visit** shows what you pay for a visit to a primary care physician after the deductible is met for other than preventative care.

**Hospital Inpatient** shows what you pay after the deductible is met for hospital services when an inpatient. The amount could be a daily copayment up to a specified amount (e.g. $50 a day up to three days), a coinsurance amount such as 20%, or a flat deductible amount (e.g. $200 per admission). This amount does not include charges from physicians or for services that may not be charged by the hospital such as lab work or radiology services.

**Outpatient Surgery** shows what you pay the doctor for surgery performed on an outpatient basis.

**Preventative Services** are often covered in full, usually with no or only a small deductible or copayment. Preventative services may also be payable up to an annual maximum dollar amount (e.g. up to $300 per person per year).

**Prescription Drug Payment Levels**

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier 1, Tier11, Level 1, etc. The 2 to 3 payment levels that plans use follow:

Level I includes most generic drugs, but may include some preferred brands.
Level II may include generics and preferred brands not included in Level I.
Level III includes all other covered drugs, with some exceptions for specialty drugs.

The level in which a medication is placed and what you pay for prescription drugs is often based on what the plan is charged.

**YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.**

**A Health Savings Account (HSA)** allows individuals to pay for current health expenses and save for future qualified medical expenses on a tax-free basis. Funds deposited into an HSA account are not taxed, the balance in the HSA grows tax-free, and that amount is available on a tax-free basis to pay medical costs. To open up an HSA a person must be covered under a High Deductible Health Plan (HDHP) and cannot be eligible for Medicare.

Features of an HSA include:
- Tax-deductible deposits you make to the HSA.
- Tax-deferred interest earned on the account.
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused funds and interest from year to year.
- Portability: the account is owned by you and yours to keep-even when you retire, leave government service or change plans.

**Health Reimbursement Arrangements (HRAs)** are a common feature of Consumer-Driven Health Plans. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA because they have Medicare. HRAs are similar to HSAs except an enrollee cannot make deposits into an HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

Features of an HRA include:
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused credits from year to year.
- Credits in an HRA do not earn interest.
- Credits in the HRA are forfeited if you leave federal employment or switch health insurance plans.

DIRECT PREMIUM REMITTANCE SYSTEM

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## Affordable Care Act (ACA) of 2010

The following information is a condensed version of information regarding the Affordable Care Act (ACA). For more details and the most up-to-date information, please visit www.opm.gov/insure.

**What are the changes to FEHB Program Dependent Eligibility Rules under the ACA?**

**Children Between ages of 22 and 26** – Children between the ages of 22 and 26 are covered under their parents Self and Family enrollment up to age 26.
**Married Children** – Married children (but NOT their spouse or their own children) are covered up to age 26.
**Children with or eligible for employer-provided health insurance** – Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
**Step Children** – Step children do not need to live with the enrollee in a parent-child relationship to be eligible for coverage up to age 26.
**Children Incapable of Self Support** – Children who are incapable of self support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
**Foster Children** – Foster children are eligible for coverage up to age 26 provided the foster parent certifies that the child meets the eligibility requirements specified on the foster child certification. See www.opm.gov/insure/health.

Children do not have to live with their parent, be financially dependent upon their parent or be students to be covered up to age 26. There is also no requirement that the child have prior or current insurance coverage. FEHB program plans will send notices to their enrollees of the coverage eligibility changes as part of that plan's Open Season communications.

**How Does This Affect Eligibility For Temporary Continuation of Coverage (TCC)?**

Children who lose coverage due to reaching age 26 are eligible for TCC for up to 36 months even if they previously had TCC.

If you are a child of an FEHB enrollee and you are now enrolled under Temporary Continuation of Coverage (TCC), you may no longer need your TCC enrollment since you will be covered under your parent's Self and Family enrollment. Once you are assured of coverage under your parent's Self and Family enrollment, you may want to cancel your TCC enrollment. To cancel your TCC, you must send a written, signed request to the National Finance Center at:

USDA, National Finance Center
DPRS Billing Unit
PO Box 61760
New Orleans, LA 70161-1760

You must include the date you wish to have your TCC account cancelled.

**Please note that your parent must take action with his/her Human Resources and/or OWCP office for you to be covered under their FEHB plan. Please do not request to have your TCC coverage cancelled until you have proof of the begin date of coverage from your parent's Human Resources and/or OWCP office.**

If you have additional questions, please contact the National Finance Center at 800-242-9630 or nfc.dprs@usda.gov.

**What is a Grandfathered Health Plan Under ACA?**
The Affordable Care Act requires that health plans include certain consumer protections and benefits coverage that affect some FEHB plan benefits beginning in 2011 and beyond. All plans in the FEHB Program have complied with all required provisions. However, certain protections and coverage terms depend upon whether the plan is considered a "grandfathered health plan" under the Act. A grandfathered health plan may preserve basic health coverage that was in effect when the law was enacted. If an FEHB plan indicates that it is a grandfathered plan that means certain benefit features including cost sharing, premium payments and covered services have not significantly changed from last year. While grandfathered health plans must comply with certain benefit requirements under the ACA, being a grandfathered plan also means that plan may not have included all benefit protections and coverage terms that apply to other plans. Information on a plan's specific benefit changes under the ACA will be available in the plan's brochure.

**How Does the ACA Affect Benefits for High Deductible Health Plans?**
Beginning January 1, 2011, currently eligible over-the-counter (OTC) products that are medicines or drugs will not be eligible for reimbursement from your Health Savings Account (HSA) or your Health Reimbursement Arrangement (HRA) – unless – you have a prescription for that item written by your physician. The only exception is insulin – you will not need a prescription from January 1, 2011 forward. Other currently eligible OTC items that are not medicines or drugs will not require a prescription. Effective January 1, 2011, the 10% penalty for non-eligible medical expenses paid from an HSA will increase to 20%.

**Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families**

- If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

- If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-**KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

- Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

DIRECT PREMIUM REMITTANCE SYSTEM

# OPEN SEASON INFORMATION

This is on page 4 of the door pkg.

The 2011 Open Season for Spouse Equity/Temporary Continuation of Coverage Enrollees/Direct Pay Annuitants under the Federal Employees Health Benefits (FEHB) Program will be from November 14 through December 12, 2011. During Open Season you may change from one plan to another, from one option to another in the same plan, or from self only to self and family. Certain former spouses are excluded from self and family. Refer to our office for eligibility. Coverage under your current enrollment will continue automatically unless you request a change or unless your current plan will no longer be participating in the FEHB Program after December 31, 2011.

This Open Season package contains information tailored especially for you. The plan comparison chart on the following pages shows the benefits and premiums effective as of January 1, 2012 for Nationwide Fee-for-Service Plans (Pages 8 & 9), the Nationwide High Deductible and Consumer Driven Health Plans, (Pages 10 & 11) and the Health Maintenance Organizations (HMOs) and Point of Service (POS) Plans available in your state (Page 12). When comparing HMOs please note that, generally, you may only enroll in an HMO that services the area you live in. In some cases, the HMO may allow you to enroll if you work within its service area even though you live outside of the service area. Check with the HMO for questions concerning your specific eligibility to enroll. If no HMO or POS plans are available in your area, page 12 is omitted from your package.

Before you make a final decision about changing your enrollment, you should carefully review the official brochure(s) for the plan or plans in which you are interested.

Please use the following letter codes to determine the benefit explanations for plans on page 9 and page 11:

A - NONE
B - N/A
C - +35%
D - DAY x 5
E - NOTHING
F - +DIFF.
G - MAX $200
H - NOT COVERED
I - OR 50%
J - MAX $150
L - $55 MAX
M - $70 MAX
N - $100 MAX
O - $90 MAX
P - OR $45
Q - $50 MIN
R - NOTHING UP TO $1,200
S - DED/25%
T - $75 DAY-$750
U - MAX $150+
V - MAX $200+

## Important

You should carefully review the 2012 premiums shown in the following plan comparison chart for your plan and option of coverage. Do not rely on the chart alone for benefit data. If you do not change your enrollment during open season, you may not be eligible to change until the next open season. You may also make changes to the name, address, or telephone number information on the form, or add eligible new dependents if you already have a family plan. To avoid delays, make sure you sign and date the form if you request any changes. No changes will be made unless the enrollee signs the form.

## Benefit Changes

Your current plan will send you a copy of its new brochure and rate sheet. Be sure to read your plan's brochure to see how benefits change in 2012. Other plan brochures you request directly from the carrier may not have premiums in them, so be sure to save the enclosed comparison chart for 2012 premium rates.

## Plans Not Participating in the FEHB Program in 2012

Some plans will withdraw from the FEHB Program after December 31, 2011. You should check the enclosed comparison chart and, if your plan is not listed in the comparison chart, contact your plan to verify their participation in the FEHB Program. If the plan will not be in the FEHB Program in 2012, you must elect new coverage during this open season. If you do not pick a new insurance plan by the end of Open Season, you will not have health coverage in 2012 unless you are a Federal retiree or survivor annuitant. If you are a Federal retiree or survivor annuitant and you don't select another plan, we will enroll you in the Blue Cross and Blue Shield Service Benefit Plan option that is most similar to your current plan's cost and benefits. The effective date of your enrollment will be January 1, 2012. If Blue Cross and Blue Shield is the plan you want, don't wait for us to enroll you. If you elect them now, you will receive your plan card sooner.

## Effective Dates of Open Season Changes

All changes to new plans will be effective January 1, 2012.

## 2012 Payment Coupons

Note: If you are enrolled under Automatic Preauthorized Debit from your bank account, coupons will be mailed to you for informational purposes only.

For those enrollees who either stay with their current plan or whose changes are received before December 31, 2011, your new 2012 payment coupons will be mailed to you during the first two weeks of January 2012. Your payment coupon for the month of January 2012 will be the first coupon to reflect the 2012 premium. If you do not receive your new coupons by January 22, call the Direct Premium Remittance System (DPRS) at 1-800-242-9630, weekdays, between the hours of 7:45 a.m. and 4:00 p.m. CST, for your new premium rate.

# 2011 DPRS OPEN SEASON INFORMATION DIRECT PAY ENROLLEES
## FEE FOR SERVICE PLANS - ENROLLMENT CODES AND RATES

| PLAN NAME | Telephone Number | Plan Option | Enrollment Code | | Your Monthly Premium | |
|---|---|---|---|---|---|---|
| | | | Self Only | Self & Family | Self Only | Self & Family |
| **PLANS OPEN TO ALL** | | | | | | |
| APWU HEALTH PLAN | 800/222-2798 | HIGH | 471 | 472 | 119.27 | 269.68 |
| BLUE CROSS AND BLUE SHIELD | LOCAL | STANDARD | 104 | 105 | 187.15 | 431.60 |
| BLUE CROSS AND BLUE SHIELD | LOCAL | BASIC | 111 | 112 | 113.87 | 265.49 |
| GEHA HEALTH BENEFIT PLAN | 800/821-8136 | HIGH | 311 | 312 | 175.19 | 415.68 |
| GEHA HEALTH BENEFIT PLAN | 800/821-8136 | STANDARD | 314 | 315 | 85.85 | 197.07 |
| MAIL HANDLERS BENEFIT PLAN | 800/410-7778 | STANDARD | 454 | 455 | 218.77 | 523.47 |
| MAIL HANDLERS BENEFIT VALUE OPTION | 800/410-7778 | VALUE OPTION | 414 | 415 | 71.48 | 170.41 |
| NALC HEALTH BENEFIT PLAN | 888/636-6252 | HIGH | 321 | 322 | 160.64 | 327.32 |
| SAMBA HEALTH BENEFIT PLAN | 800/638-6580 | HIGH | 441 | 442 | 270.25 | 682.98 |
| SAMBA HEALTH BENEFIT PLAN | 800/638-6580 | STANDARD | 444 | 445 | 125.44 | 286.49 |

| PLAN NAME | Telephone Number | Plan Option | Enrollment Code | | Your Monthly Premium | |
|---|---|---|---|---|---|---|
| | | | Self Only | Self & Family | Self Only | Self & Family |
| **PLANS OPEN ONLY TO SPECIFIC GROUPS** | | | | | | |
| COMPASS ROSE HEALTH PLAN | 800/634-0069 | HIGH | 421 | 422 | 127.82 | 309.64 |
| FOREIGN SERVICE BENEFIT PLAN | 202/833-4910 | HIGH | 401 | 402 | 123.48 | 308.17 |
| PANAMA CANAL AREA BENEFIT PLAN | 800/424-8196 | HIGH | 431 | 432 | 102.31 | 213.55 |
| RURAL CARRIERS BENEFIT PLAN | 800/638-8432 | HIGH | 381 | 382 | 174.40 | 288.95 |

# 2011 DPRS OPEN SEASON INFORMATION DIRECT PAY ENROLLEES
## FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

### PLANS OPEN TO ALL

| Enrollment Code | | Benefit Type | Medical-Surgical - You Pay | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Deductible | | | Copay ($)/Coinsurance (%) | | | | | | | | | | |
| | | | Per Person | | Hospital Inpatient | Doctors | | Hospital Inpatient | Prescription Drugs | | | | | | | |
| Self Only | Self & Family | | Calendar Year | Prescription Drug | | Office Visits | Inpatient Surgical Procedures | R&B | Level I | | Level II | | Level III | | Mail Order Discounts | |
| 471 | 472 | PPO | $275 | A | A | $18 | 10% | 10% | $5 | | 25% | | 25% | | YES | |
| | | NON PPO | $500 | A | $300 | 30%F | 30%F | 30% | 50% | | 50% | | 50% | | YES | |
| 104 | 105 | PPO | $350 | A | $250 | $20 | 15% | E | 20% | | 30% | | 30% | | YES | |
| | | NON PPO | $650 | A | $350 | 35% | 35% | 35% | 45%+ | | 45%+ | | 45%+ | | YES | |
| 111 | 112 | PPO | A | A | $150 D | $25 | $150 | E | $10 | | $40 | | $50 | I | N/A | |
| 311 | 312 | PPO | $350 | A | $100 | $20 | 10% | E | $5 | | 25% | J | | A | YES | |
| | | NON PPO | $750 | A | $300 | 25% | 25% | E | 35 | | 25% | U | | B | YES | |
| 314 | 315 | PPO | $350 | A | A | $10 | 15% | 15% | $5 | | 50% | G | | A | YES | |
| | | NON PPO | $350 | A | A | 35% | 35% | 35% | $5 | | 50% | V | | B | YES | |
| 454 | 455 | PPO | $400 | A | $200 | $20 | 10% | E | $10 | | 30% | G | 50% | G | YES | |
| | | NON PPO | $600 | A | $500 | 30% | 30% | 30% | 50% | | 50% | | 50% | | YES | |
| 414 | 415 | PPO | $800 | A | A | $30 | 20% | 20% | $10 | | 50% | | 50% | | YES | |
| | | NON PPO | $900 | H | A | 40% | 40% | 40% | | H | H | | | H | YES | |
| 321 | 322 | PPO | $300 | A | $200 | $20 | 15% | E | 20% | | 30% | | 30% | | YES | |
| | | NON PPO | $300 | A | $250 | 30% | 30% | 30% | 45%+ | | 45%+ | | 45%+ | | YES | |
| 441 | 442 | PPO | $300 | A | $200 | $20 | 10% | E | $10 | | 15% | L | 30% | O | YES | |
| | | NON PPO | $300 | A | $300 | 30% | 30% | 30% | $10 | | 15% | L | 30% | O | YES | |
| 444 | 445 | PPO | $350 | A | $200 | $20 | 15% | E | $10 | | 25% | M | 35% | N | YES | |
| | | NON PPO | $350 | A | $300 | 30% | 30% | 30% | $10 | | 25% | M | 35% | N | YES | |

### PLANS OPEN ONLY TO SPECIFIC GROUPS

| Enrollment Code | | Benefit Type | Medical-Surgical - You Pay | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Deductible | | | Copay ($)/Coinsurance (%) | | | | | | | | | | |
| | | | Per Person | | Hospital Inpatient | Doctors | | Hospital Inpatient | Prescription Drugs | | | | | | | |
| Self Only | Self & Family | | Calendar Year | Prescription Drug | | Office Visits | Inpatient Surgical Procedures | R&B | Level I | | Level II | | Level III | | Mail Order Discounts | |
| 421 | 422 | PPO | $300 | A | $150 | $10 | 10% | E | $5 | | $30 | | 30% | P | YES | |
| | | NON PPO | $300 | A | $300 | 30% | 30% | 30% | $5 | | $30 | | 30% | P | YES | |
| 401 | 402 | PPO | $300 | A | C | 10% | 10% | E | $10 | | 25% | | 30% | Q | YES | |
| | | NON PPO | $300 | A | $200 | 30% | 30% | 20% | $10 | | 25% | | 30% | Q | YES | |
| 431 | 432 | POS | A | A | $25 | $5 | E | E | 20% | | 20% | | 20% | | NO | |
| | | FFS | A | A | $100 | 50% | 50% | 50% | 20% | | 20% | | 20% | | NO | |
| 381 | 382 | PPO | $350 | $200 | $100 | $20 | 10% | E | 30% | | 30% | | 30% | | YES | |
| | | NON PPO | $400 | $200 | $300 | 25% | 20% | 20% | 30% | | 30% | | 30% | | YES | |

## Nationwide High Deductible and Consumer Driven Health Plans

| Plan Name | Telephone Number | Enrollment Code | | Premium | |
|---|---|---|---|---|---|
| | | Self | Self & Family | Self | Self & Family |
| APWU HEALTH PLAN-(CDHP) | 866/833-3469 | 474 | 475 | 84.17 | 189.37 |
| GEHA-(HDHP) | 800/521-8135 | 341 | 342 | 95.20 | 217.46 |
| MAILHANDLERS-(HDHP) | 800/554-9901 | 481 | 482 | 98.89 | 223.69 |

## High Deductible and Consumer Driven Health Plans for Your State

| Plan Name | Telephone Number | Enrollment Code | | Premium | |
|---|---|---|---|---|---|
| | | Self | Self & Family | Self | Self & Family |
| AETNA HEALTH FUND-(CDHP) | 877/459-8804 | 221 | 222 | 125.12 | 300.19 |
| AETNA HEALTH FUND-(HDHP) | 877/459-8804 | 224 | 225 | 85.34 | 166.91 |
| HUMANA COVERAGEFIRST-(CDHP) | 888/393-8765 | AD1 | AD2 | 114.77 | 258.24 |
| HUMANA COVERAGEFIRST-(CDHP) | 888/393-8765 | LM1 | LM2 | 116.83 | 262.86 |
| KAISER FOUNDATION HP-(HDHP) | 888/865-3813 | GW1 | GW2 | 82.39 | 185.23 |

## Nationwide High Deductible and Consumer Driven Health Plan (cont'd)

| Enrollment Code | | Benefit Type | Premium Contribution | | CY Deductible | | Catastrophic Limit | | Office Visit | In-patient surgery | Out-patient surgery | Preventive Services | Prescription Drugs | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Self | Self & Family | | HSA | HRA | Self | Self & Family | Self | Self & Family | | | | | Level I | Level II | Level III |
| 474 | 475 | IN-NET | $100 | $200 | $800 | $1,200 | $3,000 | $4,500 | 15% | A | 15% | E | 25% | 25% | 25% |
| | | OUT-NET | $100 | $200 | $800 | $1,200 | $3,000 | $9,000 | 40% F | A | 40% F | R | D | B | B |
| 341 | 342 | IN-NET | $62.50 | $125 | $1,500 | $3,000 | $5,000 | $10,000 | 5% | 5% | 5% | E | 25% | 25% | 25% |
| | | OUT-NET | $62.50 | $125 | $1,500 | $3,000 | $5,000 | $10,000 | 25% | 25% | 25% | S | 25%+ | 25%+ | 25%+ |
| 481 | 482 | IN-NET | $70 | $140 | $2,000 | $4,000 | $5,000 | $10,000 | $15 | T | E | E | $10 | $25 | $40 |
| | | OUT-NET | $70 | $140 | $2,000 | $4,000 | $7,500 | $15,000 | 40% | 40% | 40% | H | H | H | H |

## High Deductible and Consumer Driven Health Plan for Your State (cont'd)

| Enrollment Code | | Location | SEE PLAN BROCHURES FOR BENEFIT INFORMATION |
|---|---|---|---|
| Self | Self & Family | | |
| 221 | 222 | MOST OF GEORGIA | |
| 224 | 225 | MOST OF GEORGIA | |
| AD1 | AD2 | ATLANTA AREA | |
| LM1 | LM2 | MACON AREA | |
| GW1 | GW2 | ATL/ATHENS/COLUMBUS/MACON/SAVAN | |

## 2011 OPRS OPEN SEASON INFORMATION DIRECT PAY ENROLLEES
## HMO AND POS PLANS FOR GEORGIA

| PLAN NAME | Premium | | PLAN LOCATION | Enrollment Code | | Telephone Number |
|---|---|---|---|---|---|---|
| | Self Only | Self & Family | | Self Only | Self & Family | |
| AETNA OPEN ACCESS- HIGH | 291.42 | 553.89 | ATLANTA AND ATHENS AREAS | 2U1 | 2U2 | 877/459-6604 |
| HUMANA EMPLOYERS HEALTH PLAN | 129.39 | 291.13 | COLUMBUS | CB1 | CB2 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN | 118.45 | 262.01 | COLUMBUS | CB4 | CB5 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN | 128.79 | 288.63 | MACON | DN1 | DN2 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN | 121.66 | 274.20 | MACON | DN4 | DN5 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN- HIGH | 146.74 | 340.08 | ATLANTA | DG1 | DG2 | 888/393-6765 |
| HUMANA EMPLOYERS HEALTH PLAN- STD | 129.39 | 291.13 | ATLANTA | DG4 | DG5 | 888/393-6765 |
| KAISER FOUNDATION HP- HIGH | 131.95 | 320.67 | ATL/ATHEN/COLUMBUS/MACON/SAVANNAH | F81 | F82 | 888/865-5813 |
| KAISER FOUNDATION HP- STD | 89.65 | 204.38 | ATL/ATHEN/COLUMBUS/MACON/SAVANNAH | F84 | F85 | 888/865-5813 |