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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.

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Privacy Act Statement. The information you provide on this form is needed to document your enrollment in the Federal Employees Mealth 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 banefits 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 Faderal, 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 FEMB program. Executive Order 6397 (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 aupplies. Agencies other them 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 revisiving instructions, gatting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other lapect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Retirement Servicea Publications Team, (3208-0202), 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 reapond, unless this humber la displayed.



DR574 (revised 4/11)

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.

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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 <u>not</u> 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.

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 <u>www.opm.gov/insure/health</u>. 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 solf 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 annollee 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 11, 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 am. 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".



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DIRECT PREMIUM REMITTANCE SYSTEM

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

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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 gonarics and preferred brands not included in Level L

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.¹

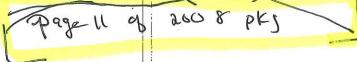
Health Maintenance Organization (HMO) An HMO provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service you receive and free you from completing paperwork or being billed for covered services. Your eligibility to enroll 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.



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 Solf/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 tex-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-doductible deposits you make to the HSA.
- Tax-deferred interest barned 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 modical 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.



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DIRECT PREMIUM REMITTANCE SYSTEM

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 Doos 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 DRS 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 <u>nfc.dprs@usda.gov</u>.

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.

In

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 Madicaid 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 <u>www.insurekidanow.gov</u> 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. MAY-10-2011 13:44 FROM USDA NFC

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DIRECT PREMIUM REMITTANCE SYSTEM

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 latter 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
- OR 50%
- J MAX 0150
- L \$55 MAX
- M 570 MAX
- N \$100 MAX
- 0 \$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 aligible 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 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 whose changes are received before becomes St. 2011, you 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, waekdays, between the hours of 7:45 a.m. and 4:00 p.m. CST, for your new premium rate.



MAY-10-2011 13:44 FROM USDA NFC

Page 8

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

			Enroll Co	ment de	Your N Prer	Monthly nium
PLAN NAME	Telephone Number	Plan Option	Self Only	Self & Family	Self Only	Self & Family
LANS OPEN TO ALL				-		-
PWU HEALTH PLAN	800/222-2798	HIGH	471	472	477.08	1078.7
LUE CROSS AND BLUE SHIELD	LOCAL	STANDARD	104	105	378,81	1306.8
LUE CROSS AND BLUE SMIELD	LOCAL	BASIC	111	112	453 48	1081.9
EHA HEALTH BENEFIT PLAN	800/821-6136	MIGH	311	312	567,62	1290.9
EHA HEALTH BENEFIT PLAN	800/821-8195	STANDARD	314	315	345, 62	788.2
AIL HANDLERS BENEFIT PLAN	800/410-7778	STANDARD	464	455	611.20	1398.
IAIL HANDLERS BENEFIT VALUE OPTIO	N 800/410-7778	VALUE OPTION	414	415	285.81	681.
IALC HEALTH BENEFIT PLAN	585/635-0252	HIGH	321	322	552.07	1202.
AMBA MEALTH BENEFIT PLAN	800/838+8589	HIGH	461	442	661.68	1558.
AMBA HEALTH BENEFIT PLAN	800/838-6589	STANDARD	444	445	501,78	1145.
			Enrol		Your	Monthl [.] mium
PLAN NAME	Telephone Number	Plan Option	Self Only	Self & Family	Self. Only	Self Family
PLANS OPEN ONLY TO SPECIFIC GROU	IP5	1				
COMPASS ROSE HEALTH PLAN	800/634-0065	<u> </u>	421	422 .	510.49	1184.
OREIGN SERVICE BENEFIT PLAN	202/833-4910	HIGH	401	402	493.96	1181.
PANAMA CANAL AREA BENEFIT PLAN	800/ <mark>424-8</mark> 198	HIGH	43.f	432	409.24	854.
RURAL CARRIERS BENEFIT PLAN	800 /638-843 2	HIGH	383	382	565.83	1155.
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2011 DPRS OPEN SEASON INFORMATION SPOUSE EQUITY ENROLLEES (100% PREMIUM) FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS																
					12		Medical	-Surgical								
Enro	oliment	Bene	fit	· · .	Deductible			Сор	ay (\$)/C	oinsurance (%)						
Co	ode	Тур	e	Par P	Person	Hospital		eror Inpittent	Hospital Inpatient	700000000000000000000000000000000000000	Prescription	Druga				
Self	Self A.			Celendar	Prascription	Inpatient	Office Visits	Surgical Procedures	R&B	Level	Level II	Lavel: 11f	Mail Order Discounts			
	Femily	N TO	WAYS S													
											AEV	504	YES			
471	472	PPO NÓN	000	\$275 \$500	A	A \$300	\$18 30%F	10% 30%	10% 30%	58 50%	25% 50%	25% 50%	YES			
			UAA				\$20	15%	E	20%	30%	30%	YES			
104	105	PPO NON	PPO	\$350 \$350	A A	\$250 \$350	35%	35%	35%	45%	45%+	45%+	YES			
111	112	PPO		A	A	\$150 D	\$25	\$150	E	\$10	\$40	\$50 J	N/A			
				A												
311	312	PPO		\$350	A	\$ 100 \$ 300	\$20 25%	10%	E	\$5 \$5	25% J 25% U	B B	YES			
		NÔN	PPU	\$350					15%	\$5	50% G	8	YES			
314	315	PPO NON	PPO	\$350 \$350	A	A A	\$10 35%	15% 35%	35%	55 55	50% V	B	YES			
				\$400	Α	\$200	\$20	10%	E	\$.10	30% G	50% G	YES			
454	495	ppô Non	PPO	\$600	Â	\$500	30%	30%	30%	50%	50%	50%	YES			
414	415	PPO		\$600	A	Å	\$30	20%	20% 40%	510 <mark>H</mark>	50%	50% H	YES YES			
		NON	PPQ	\$900	н		40%	40%				8999 A.M.	YES			
321	322	PPO NON	000	\$300 \$300	A	\$200 \$350	\$20 30%	15% -30%	E 30%	20% 43%	30% 45%+	30% 45%+	YES			
		8	PPU				\$20	10%	E	\$10	15% L	30% O	YES			
441	A42	PPO NON	PPO	\$300 \$300	Â	\$200 \$300	30%	30%	30%	\$10	15% L	-30% G				
444	445	PPO		\$350	· · A	\$200	\$20	15%	E	\$10	25% M	35% N				
		NON	PPÔ	\$350	A	\$300	30%	30%	30%	510	25% M	35% N				
	Medical-Surgical - You Pay															
	77 S								bay (\$)/C		nce (%)					
	ollment Sode	Ben	efit pe	Bert	Per Person Doctors Hospital											
				Calandar	Prescription	Hospital	Office	Surgical	Inpatient	<u></u>	1	1	Mail Order			
Only	f Salf &	S -		Year	Drug		Visita	Procedures	R&B	Level I	Level II	LAVEL	Discounts			
(28)	MS-OPI	en or	ULY: T	O SPECIF	IC GROUPS											
421	422	PPO		\$300	A	\$150	\$10	10%	E	\$ <u>5</u>	\$30	30% P				
1			PPO	\$300	A	\$360	30%	30%	30%	\$5	\$30	30% P				
401	402	PPO	-	\$300	A	5200 E	10% 30%	10% 30%	E 20%	\$10 \$10	25% 25%	30%+0				
		NON	PPO	\$300					E	20%	20%	20%	NO			
431	432	POS FFS		A	A A	\$28 \$100	\$5 50%	50% ⁶	50%	20%	20%	20%	NO			
381	382	PPO		\$350	\$200	\$ 100	\$20	TOX	E	30%	30%	30%	YES			
301			PPO	\$400	\$200	£300:	25%	20%	20%	.90%	30%	30%	YES			
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Nationwide High Deductible and Consumer Driven Health Plans

vationwide high Deductions and cons					
Plan Name		Enrolln	nont Code	Pre	mium
	Telephone	Self	Self & Family	Self	Self & Parolly
APWU HEALTH PLAN-(CDHP)	868/839-3463	474	475	336.70	767:47
GEMA-(HDHP)	800/821-8195	341	342	380.81	868.79
MAILHANDLERS-(HDHP)	800/694-9901	461	482	394.77	894.51
	888/839-9463 800/821-8135 800/694-9901		482		767: 47 868: 79 894: 51

High Deductible and Consumer Driven Health Plans for Your State

an Name	Telenhone	Enrollm	ent Code	Promium				
л. у л .	Telephone Number	Self	Self & Family	Self	Self & Family			
AETNA MEALTH FUND-(CDHP)	877/459-5504	221	222	500.48	1, 175,42			
AETNA HEALTH FUND-(HDHP)	877/458-6604	224	225	341.38	747 .69			
HUMANA COVERAGEFIRST-(CDHP)	566/393-6765	AD1	402	459.10	1.032.98			
HUMANA COVERAGEFIRST-(CDHP)	B88/393-6765	L_M1	LM2	467.31	1,051.44			
KAISER FOUNDATION HP-(HDHP)	688/869-5813	GW1	GW2	329.57	740.84			
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Nationwide High	Deductible	and	Consumer	Driven	Health	Plan	(cont d)
Mationwide migh	DROUGUDIC	anv	Quigennei	The state of the s			

Nationwide	High Deo	uctible	and u	onsume		IT HEATEN	1 7 4411 14													
Énrollment Code	Benefit		ribution Ded		CY Deductible		Deductible		it Offici		Catastrophic Limit		Limit		Office In-		Pre- ventive	Civit cesarie a	cription	-
Self Self &	Туре	HSA	HRA	Soft	Self & Family	Salf	Self & Family	Visit	surgery	surgery	Serv- ices	- Jenned - E	Lovet II	Tavai III						
474 875	IN-NET OUT-NET	\$ 100 5 100	\$200 \$200	5640 \$640	¢1 200	000,62 000,62	\$4,500 \$9,000	15% 40% F	A A	15% 40% p	R	25% B		25% B						
341 342	IN-NET	\$62.50 \$62.50	\$125 \$125	\$1,500 \$1,500	\$3,000	\$5,000 \$5,000	\$10,000	25%	25%	5% 25% E	e S	25% 25%+	25% 25%+	25% 25%+ \$40						
481 482	IN-NET OUT-NET	\$70 \$70	\$140 \$140	\$2,000 \$2,000		\$5.000		\$15 40%	•	40%	Η	910 H	\$25 H	H						

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

SEE PLAN BROCHURES FOR BENEFIT INFORMATION
NAME AND A DESCRIPTION OF A

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Page 12

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

	Premium		Enrollment Code	Telepter
PLAN NAME	Self & Self & Only Family	PLAN LOCATION	Self Self & Only Family	Telephone Number
TNA OPEN ACCESS- HIGH MANA EMPLOYERS HEALTH PLAN MANA EMPLOYERS HEALTH PLAN MANA EMPLOYERS HEALTH PLAN MANA EMPLOYERS HEALTH PLAN MANA EMPLOYERS MEALTH PLAN- HIGH MANA EMPLOYERS MEALTH PLAN- STD LISER FOUNDATION HP- HIGH LISER FOUNDATION MP- STD	517 57 1164.52 665 61 1048.08 513 13 1154.51 487 46 1096.79 540 17 1215.37 517 57 1164.54	COLUMBUS NACON NACON ATLANTA	CB1 CB2 CB4 CE5 DN1 DN2 DN4 DN5 DG1 DG2 DG4 DG5 F81 F82	877/459-66 888/383-67 868/393-67 888/393-67 888/393-67 888/393-67 888/383-67 888/383-67 888/865-58 888/865-58
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Page 7 - Open Season Information

Health Plans - Codes and Benefits

Codes and Hates

and Benefits

Page 8 - Fee for Service Plans - Enrollment

Page 9 - Fee For Service Plans - Enrollment Codes

Page 11 - High Deductible and Consumer-Driven

Page 10 - High Deductible and Consumer-Driven Health

Plans - Nationwide and State Specific - Codes and Rates

Page 12 - HMO and POS Plans for Your State (if applicable)

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LAW TCC 7011 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

Page 1 – Table of Contents, Privacy Act Statement, Public Burden Statement

Page 2 - Form DPRS-2809

Page 3 - Information and Instruction Sheet for Completing Form DPRS-2809

Page 4 - Fee for Service Plans/Health Maintenance Organization (HMO) Plans - Descriptions

Page 5 - High Deductible Health Plans and Consumer Driven Health Plans - Descriptions

Page 6 - Affordable Care Act (ACA) of 2010, Medicaid and CHIP

Privacy Act Statement. The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefite 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 Benefite Bervices or supplies, and disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job. Ilcense, disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job. Ilcense, disclosed to other batter, it may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with nationel, state, local, or other charitable or sacial security administrative agencies to determine and leave benefits under this programs. 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

entorcoment 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

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 Faderal 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 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 Burdon 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, 3208-0202 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.

COMPLETE THIS FORM ONLY IF YOU ARE MAKING CHANGES.

Form redesigned by NFC

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 fam		•			,			
1. ENROLLEE NAME (last, first, middle initial)		2. SOCIAL S	SECURITY NUMBER	2	3. DATE OF	BIRTH (mm/dd/yyyy)	4. SEX	5. ARE YOU MAP	RRIED?
								YES	NO
6, HOME MAILING ADDRESS (including ZIP Code)	I need to correct my ad The changes are indica	dress. ted in item 6	7. IF YOU ARE	COVEREI) BY MEDIC	ARE, CHECK ALL THAT APPLY	1	8. MEDICARE CL	AIM NUMBER
			A	ł	3	D			
						9. ARE YOU COVERED BY IN	SURANCE OTHER	THAN MEDICAR	E?
						YES, indicate in item 10 bel	OW.	NO NO	
10. INDICATE THE TYPE(S) OF OTHER INSURANCE	Iment covers all elic	uble family	members No	NAME O	F OTHER IN	SURANCE		POLICY NUMBE	R
TRICARE OTHER FEHB	more than one FEF	B enrollme	ent.						
Dependents' Information. Fill in the applicable information in the blo 19. Child under age 26; 09. Adopted child; 17. Step child; 10. Eligib disability that began before his/her 26th birthday.	ocks below. For a le foster child; 99	idditional . Disablec	family member I child age 26 o	s pleas or older	e use a s who is in	eparate sheet of paper capable of self-suppor	. Relationship t because of a	Codes are: (a physical or r	01. Spouse; mental
11. NAME OF FAMILY MEMBER (last, first, middle initial)		12. SOCIAL	SECURITY NUMBI	R	13. DATE C)F BIRTH (mm/dd/yyyy)	14. SEX	15. RELATIONSH	HP CODE
16. ADDRESS (if different from enrollee)				17. IF YC	OU ARE COV	ERED BY MEDICARE, CHECK	ALL THAT APPLY	18. MEDICARE C	LAIM NUMBER
				A	[38 🗍 D			
				L		19. ARE YOU COVERED BY I	NSURANCE OTHE	R THAN MEDICAI	RE?
						YES, indicate in item 20 bel	ow,	□ NO	
20. INDICATE THE TYPE(S) OF OTHER INSURANCE	Imant opyora all alia	ible femily	mombore No	NAME O	F OTHER IN	SURANCE		POLICY NUMBE	R
An FEHB self and family enrol person may be covered under	more than one FEH	B enrollme	nt.						
21. EMAIL ADDRESS (if home address is different from enrollee's) 22. PRE	FERRED TELEPHONE	NUMBER (if	home address is	dilferen	t from enro	llee's)			-
23. NAME OF FAMILY MEMBER (last, first, middle initial)		24. SOCIAL	SECURITY NUMBI	R	25. DATE C	DF BIRTH (mm/dd/yyyy)	26. SEX	27. RELATIONS	HIP CODE
28. ADDRESS (if different from enrollee)				29. IF Y0	U ARE COV	ERED BY MEDICARE, CHECH	غ ایرو است که ک	30. MEDICARE	CLAIM NUMBER
						31. ARE YOU COVERED BY I	NSURANCE OTH	R THAN MEDICA	RE?
						YES, indicate in item 32 bei		NO	
32. INDICATE THE TYPE(S) OF OTHER INSURANCE				NAME O	F OTHER IN	and the second	UW.	POLICY NUMBE	R
An FEHB self and family enrol person may be covered under	lment covers all elig more than one FEH	ible family B enrollme	members. No ent.						
	ERRED TELEPHONE	NUMBER (if	home address is	 differen	t from enro	liee's)		<u> </u>	
SECTION II - FEHB Plan You Are Currently Enrolled In			Soction III - E	сири	Jan Vor	I Are Changing to			
1. PLAN NAME	2. ENROLLMENT COL		. PLAN NAME			Are onlanging to		2. ENROLLMEN	TCODE
									0002
SECTION IV - Signature	I	I							
0			lation thanks is		ation of th	a law puplabable to a	fina af nat	na than this s	200
WARNING: Any intentionally false statement in this application or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)	wuuui misreprese	апаноп Ге	nauve tnereto l	s a vioi	auon of th	е нам рипіѕпаріе ру а	nne or not mo	ve man \$10,0	ou or

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

 3. EMAIL ADDRESS
 4. PREFERRED TELEPHONE NUMBER

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TO 912026060910

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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.

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 <u>www.opm.gov/insure/health</u>. 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 annolice 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".



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DIRECT PREMIUM REMITTANCE SYSTEM

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

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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 ellows 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.

Better - and Clurs

A Consumer-Driven Health Plan (CDHP) provides you with 148 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 Boad the HDHP/CDHP Charts:

Promium 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.

Celendar 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 Solf/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 Lovels

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.

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 barned on the account
- Tax-free withdrawals for qualified modical 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 exception 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

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.

Seit and ramity enrollment up to age 20. 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 meats the eligibility requirements specified on the foster child certification. See www.com.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.

emplease 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 <u>nfc.dors@usda.gov.</u>

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 cortain benefit features including cost sharing, promium 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.

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How Does the AGA Affect Benefits for High Deductible Health

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 employor-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

page 4

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 & 1) 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 emitted 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 latter codes to determine the banefit explanations for plans on page 9 and page 11:

- A NONE
- 8 N/A
- C +35%
- $D DAY \times 5$
- E NOTHING
- F +DIFF.
- G MAX \$200
- H NOT COVERED
- I OR 50%
- J MAX 9150
- L \$55 MAX
- M \$70 MAX
- N 9100 MAX
- 0 \$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 6200+

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 ladd 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.

Bonefit 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 11, 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 of 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.



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

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PWU NEALTH PLAN	LOCAL	STANDARD	104	105	590.18	1333.0
LUE CROSS AND BLUE SHIELD			1913	112	482.55	1083.2
BLUE CROSS AND BLUE SHIELD	LOCAL	BASIC	110			
REHA HEALTH BENEFΣT PLAN	800/821-6136	HIGM	.311	312	578.97	1316.1
SEHA HEALTH BENEFIT PLAN	800/821-6196	STANDARD	314	315	359.55	804.0
MAIL HANDLERS BENEFIT PLAN	800/410-7778	STANDARD	454	455	623.42	1426.
MAIL HANDLERS BENEFIT VALUE OPTIC	B00/410-7778	VALUE OPTION	414	415	291.53	695,
NALC HEALTH BENEFIT PLAN	888/836-6292	HIGH	324	322	583:11	1226.
SAMBA HEALTH BENEFIT PLAN	800/838-8589	HIGH	441	442	674.91	1589.
	800/638-8589	STANDARD	444	445	511:22	1168.
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PLANS OPEN ONLY TO SPECIFIC GROU	800/834-0055	HIGH	421	422 .	520,70	1208
COMPASS ROSE HEALTH PLAN	800/048-000F					
FOREIGN SERVICE BENEFIT PLAN	202/839-4910	HIGH	401	402	503.84	1205
PANAMA CANAL AREA BENEFIT PLAN	800/424+8395	HIGH	431	432	41742	871
RURAL CARRIERS BENEFIT PLAN	800/838-8432	HIGH	381	382	577,(百	1178
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2011 DPRS OPEN SEASON INFORMATION TCC ENROLLEES (102% PREMIUM) FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

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	800/821-6136	341	342	388.43	867.19
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AETNA HEALTH FUND~(HDHP)	577/459-6504	224	225 AD2	468,28	1.053/64
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Nationwide High Deductible and Consumer Driven Health Plan (cont'd)

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

High Deduct	ible and Consumer Driven Health Plan for Your Stat	e (cont'd)
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DPRS OPEN SEASC	INFORMATION	
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RETURN PAGE 2 OF THIS FORM C CHANGE.	NLY IF YOU WISH TO MAKE A	
TABLE OF C	ONTENTS	
Page 1 - Table of Contents, Privacy Act Statement, Public Burden Statement	Page 7 - Open Season Information	
Page 2 - Form DPRS-2809	Page 8 - Fee for Service Plans - Enrollment Codes and Rates	
Page 3 - Information and Instruction Sheet for Complexing Form DPRS-2809	Page 9 - Fee For Service Plans - Enrollment Codes and Benefits	
Page 4 - Fee for Service Plans/Health Maintenance Organization (HM	MO) Page 10 - High Deductible and Consumer-Driven Health Plans - Nationwide and State Specific - Codes and Rates	\$
Page 5 - High Døductible Health Plans and Consumer Driven Health Plans - Descriptions	Page 11 - High Deductible and Consumer-Driven Health Plans - Codes and Benefits	
Page 6 - Affordable Care Act (ACA) of 2010, Medicaid and CHIP	Page 12 - HMO and POS Plans for Your State (if applica	
Privacy Act StateMent. The information you provide on this form is need Program (FEHB) under Chapter 8, title 5, U.S. Code. This information will be identify your enrollment in the plen (2) verify your and for your family's eligi (3) coordinate paymont of claims with other carriers with whom you might all disclosed to other Federal agencies or Congressional offices which may have grant, or other benefit. It may also be shared and is aubject to verification, programs, with national, state, local, or other charitable or social security ad or to obtain information necessary for determination or continuation of benefi indicates a possible violation of civil or criminal law, it may be shared and enforcement agency.	ibility for payment of a claim for basith benefits services of supplies, a so make a claim for payment of benefits. This information may be a need to know it in connection with your application for a job, license, via paper, cleatronic media, or through the use of computer matching ministrative agencies to determine and issue benefits under their progra fits under this program. In addition, to the extent this information vorified, as noted above, with an appropriate Faderal, state, or local law	e, Ims
Burgeliment. We request that you provide your Social Security Number as that it may be 9397 (November 22, 1943) allows Federal agencies to use the Social Security same or similar names. Failure to furnish the requested information may reas the prompt payment of your and/or your family's claims for health benefits a Agencies other than the OPM may have further routine uses for disclosure of if this is the case, they should provide you with any such uses which are ap	used as your Individual identifier in the FEHB program. Exacutive Order Number as an Individual identifier to distinguish botween people with to suit in the U.S. Office of Personnel Management's (DPM) inability to ensu- iervices or supplies. Information for the records system in which the file copies of this for pilcable at the time they ask you to complete this form.	m.
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tting 430. Public B the needed data, and reviewing the completed form. Send comments regarding our time estimate of multipleter (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications Team, (3206-0202), Washington, D.C. 20415 for reducing completion time, to the Offlee of Personnel Management, Retirement Services Publications, Retirement, Retirement, Retirement, Retirement, Retirement, Retirement, displayed.



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FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM FEBASON 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 fan	uly men	nbers use a sepa	arate sl	heet and a	attach.)					
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SECTION II - FEHB Plan You Are Currently Enrolled In			Section III - F	FEHB	Plan Yo	u Are Chang	ing to				
1. PLAN NAME	2. ENROLLMENT COE	E	1. PLAN NAME							2. ENROLLMENT CO	DE
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WARNING: Any Intentionally false statement in this application or	wiliful misreprese	ntation	relative thereto i	is a vioi	ation of t	he law nunisha	ble hv a f	ine of n	ot mo	re than \$10 000	or
imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)		, itelion				ie ian painona				, s anun 910,000	<i></i>

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 2. DATE (mm/dd/yyyy)

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Page 2

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FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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.

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 <u>www.opm.gov/insure/health</u>. 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 Nationvide 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 Maintonance 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 Seson 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 11, 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.com.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

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- 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 am, 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 <u>www.nfc.usdagoy</u> 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".



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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.

How to road 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

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Plans use a variety of terms to define what you pay for proscription 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 Maintonance 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

botton of 2008 pIC9 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 Doductible Health Plan (HDHP) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expanses. 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 MDHP/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.

Galendar 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 dellar amount (e.g. up to 6300 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, 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.

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 exceptian 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 amployment or switch health insurance plans.



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DIRECT PREMIUM REMITTANCE SYSTEM

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 new 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/hor 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 <u>nfc.dprs@usda.gov.</u>

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 banefits 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

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 itom 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 Medicald 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 <u>www.insurekids.now.gov</u> 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

page 11 of 2008 play

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 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 & 1) 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. Chack 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
- 8 N/A
- C ~ +35%
- $D DAY \times 5$
- E NOTHING
- F +DIFF.
- G MAX \$200
- H NOT COVERED
- 1 OR 50%
- J MAX \$150
- L \$55 MAX
- M \$70 MAX
- N \$100 MAX
- .0 \$90 MAX
- P OR \$45
- 0 \$50 MIN
- R NOTHING UP TO \$1,200
- S DED/25%
- T \$75 DAY-\$750
- U MAX \$150+
- V MAX 9200+



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 ladd 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 hew 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 11, 2012. If Blue Cross and Blue Shield is the plan you want, don't wait for us to enroll you. If you elect them new, you will receive your plan card sooner.

Effective Dates of Open Season Changes

All changes to new plans will be offective 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, weakdays, between the hours of 745 a.m. and 4:00 p.m. CST, for your new premium rate.



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

			Enroll		Your Monthly Premium		
PLAN NAME	Telephone Number	Plan Option	Self Only	Self & Family	Self Only	Self & Family	
PLANS OPEN TO ALL							
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BLUE CROSS AND BLUE SHIELD	LOCAL	STANDARD	104	105	187.18	431.6	
BLUE CROSS AND BLUE SHIELD	LDCAL	BASIC	719	112	113.37	265.4	
gema mealtm benefit plan	800/821-5138	HIGH	313	312	175. 19	415.0	
geha health benefit plan	800/821-8135	STANDARD	314	315	86.65	197.0	
MAIL HANDLERS BENEFIT PLAN	800/410-7778	STANDARD	454	455	219:37	523. 4	
MAIL HANDLERS BENEFIT VALUE OPTI	ON 800/410-7778	VALUE OPTION	414	415	71,48	[.] 170.4	
NALC HEALTH BENEFIT PLAN	888/836-8252	HIGH	321	322	160.54	327.3	
SAMBA HEALTH BENEFIT PLAN	800/638-6589	нідн	441	442	270:25	682.9	
SAMBA HEALTH BENEFIT PLAN	800/838-6589	STANDARD	.444	445	125.44	286.4	
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	Tetephone Number	Plan Option	Self	Self & Family	Self	Self â Family	
PLAN NAME							
PLANS OPEN ONLY TO SPECIFIC GROU	UPS					· ·	
COMPASS ROSE HEALTH PLAN	800/634-0089	, HIGH	421	422	127.52		
FOREIGN SERVICE BENEFIT PLAN	202/833-4910	high	401	402	123 49	308.	
PANAMA CANAL AREA BENEFIT PLAN	800/424-8195	high	431	432	302.31	213.	
RURAL CARRIERS BENEFIT PLAN	800/538-8432	HIGH ·	381	382	174:40	288.9	
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2011 DPRS OPEN SEASON INFORMATION DOD-RIF ENROLLEES FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

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LP4: LP5: 800/522-0088

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2011 DPRS OPEN SEASON INFORMATION DOD-RIF ENROLLEES

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	RETURN PAGE 2 OF THIS FORM ONL CHANGE.	Y IF YOU WISH TO MAKE A
	TABLE OF CON	ITENTS
Page 1 - Table of Co Burden Statement	ontents, Privacy Act Statement, Public	Page 7 - Open Sesson Information
Page 2 - Form DPRS	-2809	Page 8 - Fee for Service Plans - Enrollment Codes and <mark>Rates</mark>
Form DPRS-2809	and Instruction Sheet for Completing	Page 9 - Fee For Service Plans - Enrollment Codes and Benefits
Page 4 - Fee for Ser Plans - Descriptions	vice Plans/Health Maintenance Organization (HMO)	Page 10 - High Deductible and Consumer-Driven Health Plans - Nationvvide and State Specific - Codes and Rates
Page 5 <mark>– H</mark> igh Deduct Health Plans – Descrip	ible Health Plans and Consumer Driven	Page 11 - High Deductible and Consumer-Driven Health Plans - Codes and Benefits
	Care Act (ACA) of 2010, Medicaid and CHIP	Page 12 - HMO and POS Plans for Your State (if applicable)
 Program (FEHE) under Chap Identify your enrollment i (S) coordinate payment of discloaed to other Federal grant, or other benefit. I programs, with national, s or to obtain information r indicates a possible viola	pter 8, title 5, U.S. Code. This information will be analy in the plan (2) verify your and lor your family's eligibilit claims with other carriers with whom you might also m I agencies or Congressional effices which may have a ne t may also be shared and is aubject to verification, via stato, local, or other charitable or social security admini- necessary for determination or continuation of benefits u stion of civil or criminal law, it may be shared and verif	b document your enrollment in the Federal Employees Mealth Benefita ed with the health Insurance carrier you aelect so that if may (1) y for payment of a claim for health benefits services or supplies, and ake a claim for payment of benefits. This information may be and to know it in connection with your application for a job, license, paper, electronic media, or through the use of computer matching strative agancies to determine and labue benefits under their programs inder this program. In addition, to the extent this information 'led, as noted above, with an appropriate Federal, state, or local law a form, doing so will assist in the prompt proceeding of your
anrollment, We request that you provi 9397 (November 22, 1943) same or similar names. If the prompt payment of yo Agoncies other than the C If this is the case, they s	ida your Sacial Security Number so that it may be used allows Federal agencies to use the Social Security Num Failure to furnish the requested information may result it sur and/or your family's claims for health benefits servic OPM may have further routine uses for disclosure of info should provide you with any such uses which are applicat	as your individual Identifier in the FEHD program. Executive Order that as an individual identifier to distinguish between people with the h the U.S. Office of Personnel Management's (OPM) inability to ensure es or aupplies. armation for the records system in which the file copies of this form.
the needed data, and revie	ewing the completed form. Sond comments regarding ou	nutes to complete, including the time for reviewing instructions, getting r time estimate or any other speet of this form, including suggestions Services Publications Team, (3206-0202), Weshington, D.C. 20415-3430. tion, and you are not required to respond, unless this number is



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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.

Form redesigned by NFC

Do not take any action to maintain your present coverage.

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 Informat	ion (For additional fam	nily mem	bers use a sepa	arate sh	eet and a	attach.)						
1. ENROLLEE NAME (last, first, middle initial)		2. SOCIAL SECURITY NUMBER			3. DATE O	fe of Birth <i>(mm/dd/</i> yyyy)		4. SEX		5. ARE YOU MARRIED?		
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Dependents' Information. Fill in the applicable information in the 19. Child under age 26; 09. Adopted child; 17. Step child; 10. I disability that began before his/her 26th birthday.												
11. NAME OF FAMILY MEMBER (last, first, middle initial)		12. SOCIA	L SECURITY NUMBI	ER	13. DATE	OF BIRTH (mm/dd/y)	yyy)	14. SEX		15. RELATIONSHIP CO	DE	
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21. EMAIL ADDRESS (if home address is different from enrollee's) 2	2. PREFERRED TELEPHONE	NUMBER (i	f home address is	differen	t from enro	ollee's)						
23. NAME OF FAMILY MEMBER (last, first, middle initial)		24. SOCIA	L SECURITY NUMBI	ER	25. DATE	OF BIRTH (mm/dd/y	yyy)	26. SEX		27. RELATIONSHIP CO	DE	
								М	F			
28. ADDRESS (if different from enrollee)		1		29. IF YO	U ARE CO	VERED BY MEDICARE	E, CHECK A		<u> </u>		NUMBER	
				HA			סך					
						31. ARE YOU COVER	L RED BY INS	URANCI	E OTH I	ER THAN MEDICARE?		
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32. INDICATE THE TYPE(S) OF OTHER INSURANCE				NAME O	F OTHER IN	YES, indicate in ite	em 32 below	·		POLICY NUMBER		
An FEHB self and family	/ enrollment covers all elig under more than one FEH	ible family B enrollm	/ members. No ent.							I OLIOT NONDER		
TRICARE OTHER FEITS	4. PREFERRED TELEPHONE			different	from one							
33. EMAIL ADDRESS (if home address is different from enrollee's) 3	4. PREFERRED TELEPHONE I	NUMBER (#	nome address is	uneren	nomenic	mee sj						
SECTION II - FEHB Plan You Are Currently Enrolle	1			FEHB	Plan Yo	u Are Changir	ıg to			1		
1. PLAN NAME	2. ENROLLMENT COE	DE	1. Plan Name							2. ENROLLMENT CODE	-	
SECTION IV - Signature												
WARNING: Any intentionally false statement in this application	on or willful misreprese	ntation r	elative thereto i	is a viol	ation of ti	he law punishabi	le by a fir	1e of n	ot ma	ore than \$10,000 oi	-	
imprisonment of not more than 5 years, or both. (18 U.S.C. 1	001.)											

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

FROM USDA NFC

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P.004

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 banefits 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, 20(0) 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 Brochura 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.com.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 enrollmont 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 salf 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 Latters. If you made a change in your enrollment coverage during the Open Sesson, 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/insuro/bealth 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 0
- FEHB Handbook
- Frequently Asked Questions 0
- Medicare and FEHB
- Medicare Information for Caregiver 0
- 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 <u>www.nfc.usda.gov</u> 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".



912026060910 P.005 TO MAY-10-2011 13:36 FROM USDA NFC Page 4 DIRECT PREMIUM REMITTANCE SYSTEM PKS 8 2008 Nationwide Fee-For-Service Plans (Pages 8 & 9) Prescription Drug Payment Levels Plans use a variety of terms to define what you pay for Always consult plan brochures before making your final prescription drugs such as generic, brand name, Tier 1; decision. The chart does not show all of your possible out-of-pocket expenses. use follow: Level 1 includes most generic drugs, but may include some Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO) A FFS plan provides flexibility in using preferred brands. 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 Lavel II may include generics and preferred brands not included in Level I. not contacted with the plan, but you will pay more of the cost. Level III includes all other covered drugs, with some Medical providers who have contracts with the health plan (Preferred Provider Organization or PPO) have agreed to accept exceptions for specialty drugs. the health plan9s reimbursement. You usually pay a copayment or a coinsurance charge and do not file claims or other paperwork. The level in which a medication is placed and what you Going to a PPO hospital does not guarantee PPO benefits for all services received in the hospital, however, Lab work, radiology is charged. services, and other services from independent practitioners within the hospital are frequently not covered by the hospital9s YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE 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 BENEFITS. plan, or the health plan pays the provider directly according to Health Maintenance Organization Plans and Plans Offering plan coverage and you pay a deductible, coinsurance or the balance of the billed charge. In any case, you pay a greater a Point-of-Service Product (Page 12) amount of out-of-pocket cost Always consult plan brochures before making your final decision. The chart does not show all of your possible PPO only A PPO-only plan provides medical services only through medical providers that have contracts with the plan. With out-of-pocket expenses. few exceptions, there is no medical coverage if you or your Health Maintenance Organization (HMO) An HMO provides family members receive care from providers not contracted with care through a network of physicians and hospitals in 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 road the Fee-for-Service Chart:

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

Calendør 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 daductible. 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.

Tier11, Level 1. etc. The 2 to 3 payment levels that plans

pay for prescription drugs is often based on what the plan

DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER

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 copsyment 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. 6) 7008 5K2

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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 Impatient shows what you pay after the deductible is met for hospital services when an inpatient. The amount could be a dally 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). Proscription 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, Lovel 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-deterred 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 ratire, 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 learned 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.



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DIRECT PREMIUM REMITTANCE SYSTEM

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 <u>www.opm.gov/insure</u>.

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 Doas 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.dors@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 Doas the ACA Affect Benefits for High Deductible Health

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 employed-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

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
- 8 N/A
- <mark>C ∻3</mark>5%
- $D DAY \times 5$
- e Nothing
- F +DIFF.
- G MAX 5200
- H NOT COVERED
- OR 50%
- J MAX 9150
- L S55 MAX
- M \$70 MAX
- N \$100 MAX
- 0 \$90 MAX
- P OR \$45
- Q \$50 MIN
- R NOTHING UP TO \$1,200
- S DED/25%
- T \$75 DAY-\$750
- U MAX \$150+
- <mark>v m</mark>ax 5200+

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 not 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.



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

			Enrollment	Your Monthly Premium
	Talephone Number	Plan Option	Self & Self & Only Family	Self & Self & Only Family
PLAN NAME				
LANS OPEN TO ALL			473 472	119.27 269.6
apmi health plan	600/222+2798	HIGH		
SLUE CROSS AND BLUE SHIELD	LOCAL	STANDARD	104 105	487, 18 431.6
BLUE CROSS AND BLUE SHIELD	LOCAL	BASIC	111 112	443.37 265.4
GEHA MEALTH BENEFIT PLAN	800/821-6436	High .	314 312	176, 19 415.6
GEHA MEALTH BENEFIT PLAN	800/821-6136	STANDARD	316	86.65 197.0
MAIL HANDLERS BENEFIT PLAN	800/410-7778	STANDARD	464 455	218,77 523.4
MAIL MANDLERS BENEFIT VALUE OPTIC	NE 800/410-7778	VALUE OPTION	414 415	71.48 170.4
NALC MEALTH BENEFIT PLAN	558/635-6252	нідн	921 922	160.64 327.3
SAMBA HEALTH BENEFIT PLAN	600/678+6589	HIGH	441 442	270.25 682.9
SAMBA HEALTH BENEFIT PLAN	800/638-6559	STANDARD	445	125.44 286.4
			Enrollment	Your Monthly Premium
2 a d	Telephone Number	Plan Option	Self Self &	self Self
PLAN NAME			Only Family	
PLANS OPEN ONLY TO SPECIFIC GROU		IIACH	421 422	127.62 309.
COMPASS ROSE HEALTH PLAN	800/634-0059	HYGH		
FOREIGN SERVICE BENEFIT PLAN	202/833+4910	HIGH	401 402	123,48 308.
PANAMA CANAL AREA BENEFIT PLAN	800/424-8195	HIGH	434 432	162 31 213.
RURAL CARRIERS BENEFIT PLAN	800/638-8432	нібн	981 982	\$74,40 288.
				3000020000000000000000

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2011 DPRS OPEN SEASON INFORMATION DIRECT PAY ENROLLEES ENROLLEES

		-	2011 DP FEE	FOR SERVI	CE PLANS	- ENROLL	MENT CODE	S AND BEI	VEFEIS	and spectra states and a	~~~~~	
Medical-Surgical - You Pay Deductible Copay (\$)/Coinsurance (%)												
	llmont	Benefit				Daci	1	onsurar :	Prescription	Drugs		
Co	da	Туре		erson	Hoapital	Office	Inpations	Hospital Inpatient	i			Mail Orde
Self	Self & Eamily		Colondar. Veor	Prescription Drug	Inpatropt	Visits	Sprgical Pracedures	R&B	Level 1	Level 1	Level (1)	Discounts
		N TO ALL				<u>.</u>						
171	472	PPO Non PPO	\$275 \$500	A A	A 5300	\$18 30%F	10% 30%E	10% 30%	\$8 50%	25% 50%	25% 50%	YES YES
104	105	PPO Non Ppo	\$350 \$350	A A	\$250 \$360	\$20 35%	15% 35%	E 35%	20% 45%+	30% 45%*	30% 45%+	YES YES
171	112	PPO	A	·	\$150 D	\$25	\$150	E	\$10	\$40	1 . 982	N/A
311	312	ppo Non ppo	\$350 \$350	A	\$100 \$300	\$20 25%	10% 25%	e e	\$5 95	25% J 25% U	川 日 日	YES .
314	315	ppo Non ppo	\$350 \$350	A A	A A	\$ 10 35%	15% 36%	15% 35%	\$5 \$5	50% G 50% V	H B	VES
454	485	ppo Non ppo	\$400 \$600	A A	\$200 \$500	\$20 30%	10% 30%	е 30%	\$10 50%	30% G 50%	50% G 50%	YES
414	415	ppo Non ppo	\$800 \$800	A H	A A	\$30 40%	20% 40%	20% 40%	\$10 H	8	50% H	
321	322	PPO Non Ppo	\$300 \$300	A A	\$200 \$350	\$20 30%	1日% 30%	e 30%	20% 45%	30% 45%+	30% 45%+	YES
441	442	PPÓ Non Ppo	\$300 \$300	A A	\$200 \$200	\$20 30%	10% 30%	E 30%	510 \$10	15% L 15% L	30% C	r VES
444	445	PPO Non Ppo	\$350 \$350	· A A	\$200 \$300	\$20 30%	15% 30%	е 30%	\$10 \$10	25% M 25% M	36% N 35% N	VES
		<u>».</u>]	1			Medica	al-Surgica	al - You	Pay			
C==	ollment	ent Bonefit Typo	Per Porson		1	Co	Coinsur	oinsurance (%)				
C	ode				Hosoital	De	Anpationt	Hospital		Prescription Drugs		
Soli	Sett 3		Ca)endar Year	Prescription Drug	All and a strategy and the state of the s	Office Visits	Surgical Procedure	<u></u>	lavel.	Level II	Level I	323
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421	422	PPO Non PPC	\$300	A	s 150 \$380	\$10 30%	10% 30%	e 30%	\$5 \$5	\$30 \$30	20% 30%	P VES
401	402	PPO NON PPO	\$300 \$300	A A	E \$200	10% 30%	10% 30%	e 20%	5.10 5.10	25% 25%	30%+ 30%+	Q YES
431	432	POS FFS	A A	A A	\$25 \$100	\$5 50%	e 50%	e 50%	20% 20%	20% 20%	20% 20%	NO
381	982	ppô Non pp(\$350 \$400	\$200 \$200	5 100 5 300	\$20 25%	10% 20%	е 20%	30%	90% 30%	30% 30%	YES YES
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Plan Name	Telephone Number	Self	nent Code Self & Family	Self	Şelf A Paruly
APWJ HEALTH PLAN~(CDHP)	886/833-34 5 3	474	475	84, 17	189.37
geha-(MDMP)	800/821-0195	341	942	95.20	217.45
MAILHANDLERS-(HDHP)	800/584-8901	481	482	98.69	223.63
<i>x</i>					
		ž 2			
ligh Deductible and Consumer Driven	Health Plans for You	ur State	nent Code	Pro	mium
Plan Name	Telephone Number	Self	Self &	Self	Selt & Family
AETNA HEALTH FUND-(CDHP)	877/459-6804	221	Z22	125.12	300.13
AETNA HEALTH FUND-(HDHP)	877/458-6504	224	229	85.34	165.81
HUMANA COVERAGEFIRST-(CDHP)	888/393-8765	AD1	AD2	114.77	25824
HUMANA COVERAGEFIRST-(CDHP)	884/393+6765	LM1	LM2	118.83	262.80
KAISER FOUNDATION HP-(HOHP)	888/865+5813	GW1	GW2	82.39	185.23
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Nationwide High Deductible and Consumer Driven Health Plan (cont'd)

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	oda	Benefit	Contril	oution	Deduc	tible	Lim	~~~~~	Office	patient	patient	Serv-			
C. C. C. C. C. C. C. C. C. C. C. C. C. C	Self &	Тура	H9A	HRA	Co is	Solf B	Self	Self & Family	Visit	surgery	SURGERY	ices	Lavel. I	Level (I	25% B
Self	Ramily		10-97A	2525225 17	्रिष् 1	Family	<u>[]</u>	200000000000000000000000000000000000000			1010000000000			A 1944	
		Phi-AET	\$100	\$200	5800	\$1,200	\$3,000	\$4,500	15%	A	15% 46% F	E	25%	25%	207
67	4 4/7	IN-NET Out-Net	\$100	\$200	\$800	\$1,200	\$9,000	\$9,000) 40% F		40% *	R			State data a state to the second second
				_			\$5,000 \$5,000	¢10 000	N FIOL	5%	<u>%</u> Е	Е	25%	25%	25% 25%+
34	1 342	IN-NET	\$62,50 \$67,50	\$125	51,500	\$3,000	45 000	\$10,000) 26%	25%	李雪弘	S	25%*	25%+	25%+
		OUT-NET	562.50	\$125	247288	JU, 999		0.010			е 40%	ji s	33361001000000		
40	1 442	IN-NET	\$70	\$140	\$2,000	\$4,000	\$5,000 \$7,500	\$10,00	0 \$15	T	ABO	E	\$10 H	\$25 ·	940 H
ф <u>н</u>		OUT-NET	\$70	s140	\$2,000	\$4,000	\$7,500	\$15,00	0.40%	40%		; II ;	******************		
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High Deductible and Consumer Driven Health Plan for Your State (cont'd)

Enrollment Code Solf Family	Location	SEE PLAN BROCHURES FOR BENEFIT INFORMATION
221 222	MOST OF GEORGIA	
224 225		
AD 1 AD 2		
LM1 LM2	MACON AREA	
GW 1 GW 2	ATL/ATHENS/COLUMBUS/MACON/SAVAN	
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2011 DPRS OPE	N SEASON D HMO AND D	INFORM	ATION DIRECT PAY ANS FOR <mark>GEORGIA</mark>	ENROLLEES		
	Promit	um			Enrollment Code	Telephone
PLAN NAME		Self & Family	PLAN LOCATION		Self Self & Only Family	Number
AETNA OPEN ACCESS- HIGH HUMANA EMPLOYERS HEALTH PLAN HUMANA EMPLOYERS HEALTH PLAN HUMANA EMPLOYERS HEALTH PLAN HUMANA EMPLOYERS HEALTH PLAN HUMANA EMPLOYERS HEALTH PLAN- HIGH HUMANA EMPLOYERS HEALTH PLAN- STD KAISER FOUNDATION HP- HIGH KAISER FOUNDATION HP- STD	129, 39 110, 45 126, 20 121, 66 146, 74 129, 39	291.13 262.01 288.63 274.20 340.08 291.13	ATLANTA AND ATHENS COLUMBUS COLUMBUS MACON ATLANTA ATLANTA ATLANTA ATLANTA ATL/ATHEN/COLUMBUS ATL/ATHEN/COLUMBUS	ZMACON/SAVANNAH	CB1 CB2 CB4 CB5 DN1 DN2 DN4 DN5 DG1 DG2 DG4 QG5 F81 F82	877/459-6604 888/393-6765 888/393-6765 888/393-6765 888/393-6765 888/393-6765 888/393-6765 888/393-6765 888/393-6765 888/393-6765 888/393-575813
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