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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 Health Benefits Program (FEHB) under Chapter 8, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that if may (1) Program (FEHB) under Chapter 8, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that if may (1) electify your enrollment in the plan (2) verify your and for your family's eligibility for payment of a claim for health benefits services or supplies, and identify your enrollment in the plan (2) verify your and for your family's eligibility 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, 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, 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, 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, disclosed to other Federal agencies to computer matching grant, or other benefits. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching grant, or other benefits. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching grant, or other benefits. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching grant, or other 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 appropria

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 1939 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

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

Public Burden Statement. We think, this from takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the ruplic burden Statement, we think, this from 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, OPM Forms Officer, (3206-0202), Washington, D.C. 20415-7900. The OMB number, 3206-0409 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Section II. Enrollment Codes and Plan Names. Mark the appropriate blocks. If you are changing your enrollment from self only to self and family, please list your eligible dependents and their birth dates in Section III. I need to correct my address. The changes are indicated in the box below. 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 or CDHP Change Enrollment. I want to change my FEHB enrollment, I have indicated my selection in Section II. I have either: (1) marked the block of a Nationwide plan, or (2) entered the enrollment code and plan name of an Health Maintenace Organization (HMO) plan, Regional High Deductible Health Plan (HDHP), or Consumer Driven Health Plan (CDHP). Note: If changing. Plans to an HMO Plan or HDHP please use the box above to request the change. All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site Name of Plan Section IV. Address Correction HWO Plan or HDHP or CDHP Do not take any action to maintain your present coverage. COMPLETE THIS FORM UNLY IF YOU ARE MAKING CHANGES. TO STANDE THE HINDLINGST FOR 2008 PLAN YEAR Enrollment Code Section I. Action. Mark the Change Enrollment block to change your FEHB enrollment. Nationwide High Deductible and Consumer-Driven Health Plans 474 APWU-CDHP-Self Only 475 APWU-CDHP-Self and Family Association Benefit Plan-Self Only Association Benefit Plan-Self and Family Nationwide Fee-for-Service Plans Open Only ☐ Mail Handlers-HDHP-Self Only ☐ Mail Handlers-HDHP-Self and Family Panama Canal Area-Self and Family Foreign Service-Self and Family Section III. Dependents' Information. Fill in the applicable information in the blocks below. Rural Carriers-Self and Family SAMBA-High-Self and Family SAMBA-Stnd-Self and Family APWU-CDHP-Self and Family Panama Canal Area-Self Only GEHA-HDHP Self and Family Foreign Service-Self Only Rural Carriers-Self Only SAMBA-Stnd-Self Only SAMBA-High-Self Only GEHA-HDHP Self Only to Specific Groups 401 402 421 431 341 342 481 at www.opm.gov/insure.health. Blue Cross/Blue Shield-Stnd-Self and Family Blue Cross/Blue Shield-Basic-Self Only Blue Cross/Blue Shield-Basic-Self and Family GEHA-High-Self Only Handlers-Value Option-Self and Family Nationwide Fee-for-Service Plans Open to All Blue Cross/Blue Shield-Stnd-Self Only Handlers-Value Option-Self Only Handlers-Stnd-Self and Family Mail Handlers-Stnd-Self Only GEHA-High-Self and Family GEHA-Stnd-Self and Family APWU-Self and Family GEHA-Stind-Self Only NALC-Self and Family APWU-Self Only NALC-Self Only OPEN SEASON DPRS-2809 OMB 3206-0202 (Revised (11/07) HEALTH BENEFITS PHH H PROGRAM Mail Mail 471 🗆 105 311 312 315 454 104 455 414 415

additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. Unmarried dependent child under age 22, 09. Adopted child; 17. Step child; 10. Foster child; or recognized child; 99. Unmarried disabled child over age 22 incapable of self-support because of a physical or mental

Name of Family Member (last, first, middle initial) (Social Security number (Date of Birth

disability that began before age 22

Address (if different from enrollee)

Section V. Authorization. You must sign and date this form. Enter the daytime area code and telephone number where you can be contacted to answer questions,

Insurance Policy Number

Name of Insurance A B D

Other Insurance

TRICARE

Medicare

Form has been revised by

Signature

Daytime Telephone Number

Date

DR25A (revised 11/07)

FEDERAL EMPLOYEES
HEALTH BENEFITS
PROGRAM
FEHB
OPEN SEASON

# INFORMATION AND INSTRUCTION SHEET FOR COMPLETING FORM DPRS-2809

Carefully read the following instructions before completing your request form.

You must make all changes through the National Finance Center.

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

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

If you decide not to make an enrollment change this year, it is <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 2008. If your plan is not listed, you must select another plan during this Open Season period (November 12 through December 10, 2007) to be assured of continued health benefits coverage.

Important. You should also carefully review the 2008 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: New 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 <a href="https://www.opm.gov/insure/health">www.opm.gov/insure/health</a>. 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 Fee-for-Service Plans Open to All or Nationwide Fee-for-Service Open Only to Specific Groups 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 9-10. 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.

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, 2008.

Section V, Authorization. You must sign and date the form. No changes will be made unless the enrollee signs 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, 2008. If your change is processed before January 1, 2008, 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, 2008.

Identification Cards. These cards are issued by the health plans, not DPRS. You should direct questions about identification (ID) cards to your plan. It may take up to THREE months after DPRS has processed your open season change for you to receive an identification card. Should you or your family require medical attention after the January 1, 2008 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 <a href="https://www.opm.gov/insure/health">www.opm.gov/insure/health</a> 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 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 and scroll down to the DPRS web site.

Visit our web site at www.nfc.usda.gov and scroll down to the DPRS web site.



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DIRECT PREMIUM REMITTANCE SYSTEM

# OPEN SEASON INFORMATION

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The 2007 Open Season for Spouse Equity/Temporary Continuation of Coverage Enrollees/Direct Pay Annuitants under t<mark>h</mark>e Federal Empl<mark>oyee</mark>s Health Benefits (FEHB) Program will be from November 12 through December 10, 2007. 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, 2007.

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, 2008 for Nationwide Fee-for-Service Plans (Page 6 & 8), the Nationwide High Deductible and Consumer Driven Health Plans (Page 9 & 10) 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 HMOs or plans are available in your area, page 12 is omitted from your

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 8 and page 10:

A - NONE

B - N/A

C - NOTHING

D' - NOT COVERED

E - NOTHING UP TO \$1200

F - DEDUCTIBLE PLUS 25%

G - \$75 PER DAY UP TO \$750

H - DEDUCTIBLE + 30%

I ~ NOTHING TO 10%

J - PER DAY x 5

K - 1 REFILL

L - OR 50%

M - OR \$45

N - \$25 MINIMUM

O - \$30 MINIMUM

P - 15% OR 30%

Q - PLUS DIFFERENCE

# PRESCRIPTION DRUG PAYMENT LEVELS

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier I, Tier II, Level I, 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.

Many plans are basing how much you pay for prescription drugs on what they are charged. YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.

# Important

You should carefully review the 2008 premiums shown in the following plan comparison chart for your plan and option of following plan comparison chart for your plan and option of coverage. Do not rely on the chart alone for benefit data. If you do not change your enrollment during open season, you may not be eligible to change until the next open season. You may also make changes to the name, address, or telephone number information on the form, or add eligible new dependents if you already have a family plan. To avoid delays, make sure you sign and date the form if you request any changes. No changes will be made unless the enrollee signs the form. 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 2008. 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 2008 premium rates.

Plans Not Participating in the FEHB Program in 2008

Some plans will withdraw from the FEHB Program after December 31, 2007. 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 2008, 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 2008.

Effective Dates of Open Season Changes

All changes to new plans will be effective January 1, 2008.

2008 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, 2007, your new 2008 payment coupons will be mailed to you during the first two weeks of January, 2008. Your payment coupon for the month of January 2008 will be the first coupon to reflect the 2008 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.

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 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 can choose medical providers who are not contracted 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) offered discounted charges. 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. Lab work and radiology services from independent practitioners within the hospital are frequently not covered by the hospital's 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 the 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.

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 9 & 10)

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.

When you enroll, your plan establishes for you either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The plan automatically deposits the monthly "premium pass through" into your HSA. The plan credits an amount into the HRA. (This is the "Premium Contribution to HSA/HRA column in the chart.)

Preventative care is often covered in full, usually with no or only a small deductible or copayment. Preventative care expenses may also be payable up to an annual maximum dollar amount. As you receive other non-preventative medical care, you must meet the plan deductible before the plan pays benefits. You can choose to pay your deductible with funds

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from your HSA or you can choose instead to pay for your deductible out-of-pocket, allowing your savings to continue to grow.

The HDHP features higher annual deductibles (a minimum of \$1,100 for Self Only and \$2,200 for Self and Family coverage) and annual out-of-pocket limits (not to exceed \$5,600 for Self and \$11,200 for Family coverage) than other insurance plans. Depending on the HDHP you choose, you may have the choice of using in-network and out-of-network providers. Using in-network providers will save you money.

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 HAS.
- 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 haveMedicare. HRAs are similar to HSAs except an enrollee cannotmake 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.

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.



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2008 DPRS OPEN SEASON INFORMATION SPOUSE EQUITY ENROLLEES (100% PREMIUM)
FEE FOR SERVICE PLANS - ENROLLMENT CODES AND RATES

FEE FOR SERVICE PLANS	S - ENROLLMENT CODES AND DATES	S AND DAIRS				# 41- Pr
			Enrollment Code	nent e	Your N	Your Montnly Premium
	Telephone Number	Plan Option	Self Only:	Self & Family	Self Only	Self & . Family
1						7 7 0
PLANS OPEN TO ALL APUN HEALTH PLAN	800/222-2798	HIGH	471	472	416 24	1
**************************************	10001	STANDARD	104	105	448 91	1027.95
BLUE CROSS AND BLUE SHIELD RIUF CROSS AND BLUE SHIELD	LOCAL	BASIC	111	112	339.17	794.43
	800/821-6136	HIGH	311	312	512.44	1115.27
GEHA HEALTH BENEFIT PLAN	800/821-6136	STANDARD	314	ω π.	288 41	655.40.
	000/410-7778	STANDARD	454	45 10	427.42	954 35
MAIL HANDLERS BENEFIT PLAN	800/410-7778	VALUE OPTION	4 + 4	4 15	177.71	423 69
	888/636-6252		.321	322	441.65	960.48
NALC HEALTH BENEFIT PLAN				ž.		
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PLANS OREN ONLY TO SPECIFIC GROUPS.	800/634-0069	٠	421	422	440.16	1013.98
ASSOCIATION BENEFIT PLAN	2007/833-4910		401	402	419.49	996 91
FOREIGN SERVICE BENEFIT PLAN	202/202		431	432	385 75	805.18
PANAMA CANAL AREA BENEFIT PLAN	800/638-8432		188	382	51 50 65 65 65 65 65 65 65 65 65 65 65 65 65	1045.07
RURAL CARRIERS BENETI THAN	**				0 0 0	1293.76
NA Id Transfer	800/638-6589	HIGH	441	442	0 0 0 0 0	t t
SAMBA HEALTH BENEFIT PLAN	800/658-6589	STANDARD	444	445	397.89	20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
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# Federal Employees Health Benefits (FEHB) Program Health Information Technology and Price/Cost Transparency Leaders

Over the past few years, OPM has encouraged FEHB health benefits plans to increase their use of health information technology (HIT) to create efficient care delivery and to develop tools to help you determine the quality of the doctors, hospitals and other providers that you and your family use for day-to-day healthcare needs.

HIT based on broadly accepted standards allows patients, healthcare providers, and health plans to share information securely, driving down costs by avoiding duplicate procedures and manual transactions. More importantly, HIT reduces medical errors from, misread handwritten prescriptions, and emergency care medical decisions made without complete and accurate for instance, misread handwritten prescriptions, and emergency care medical decisions made without complete and accurate for instance, misread handwritten prescriptions, and emergency care medical decisions made without complete and accurate information. HIT can also help you find appropriate health information to aid you and your doctor in making appropriate clinical decisions regarding your care. Since privacy and security considerations are vitally important, safeguards are being established to keep your records safe from inappropriate disclosure.

# Health Information Technology

The health plans listed below have made a commitment to offer you and your family access to internet based personal health records (PHR). PHRs come in a variety of forms but what they all have in common is that they give you a convenient way to track, view, and manage your personal health information. PHRs also allow you to share your health information with your health care providers so they have a better picture of your health history. When providers know your health history they can health care providers and providers are the providers are th rnake more accurate diagnoses and provide you with safer, more efficient care.

# Quality and Price/Cost Transparency On-line Tools

The health plans listed here have also made a commitment to offer you and your family access to healthcare quality and price/cost information so you can make more informed choices on which providers to use to receive care. The website information available includes online decision tools with cost estimators and quality indicators for physician and hospital services and prescription drugs used to treat common illnesses and conditions. These health plans describe the sources of this health and prescription drugs used to treat common limesses and conditions. These health plans describe the sources of this health information and any limitations so you can understand what the information means. Some examples of the types of surgical procedures for which you can obtain cost and quality information include: arthroscopy knee/shoulder, breast biopsy, cataract procedures for which you can obtain cost and quality information include, artificiscopy kneershoulder, preast property, catalact repair, cesarean delivery, colonoscopy, corneal surgery, gall bladder removal, heart catheterization, hysterectomy, inguinal hernia repair, knee replacement, and tonsillectomy. This information helps you understand the true price/cost and quality of your healthcare and enhances your ability to compare hospital, physician, prescription and other provider value as you make healthcare choices, FEHB health plans are working to expand the price/cost and quality information they provide to you.

The health plans listed on the following page met OPM's HIT, quality and price/cost transparency standards at the time this Guide went to press. As other plans bring these tools on line, we will add them to the list on our website. So, please check the updated information at www.opm.gov/insure before you make your healthcare decisions.No.

The following health plans have demonstrated their commitment to efficiency, safety and quality through computer system enhancements that offer PHRs and quality and price/cost transparency decision support tools:

Aetna APWU Health Plan AvMed Health Plans Blue Cross & Blue Shield of RI BlueCross BlueShield Government Wide Service Benefit Plan CareFirst BlueChoice, Inc. ConnectiCare, Inc. Blue Choice Geisinger Health Plan Government Employees Health Association, Inc. (GEHA) Group Health Incorporated Health Net of Arizona, Inc. Health Net of California HealthPartners, Inc. HealthPlus of Michigan

HIP Health Plan of New York HMO Health Ohio Independent Health Association, Inc. Kaiser Foundation Health Plan (except Hawaii) M.D. IPA Medica Health Plans MVP Health Care, Inc. NALC Health Benefit Plan PacifiCare Health Plans Panama Canal Area Benefit Plan SAMBA SuperMed HMO UnitedHealthcare (except the River Valley, Inc. in Iowa and Illinois) UPMC Health Plan



2008 DPRS OPEN SEASON INFORMATION SPOUSE EQUITY ENROLLEES (100% PREMIUM)
FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

		Mail Order Discount		YES	YES	DN .	O. O.	0 0 2 Z	Υ Υ ΚΕS ΥES	YES	NO NO			ice Man		YES	YES	N N	YES YES	S S S S S S S S S S S S S S S S S S S	· · · · · · · ·
tion Drugs		Level III		25%	24 10 4 12 % 14 %	\$32 L	69 69 50 50	. 50% 50%	\$60	20%	25%	*		4		30% M 30% M	0 0 % 000 000 000	40%	%0e 80e	\$40	\$45 +C
Prescription		Level II		25%	25% 45%+	02\$	25% 25%	50% 100% 100%	\$40 50%	50% D	25% 50%÷			8		\$ \$2 20 20 20 20 30 30 30 30 30 30 30 30 30 30 30 30 30	25% 25% 25% 25%	40% %04	%0° 80° 80°	\$25 \$25 \$25	7+ + OE &
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Amounts	Doctor	Primary Office Visits		\$18	\$15 25%	\$20	\$20	\$10 35%	\$20 C	20% 40%	30%					\$ 10 30%	30%	\$10%	\$20 25%	\$20 c	\$20
Irgical -		Hospital Inpatient		\$300	\$1000 H	\$100 K	\$300	ৰব	\$200	বব.	\$ 100					\$100	\$200	\$ 125	\$ 100 \$ 300 \$ 300	\$200	.\$200
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Nationwide High Deductible and Consumer Driven Health Plans

Plan Name	Telephone Number	Enrollme	ent Code	Premiu	ım
		Self	Self & Family	Self	Self & Family
APWU HEALTH PLAN-(CDHP)	800/222-2798	474	475	336 70	757 47
GEHA-(HDHP)	800/821-6136	341	342	380.81	869,79
MAILHANDLERS-(HDHP)	800/410-7778	481	482	292 _98	663.9
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High Deductible and Consumer Driven Health Plans for Your State

Dies Manes	Telephone	Enrollme	ent Code	Premi	um
Plan Name	Number	Self	Self & Family	Self	Self & Family
AETNA HEALTH FUND-(CDHP)	877/459-6604	221	222	328.25	755.00
AETNA HEALTH FUND-(HDHP)	877/459-6604	224	225	268.00	586.89
FALLON CHP-(HDHP)	800/868-5200	DV1	DV2	463 . 28	1,126.02
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High Deductible and Consumer Driven Health Plans for Your State (cont'd)

# SEE PLAN

CENTRAL/EASTERN MASSACHUSETTS

MOST OF MASSACHUSETTS
MOST OF MASSACHUSETTS

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Location

Enrollment Code
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# BROCHURES FOR

BENEFIT

# INFORMATION

# DIRECT PREMIUM REMITTANCE SYSTEM

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 for 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 not 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 are (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.

page 4 of 2011 pkg



2008 DPRS OPEN SEASON INFORMATION SPOUSE EQUITY ENROLLEES (100% PREMIUM)
HMO AND POS PLANS FOR MASSACHUSETTS

				SEE PLAN	BROCHURES	FOR BENEFIT	INFORMATION,		
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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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Page 6 - Fee for Service Plans - Enrollment Codes and

Page 7 - Federal Employees Health Benefits Program Health Information Technology and Price/Cost Transparency Leaders

Page 8 - Fee for Service Plans - Enrollment Codes and Benefits

Page 9 - High Deductible and Consumer-Driven Health Plans Nationwide and State Specific

Page 10 - High Deductible and Consumer-Driven Health Plans - codes and benefits

Page 1:1 - Health Maintenance Organization (HMO) Plans, Point of Service (POS) (if applicable) - Descriptions

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

Privacy Act Statement. The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program (FEHB) under Chapter 8, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan (2) verify your and for your family's eligibility for payment of a claim for health benefits services or supplies, and identify your enrollment in the plan (2) verify your and for your family's eligibility for payment of benefits. This information may be (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, 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, 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, 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, disclosed to other Federal agencies to determine and issue benefits under their programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

entorgenient 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 Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

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

Public Burden Statement. We think, this from 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, OPM Forms Officer, (3206-0202), Washington, D.C. 20415-7900. The OMB number, 3206-0-160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

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The state of the s	REQUEST TO CHANGE FEHB ENROLLMENT FOR 2008 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  Do not take any action to maintain your present coverage.  COMPLETE THIS FORM ONLY IF YOU ARE MAKING CHANGES.	selection in Section II. I have either: (1) marked the block the Maintenace Organization (HMO) plan, Regional High	(Revised (11/07)  All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FERD web site at <a href="https://www.opm.gov/insure.health.">www.opm.gov/insure.health.</a> at <a href="https://www.opm.gov/insure.health.">www.opm.gov</a>	HMO Plan or HDHP or CDHP  Enrollment Code  Name of Plan		Note: If changing Plans to an HMO Plan or HDHP or CDHP, please use the box above to request the change.	16.	Section IV. Address Correction	
	REQUEST TO CHANGE FEHB ENROLLMENT FOR 2008 PLAN YEAR fore completing this form Return this form to: USDA/NFC, DPRS Billing Unit, P.O. Do not take any action to maintain your present coverage.  COMPLETE THIS FORM ONLY IF YOU ARE MAKING CHANGES.	Section I. Action. Mark the Change Enrollment block to change your FEHB enrollment.  Change Enrollment. I want to change my FEHB enrollment. I have indicated my selection in Section II. I have either: (1) marked the block of a Nationwide plan, or (2) entered the enrollment code and plan name of an Health Maintenace Organization (HMO) plan, Regional High Deductible Health Plan (HDHP), or Consumer Driven Health Plan (CDHP).	All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the remainent web site at <a href="https://www.opm.gov/insure.health.">www.opm.gov/insure.health.</a> .  The plant only to self and family, please list is the remained from self only to self and family, please list is the remaining the plant of t	Mark the appropriate blocks. It you are charging your mationwide Fee-for-Service Plans Open Only to Specific Groups	ام و م د	agoo <mark>c</mark>	441 SAWDA-THRI CH. 742 SAWDA-THRI SAWDA-HIGH FAMILY		
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ection V. Authorization. You must sign and date this form. Enter the daytime area code and ephone number where you can be contacted to answer questions. Date

Daytime Telephone Number

iection III. Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19. numerried dependent child under age 22: 09. Adopted child; 17. Step child; 10. Foster child; or recognized hild; 99. Unmarried disabled child over age 22 incapable of self-support because of a physical or mental isability that began before age 22.

Helatronship Code

Social Security number Date of Birth

ame of Family Member (last, first, middle initial)

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Other Insurance

TRICARE

Medicare

Insurance Policy Number

Name of Insurance

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R25A (revised 11,07)

# 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 2008. If your plan is not listed, you must select another plan during this Open Season period (November 12 through December 10, 2007) to be assured of continued health benefits coverage.

Important. You should also carefully review the 2008 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: New 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 <a href="https://www.opm.goy/insure/health">www.opm.goy/insure/health</a>. 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 Tyour FEHB enrollment.

Section II, Enrollment Codes and Plan Names. Mark one block only in the Nationwide Fee-for-Service Plans Open to All or Nationwide Fee-for-Service Open Only to Specific Groups 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 9-10. 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.

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 mall 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, 2008.

Section V, Authorization. You must sign and date the form. No changes will be made unless the enrollee signs 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, 2008. If your change is processed before January 1, 2008, 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, 2008.

Identification Cards. These cards are issued by the health plans, not DPRS. You should direct questions about identification (ID) cards to your plan. It may take up to THREE months after DPRS has processed your open season change for you to receive an identification card. Should you or your family require medical attention after the January 1, 2008 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 <a href="www.opm.gov/insure/health">www.opm.gov/insure/health</a> 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 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 <a href="https://www.nfc.usda.gov">www.nfc.usda.gov</a> and scroll down to the DPRS web site.

Visit our web site at www.nfc.usda.gov and scroll down to the DPRS web site.



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# DIRECT PREMIUM REMITTANCE SYSTEM

## OPEN SEASON INFORMATION

page 7 of 2011 pkg.

The 2007 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 12 through December 10, 2007. 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, 2007.

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, 2008 for Nationwide Fee-for-Service Plans (Page 6 & 8), the Nationwide High Deductible and Consumer Driven Health Plans (Page 9 & 10) 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 HMOs or 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 8 and page 10:

A - NONE

B - N/A

C - NOTHING

D' - NOT COVERED

E - NOTHING UP TO \$1200

P - DEDUCTIBLE PLUS 25%

G - \$75 PER DAY UP TO \$750

H - DEDUCTIBLE + 30%

I - NOTHING TO 10%

J - PER DAY x 5

K - 1 REFILL

L - OR 50%

M - OR \$45

N - \$25 MINIMUM

O - \$30 MINIMUM

P - 15% OR 30%

Q - PLUS DIFFERENCE

PRESCRIPTION DRUG PAYMENT LEVELS

Not on pg?

Plans use a variety of terms to define what you pay for the prescription drugs such as generic, brand name, Tier I, Tier II, Level I, 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.

Many plans are basing flow much you pay for prescription drugs on what they are charged. YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.

## Important

You should carefully review the 2008 premiums shown in the following plan comparison chart for your plan and option of coverage. Do not rely on the chart alone for benefit data. If you do not change your enrollment during open season, you may not be eligible to change until the next open season. You may also make changes to the name, address, or telephone number information on the form, or add eligible new dependents if you already have a family plan. To avoid delays, make sure you sign and date the form if you request any changes. No changes will be made unless the enrollee signs the form.

# Benefit Changes

Your current plan will send you a copy of its new brochure and rate sheet. Be sure to read your plan's brochure to see how benefits change in 2008. 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 2008 premium rates.

Plans Not Participating in the FEHB Program in 2008

Some plans will withdraw from the FEHB Program after December 31, 2007. 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 2008, 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 2008.

Effective Dates of Open Season Changes

All changes to new plans will be effective January 1, 2008.

2008 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, 2007, your new 2008 payment coupons will be mailed to you during the first two weeks of January, 2008. Your payment coupon for the month of January 2008 will be the first coupon to reflect the 2008 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.

# pg 4 g zon pkg

Nationwide Fee for Service Health Plans (Page 6 & 8)

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 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 can choose medical providers who are not contracted 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) offered discounted charges. 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. Lab work and radiology services from independent practitioners within the hospital are frequently not covered by the hospital's 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 the 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.

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 9 & 10)

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.

When you enroll, your plan establishes for you either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The plan automatically deposits the monthly "premium pass through" into your HSA. The plan credits an amount into the HRA. (This is the "Premium Contribution to HSA/HRA column in the chart.)

Preventative care is often covered in full, usually with no or only a small deductible or copayment. Preventative care expenses may also be payable up to an annual maximum dollar amount. As you receive other non-preventative medical care, you must meet the plan deductible before the plan pays benefits. You can choose to pay your deductible with funds

from your HSA or you can choose instead to pay for your deductible out-of-pocket, allowing your savings to continue to grow.

The HDHP features higher annual deductibles (a minimum of \$1,100 for Self Only and \$2,200 for Self and Family coverage) and annual out-of-pocket limits (not to exceed \$5,600 for Self and \$11,200 for Family coverage) than other insurance plans. Depending on the HDHP you choose, you may have the choice of using in-network and out-of-network providers. Using in-network providers will save you money.

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 HAS.
- 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 haveMedicare. HRAs are similar to HSAs except an enrollee cannotmake 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.

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.

432.16 1016 85 821 28 1065,97 1319,64 926 91 1034 ,26 Self & Family 668.51 979.69 810.32 1137.58 959.96 1048.51 973.44 Your Monthly Premium 560 35 405.85 457 89 345 95 435.97 427.88 393.47 523.92 448 96 522.69 450.48 294.18 424.56 181 26 Self Self & Family 442 445 422 402 432 382 322 455 4.5 0,0 172 472 105 Enrollment Code 444 441 421 431 381 314 454 321 401 414 111 2008 DPRS OPEN SEASON INFORMATION TCC ENROLLEES (102% PREMIUM)
FEE FOR SERVICE PLANS - ENROLLMENT CODES AND RATES 471 104 31. Self VALUE OPTION Plan Option STANDARD STANDARD STANDARD STANDARD BASIC HIGH HIGH HIGH Telephone Number 800/638-6589 202/833-4910 800/548-8969 800/658-6589 800/634-0069 800/638-8432 800/410-7778 800/410-7778 888/636-6252 800/821-6136 800/821-6136 800/222-2798 LOCAL LOCAL MAIL HANDLERS BENEFIT VALUE OPTION PLANS OPEN ONLY TO SPECIFIC GROUPS PANAMA CANAL AREA BENEFIT PLAN FOREIGN SERVICE BENEFIT PLAN RURAL CARRIERS BENEFIT PLAN MAIL HANDLERS BENEFIT PLAN SAMBA HEALTH BENEFIT PLAN BLUE CROSS AND BLUE SHIELD BLUE CROSS AND BLUE SHIELD SAMBA HEALTH BENEFIT PLAN GEHA HEALTH BENEFIT PLAN ASSOCIATION BENEFIT PLAN NALC HEALTH BENEFIT PLAN GEHA HEALTH BENEFIT PLAN APWU HEALTH PLAN DR571 (revised 10/02)

# DIRECT PREMIUM REMITTANCE SYSTEM

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# Federal Employees Health Benefits (FEHB) Program Health Information Technology and Price/Cost Transparency Leaders

Over the past few years, OPM has encouraged FEHB health benefits plans to increase their use of health information technology (HIT) to create efficient care delivery and to develop tools to help you determine the quality of the doctors, hospitals and other providers that you and your family use for day-to-day healthcare needs.

HIT based on broadly accepted standards allows patients, healthcare providers, and health plans to share information securely, driving down costs by avoiding duplicate procedures and manual transactions. More importantly, HIT reduces medical errors from, for instance, misread handwritten prescriptions, and emergency care medical decisions made without complete and accurate information. HIT can also help you find appropriate health information to aid you and your doctor in making appropriate clinical decisions regarding your care. Since privacy and security considerations are vitally important, safeguards are being established to keep your records safe from inappropriate disclosure.

# Health Information Technology

The health plans listed below have made a commitment to offer you and your family access to internet based personal health records (PHR). PHRs come in a variety of forms but what they all have in common is that they give you a convenient way to track, view, and manage your personal health information. PHRs also allow you to share your health information with your healthcare providers so they have a better picture of your health history. When providers know your health history they can make more accurate diagnoses and provide you with safer, more efficient care.

# Quality and Price/Cost Transparency On-line Tools

The health plans listed here have also made a commitment to offer you and your family access to healthcare quality and price/cost information so you can make more informed choices on which providers to use to receive care. The website information available includes online decision tools with cost estimators and quality indicators for physician and hospital services and prescription drugs used to treat common illnesses and conditions. These health plans describe the sources of this health information and any limitations so you can understand what the information means. Some examples of the types of surgical procedures for which you can obtain cost and quality information include: arthroscopy knee/shoulder, breast biopsy, cataract procedures for which you can obtain cost and quality information include: arthroscopy knee/shoulder, breast biopsy, cataract procedures for which you can obtain cost and quality information include: arthroscopy knee/shoulder, breast biopsy, cataract procedures for which you can obtain cost and quality information include: arthroscopy knee/shoulder, breast biopsy, cataract procedures for which you can obtain cost and quality information heart catheterization, hysterectomy, inguinal hernia repair, knee replacement, and tonsillectomy. This information helps you understand the true price/cost and quality of your healthcare and enhances your ability to compare hospital, physician, prescription and other provider value as you make healthcare choices. FEHB health plans are working to expand the price/cost and quality information they provide to you.

The health plans listed on the following page met OPM's HIT, quality and price/cost transparency standards at the time this Guide went to press. As other plans bring these tools on line, we will add them to the list on our website. So, please check the updated information at <a href="https://www.opm.gov/insure">www.opm.gov/insure</a> before you make your healthcare decisions. It was a support of the plans of the time this Guide went to press. As other plans bring these tools on line, we will add them to the list on our website. So, please check the updated information at <a href="https://www.opm.gov/insure">www.opm.gov/insure</a> before you make your healthcare decisions. It was a support of the plans bring these tools on line, we will add them to the list on our website. So, please check the updated information at <a href="https://www.opm.gov/insure">www.opm.gov/insure</a> before you make your healthcare decisions.

The following health plans have demonstrated their commitment to efficiency, safety and quality through computer system enhancements that offer PHRs and quality and price/cost transparency decision support tools:

Aetna APWU Health Plan AvMed Health Plans Blue Cross & Blue Shield of RI BlueCross BlueShield Government Wide Service Benefit Plan CareFirst BlueChoice, Inc ConnectiCare, Inc Blue Choice Geisinger Health Plan Government Employees Health Association, Inc. (GEHA) Group Health Incorporated Health Net of Arizona, Inc. Health Net of California HealthPartners, Inc. HealthPlus of Michigan

HIP Health Plan of New York HMO Health Ohio Humana Independent Health Association, Inc. Kaiser Foundation Health Plan (except Hawaii) Medica Health Plans MVP Health Care, Inc. NALC Health Benefit Plan PacifiCare Health Plans Panama Canal Area Benefit Plan SAMBA SuperMed HMO UniCare UnitedHealthcare (except the River Valley, Inc. in Iowa and Illinois) UPMC Health Plan



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Nationwide High Deductible and Consumer Driven Health Plans

Plan Name	Telephone	Enrollme	nt Code	Premiu	m
Plan Mante	. Number	Self	Self & Family	Self	Self & Family
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APWU HEALTH PLAN-(CDHP)	800/222-2798	474	475	343,43	772,62
GEHA-(HDḤP)	800/821-6136	341	342	388 43	887_19
MAILHANDLERS-(HDHP)	800/410-7778	481	482	298.84	677,19
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High Deductible and Consumer Driven Health Plans for Your State

	Telephone	Enrollme	nt Code	Premiu	TIM)
Plan Name	Number	Self	Self & Family	Self	Self & Family
AETNA HEALTH FUND-(CDHP)	877/459-6604	221	222	334.82	770.10
AETNA HEALTH FUND-(HDHP)	877/459-6604	224	225	273.36	598 .63
HEALTH AMERICA-(HDHP)	866/351-5946	Y61	Y62	335.68	825.26
HEALTHAMERICA-(HDHP)	866/351-5946	YN1	Y,N2	531.31	1,205.2
HEALTHAMERICA-(HDHP)	866/351-5946	YW1	YW2	402.73	909.6
HEALTHAMERICA-(HDHP)	866/351-5946	9N1	9N2	392.67	885.9
UPMC HEALTH PLAN-(HDHP)	888/876-2756	8W4	8W5	481.43	1,160.8
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High Deductible and Consumer Driven Health Plans for Your State (cont'd)	;	Location	PHIL/PITTS/LEHIGH VLLY/CENT/NE/SE PA	PHIL/PITTS/LEHIGH VLLY/CENT/NE SE PA	GREATER PITTSBÜRGH AREA	NORTHEAST PENNSYLVANIA	CENTRAL PENNSYLWANIA	SOUTHEASTERN PA	WESTERN PENNSYL						
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# DIRECT PREMIUM REMITTANCE-SYSTEM

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 for 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 not 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 are (like an HMO), or (2) out-of-network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non- HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

ON page 4 &

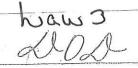


ENROLLEES (102% PREMIUM) 2008 DPRS OPEN SEASON INFORMATION

INFORMATION BROCHURES SEE FOR 800/447-4000 800/447-4000 866/351-5946 866/351-5946 866/351-5946 866/351-5946 800/227-3115 TELEPHONE 877/459-6604 877/459-6604 866/351-5946 866/351-5946 866/351-5946 866/351-5946 800/622-2843 800/622-2843 888/876-2756 888/876-2756 NUMBER Self & Family Enrollment Code P35 ED5 542 Self 18 HEALTHAMERICA NE- STD
12 HEALTHAMERICA PA CENTRAL- HIGH
28 HEALTHAMERICA PA CENTRAL- STD
37 HEALTHAMERICA PA PITTS- HIGH
38 HEALTHAMERICA PA PITTS- STD
48 HEALTHAMERICA SE- HIGH
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48 KEYSTONE HITHPLAN EAST- STD 1287 62 AETNA OPEN ACCESS PITTS- HIGH
1287 62 AETNA OPEN ACCESS- HIGH
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18 1230. 35 GEISINGER HEALTH PLAN- STD
1470. 48 HEALTHAMERICA NE- HIGH
16 175. 48 HEALTHAMERICA NE- STD
18 1385 -12 HEALTHAMERICA NE- STD
19 998. 08 HEALTHAMERICA PA CENTRAL- STD
10 1250 57 HEALTHAMERICA PA PITTS- HIGH
18 18 18 16 HEALTHAMERICA SE- HIGH
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# IMPORTANT DPRS OPEN SEASON INFORMATION

PLEASE READ ALL. INFORMATION AND INSTRUCTIONS.

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

# TABLE OF CONTENTS

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Page 6 - Fee for Service Plans - Enrollment Codes and Rates

Page 7 - Federal Employees Health Benefits Program Health Information Technology and Price/Cost Transparency Leaders

Page 8 - Fee for Service Plans - Enrollment Codes and Benefits

Page 9 - High Deductible and Consumer-Driven Health Plans Nationwide and State Specific

Page 10 - High Deductible and Consumer-Driven Health Plans - codes and benefits

Page 11 - Health Maintenance Organization (HMO) Plans, Point of Service (POS) (if applicable) - Descriptions

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

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

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

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

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

Public Burden Statement. We think, this from 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, OPM Forms Officer, (3206-0202), Washington, D.C. 20415-7900. The OMB number, 3206-0189 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.



eligible 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

Do not take any action to maintain your present coverage.

COMPLETE THIS FORM O/VLY IF YOU ARE MAKING CHANGES. Change Enrollment. I want to change my FEHB enrollment. I have indicated my selection in Section II. I have either: (1) marked the block of a Nationwide plan, or (2) entered the enrollment code and plan name of an Health Maintenace Organization (HMO) plan, Regional High Deductible Health Plan (HDHP), or Consumer Driven Health Plan (CDHP). All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the FEHB web site Section i. Action. Mark the Change Enrollment block to change your FEHB enrollment. OPEN SEASON DPRS-2809 OMB 3206-0202 (Revised (11/07) PEUERAL EMPLUYEES HEALTH BENEFITS PROGRAM 

appropriate blocks. If you are changing your enrollment from self only to self and family, please list your eligible	inly HMO Plan or HDHP or CDHP	Enrollment Code Name of Plan	amily	Note: If changing Plans to an HMO Plan or HDHP or CDHP, please use the box above to request the change.	Driven Section IV. Address Correction □ I need to correct my address. The changes are indicated in the box below.			pazi
Enrollment Codes and Plan Names, Mark the appropriate blocks. If you are changing	Nation	ans Open to	47.1 ☐ AFVOC Self Only 47.2 ☐ APVVU—Self and Family 47.2 ☐ APVVU—Self and Family 40.2 ☐ Foreign Service—Self and Family 40.4.1 ☐ Association Benefit Plan—Self Only 42.1 ☐ Association Benefit Plan—Self and Family 42.2 ☐ Association Benefit Plan—Self and Family	c-Self and Family 432 0	Family 445 Colly Nationwill Health Period	Family 475 341	342 — GEHA-HDHP Self and ramily 481 — Mail Handlers-HDHP-Self Only 482 — Mail. Handlers-HDHP-Self and Family	Section III. Dependents' Information. Fill in the applicable information in the blocks below. For additional family members please use a separate sheet of paper. Relationship Codes are: 01. Spouse; 19.

Daytime Telephone Number

Section V. Authorization. You must sign and date this form. Enter the daytime area code and

telephone number where you can be contacted to answer questions.

Date

Insurance Policy Number

Name of Insurance A B B

Other Insurance

M | F

Medicare

|Social Security number | Date of Birth

lame of Family Member (last, first, middle initial)

Address (if different from enroilee)

disability that began before age 22.

DR25A (revised 11/07).

Signature

FEDERAL EMPLOYEES
HEALTH BENEFITS
PROGRAM

FEHB OPEN SEASON

# INFORMATION AND INSTRUCTION SHEET FOR COMPLETING FORM DPRS-2809

Carefully read the following instructions before completing your request form.

You must make all changes through the National Finance Center.

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

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

If you decide not to make an enrollment change this year, it is not necessary to complete the form, DPRS-2809. Please read both the form and the accompanying plan comparison charts to make sure your current health benefits plan and option of coverage, especially Health Maintenance Organization (HMO) plans, will still be available to you in 2008. If your plan is not listed, you must select another plan during this Open Season period (November 12 through December 10, 2007) to be assured of continued health benefits coverage.

Important. You should also carefully review the 2008 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: New 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 <a href="https://www.opm.gov/insure/health">www.opm.gov/insure/health</a>. 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 Fee-for-Service Plans Open to All or Nationwide Fee-for-Service Open Only to Specific Groups 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 9-10. 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.

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, 2008.

Section V, Authorization. You must sign and date the form. No changes will be made unless the enrollee signs 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, 2008. If your change is processed before January 1 2008, 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, 2008.

Identification Cards. These cards are issued by the health plans, not DPRS. You should direct questions about identification (ID) cards to your plan. It may take up to THREE months after DPRS has processed your open season change for you to receive an identification card. Should you or your family require medical attention after the January 1, 2008 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 <a href="www.opm.gov/insure/health">www.opm.gov/insure/health</a> 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 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 and scroll down to the DPRS web site.

Visit our web site at www.nfc.usda.gov and scroll down to the DPRS web site.



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# DIRECT PREMIUM REMITTANCE SYSTEM

# OPEN SEASON INFORMATION

The 2007 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 12 through December 10, 2007. 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, 2007.

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, 2008 for Nationwide Fee-for-Service Plans (Page 6 & 8), the Nationwide High Deductible and Consumer Driven Health Plans (Page 9 & 10) 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 HMOs or 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 8 and page 10:

A - NONE

B - N/A

C → NOTHING

D - NOT COVERED

E - NOTHING UP TO \$1200

F - DEDUCTIBLE PLUS 25%

G - \$75 PER DAY UP TO \$750

H - DEDUCTIBLE + 30%

I - NOTHING TO 10%

J - PER DAY x 5

K - 1 REFILL

L - OR 50%

M - OR \$45

N - \$25 MINIMUM

0 - \$30 MINIMUM

P - 15% OR 30%

Q - PLUS DIFFERENCE

# PRESCRIPTION DRUG PAYMENT LEVELS NO CM

Plans use a variety of terms to define what you pay for the prescription drugs such as generic, brand name, Tier I, Tier II, Level I, 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.

Many plans are basing how much you pay for prescription drugs on what they are charged. YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.

# Important

You should carefully review the 2008 premiums shown in the following plan comparison chart for your plan and option of coverage. Do not rely on the chart alone for benefit data. If you do not change your enrollment during open season, you may not be eligible to change until the next open season. You may also make changes to the name, address, or telephone number information on the form, or add eligible new dependents if you already have a family plan. To avoid delays, make sure you sign and date the form if you request any changes. No changes will be made unless the enrollee signs the form.

## Benefit Changes

Your current plan will send you a copy of its new brochure and rate sheet. Be sure to read your plan's brochure to see how benefits change in 2008. 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 2008 premium rates.

Plans Not Participating in the FEHB Program in 2008

Some plans will withdraw from the FEHB Program after December 31, 2007. 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 2008, 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 2008.

Effective Dates of Open Season Changes

All changes to new plans will be effective January 1, 2008.

# 2008 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, 2007, your new 2008 payment coupons will be mailed to you during the first two weeks of January, 2008. Your payment coupon for the month of January 2008 will be the first coupon to reflect the 2008 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.

Nationwide Fee for Service Health Plans (Page 6 & 8)

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 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 can choose medical providers who are not contracted 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) offered discounted charges. 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. Lab work and radiology services from independent practitioners within the hospital are frequently not covered by the hospital's 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 the 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.

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 9 & 10)

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.

When you enroll, your plan establishes for you either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The plan automatically deposits the monthly "premium pass through" into your HSA. The plan credits an amount into the HRA. (This is the "Premium Contribution to HSA/HRA column in the chart.)

Preventative care is often covered in full, usually with no or only a small deductible or copayment. Preventative care expenses may also be payable up to an annual maximum dollar amount. As you receive other non-preventative medical care, you must meet the plan deductible before the plan pays benefits. You can choose to pay your deductible with funds

from your HSA or you can choose instead to pay for your deductible out—of—pocket, allowing your savings to continue to grow.

The HDHP features higher annual deductibles (a minimum of \$1,100 for Self Only and \$2,200 for Self and Family coverage) and annual out-of-pocket limits (not to exceed \$5,600 for Self and \$11,200 for Family coverage) than other insurance plans. Depending on the HDHP you choose, you may have the choice of using in-network and out-of-network providers. Using in-network providers will save you money.

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 HAS.
- 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 haveMedicare. HRAs are similar to HSAs except an enrollee cannotmake 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.

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.

PICE



Self & Family

Self

Your Monthly Premium

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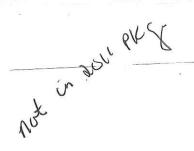
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# DIRECT PREMIUM REMITTANCE SYSTEM

# Federal Employees Health Benefits (FEHB) Program Health Information Technology and Price/Cost Transparency Leaders

Over the past few years, OPM has encouraged FEHB health benefits plans to increase their use of health information technology (HIT) to create efficient care delivery and to develop tools to help you determine the quality of the doctors, hospitals and other providers that you and your family use for day-to-day healthcare needs.

HIT based on broadly accepted standards allows patients, healthcare providers, and health plans to share information securely, driving down costs by avoiding duplicate procedures and manual transactions. More importantly, HIT reduces medical errors from, for instance, misread handwritten prescriptions, and emergency care medical decisions made without complete and accurate the standard procedure. information. HIT can also help you find appropriate health information to aid you and your doctor in making appropriate clinical decisions regarding your care. Since privacy and security considerations are vitally important, safeguards are being established to keep your records safe from inappropriate disclosure.

# Health Information Technology

The health plans listed below have made a commitment to offer you and your family access to internet based personal health records (PHR). PHRs come in a variety of forms but what they all have in common is that they give you a convenient way to track, view, and manage your personal health information. PHRs also allow you to share your health information with your healthcare providers so they have a better picture of your health history. When providers know your health history they can make more accurate diagnoses and provide you with safer, more efficient care.

# Quality and Price/Cost Transparency On-line Tools

The health plans listed here have also made a commitment to offer you and your family access to healthcare quality and price/cost information so you can make more informed choices on which providers to use to receive care. The website information available includes online decision tools with cost estimators and quality indicators for physician and hospital services and prescription drugs used to treat common illnesses and conditions. These health plans describe the sources of this health information and any limitations so you can understand what the information means. Some examples of the types of surgical procedures for which you can obtain cost and quality information include: arthroscopy knee/shoulder, breast biopsy, cataract repair, cesarean delivery, colonoscopy, corneal surgery, gall bladder removal, heart catheterization, hysterectomy, inguinal hernia repair, knee replacement, and tonsillectomy. This information helps you understand the true price/cost and quality.of your healthcare and enhances your ability to compare hospital, physician, prescription and other provider value as you make healthcare choices. FEHB health plans are working to expand the price/cost and quality information they provide to you.

The health plans listed on the following page met OPM's HIT, quality and price/cost transparency standards at the time this Guide went to press. As other plans bring these tools on line, we will add them to the list on our website. So, please check the updated information at www.opm.gov/insure before you make your healthcare decisions.

The following health plans have demonstrated their commitment to efficiency, safety and quality through computer system enhancements that offer PHRs and quality and price/cost transparency decision support tools:

APWU Health Plan AvMed Health Plans Blue Cross & Blue Shield of RI BlueCross BlueShield Government Wide Service Benefit Plan CareFirst BlueChoice, Inc. ConnectiCare, Inc. Blue Choice Geisinger Health Plan Government Employees Health Association, Inc. (GEHA) Group Health Incorporated Health Net of Arizona, Inc. Health Net of California HealthPartners, Inc. HealthPlus of Michigan

HIP Health Plan of New York HMO Health Ohio Independent Health Association, Inc. Kaiser Foundation Health Plan (except Hawaii) MD IPA Medica Health Plans MVP Health Care, Inc. NALC Health Benefit Plan PacifiCare Health Plans Panama Canal Area Benefit Plan SAMBA SuperMed HMO UnitedHealthcare (except the River Valley, Inc. in Iowa and Illinois) UPMC Health Plan



2008 DPRS OPEN SEASON INFORMATION -- ENROLLEES FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

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Nationwide High Deductible and Consumer Driven Health Plans

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APWU HEALTH PLAN-(CDHP)		800/222-2798	474	475	84 17	189.37
GEHA-(HDHP)		800/821-6136	341	342	95.20	217 4
MAILHANDLERS-(HDHP)		800/410-7778	481	482	73 24	165 9
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High Deductible and Consumer Driven Health Plans for Your State

Telephone	Enrollme	nt Code	Premium			
Number	Self	Self & Family	Self	Self & Family		
877/459-6604	221	222	82 06	188 75		
877/459-6604	224	225	67,00	146 72		
330/363-6360	3A4	3A5	91.29	182.91		
LOCAL PHONE	114	1,15	84.79	198.6		
888/393-6765	L81	L82	75.94	174.6		
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# SEE PLAN

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CLEVELAND AND COLUMBUS AREAS

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OHIO

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

Location

Enrollment Code
Self Self & Family

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224 224 3A4

# BROCHURES FOR

# BENEFIT

# DR5C7 (11/06)

# DIRECT PREMIUM REMITTANCE SYSTEM

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 for 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 not 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 are (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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# 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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Page 6 - Fee for Service Plans - Enrollment Codes and Rates

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Nationwide and State Specific

Page 10 - High Deductible and Consumer-Driven Health Plans - codes and benefits

Page 11 - Health Maintenance Organization (HMO) Plans, Point of Service (POS) (if applicable) - Descriptions

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

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

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

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

the prompt payment of your and/or your family's claims for health benefits services or supplies.

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

Public Burden Statement. We think, this from 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, OPM Forms Officer, (3206-0202), Washington, D.C. 20415-7900. The OMB number, 3206-6160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

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at www.opm.gov/insure.health

Nationwide Fee-for-Service Plans Open to All

Section II. Enrollment

OPEN SEASON

DPRS-2809 OMB 3206-0202 (Revised (11/07)

HEALTH BENEFITS

PROGRAM

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Blue Cross/Blue Shield-Basic-Self and Family Blue Cross/Blue Shield-Stnd-Self and Family

GEHA-High-Self and Family GEHA-Stnd-Self and Family

GEHA-Stnd-Self Only GEHA-High-Self Only

Blue Cross/Blue Shield-Basic-Self Only

APWU-Self and Family Blue Cross/Blue Shield-Stnd-Self Only

471 APWU-Self only 472 APWU-Self and

" LOUIS IN CHANGE PEHB ENROLLMENT FOR 2008 PLAN YEAR

Section V. Authorization. You must sign and date this form. Enter the daytime area code and telephone number where you can be contacted to answer questions.

Insurance Policy Number

ABD

Other Insurance

MICARE

Medicare

Social Security number | Date of Birth

Name of Family Member (last, first, middle initial)

Address (if different from enrollee)

disability that began before age 22.

Health Plans

Mail Handlers-Value Option-Self and Family

NALC-Self and Family

NALC-Self Only

Mail Handlers-Value Option-Self Only

Handlers-Stnd-Self and Family

Mail

Mail Handlers-Stnd-Self Only

Signature

Date

Daytime Telephone Number

DR25A (revised 11/07)

FEDERAL EMPLOYEES, HEALTH BENEFITS PROGRAM
FEHB
OPEN SEASON

## INFORMATION AND INSTRUCTION SHEET FOR COMPLETING FORM DPRS-2809

Carefully read the following instructions before completing your request form.

You must make all changes through the National Finance Center.

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

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

If you decide not to make an enrollment change this year, it is not necessary to complete the form, DPRS-2809. Please read both the form and the accompanying plan comparison charts to make sure your current health benefits plan and option of coverage, especially Health Maintenance Organization (HMO) plans, will still be available to you in 2008. If your plan is not listed, you must select another plan during this Open Season period (November 12 through December 10, 2007) to be assured of continued health benefits coverage.

Important. You should—also—carefully review the 2008 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: New 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 <a href="https://www.opm.gov/insure/health">www.opm.gov/insure/health</a>. 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 Fee-for-Service Plans Open to All or Nationwide Fee-for-Service Open Only to Specific Groups 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 9-10. 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.

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, 2008.

Section V, Authorization. You must sign and date the form. No changes will be made unless the enrollee signs 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, 2008. If your change is processed before January 1, 2008, 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, 2008.

Identification Cards. These cards are issued by the health plans, not DPRS. You should direct questions about identification (ID) cards to your plan. It may take up to THREE months after DPRS has processed your open season change for you to receive an identification card. Should you or your family require medical attention after the January 1, 2008 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 <a href="https://www.opm.gov/insure/health">www.opm.gov/insure/health</a> can help you choose your health plan. In addition to the info contained in this guide you will find information on:

- Who is Eligible
- I 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 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 and scroll down to the DPRS web site.

Visit our web site at www.nfc.usda.gov and scroll down to the DPRS web site.



#### DIRECT PREMIUM REMITTANCE SYSTEM

## OPEN SEASON INFORMATION This is an page 7 of the

The 2007 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 12 through December 10, 2007. 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, 2007.

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, 2008 for Nationwide Fee-for-Service Plans (Page 6 & 8), the Nationwide High Deductible and Consumer Driven Health Plans (Page 9 & 10) 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 HMOs or 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 8 and page 10:

A - NONE

B - N/A

C - NOTHING

D - NOT COVERED

E - NOTHING UP TO \$1200

F - DEDUCTIBLE PLUS 25%

G - \$75 PER DAY UP TO \$750

H - DEDUCTIBLE + 30%

I - NOTHING TO 10%

J - PER DAY x 5

K - 1 REFILL

L - OR 50%

M - OR \$45

N - \$25 MINIMUM

O - \$30 MINIMUM

P - 15% OR 30%

Q - PLUS DIFFERENCE

#### PRESCRIPTION DRUG PAYMENT LEVELS

Plans use a variety of terms to define what you pay for prescription drugs such as generic, brand name, Tier I, Tier II, Level I, 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.

Many plans are basing how much you pay for prescription drugs on what they are charged. YOU MUST READ THE PLAN BROCHURE FOR A COMPLETE DESCRIPTION OF PRESCRIPTION DRUG AND ALL OTHER BENEFITS.

#### Important

You should carefully review the 2008 premiums shown in the following plan comparison chart for your plan and option of coverage. Do not rely on the chart alone for benefit data. If you do not change your enrollment during open season, you may not be eligible to change until the next open season. You may also make changes to the name, address, or telephone number information on the form, or add eligible new dependents if you already have a family plan. To avoid delays, make sure you sign and date the form if you request any changes. No changes will be made unless the enrollee signs the form.

#### Benefit Changes

Your current plan will send you a copy of its new brochure and rate sheet. Be sure to read your plan's brochure to see how benefits change in 2008. 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 2008 premium rates.

#### Plans Not Participating in the FEHB Program in 2008

Some plans will withdraw from the FEHB Program after December 31, 2007. 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 2008, 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 2008.

#### Effective Dates of Open Season Changes

All changes to new plans will be effective January 1, 2008.

#### 2008 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, 2007, your new 2008 payment coupons will be mailed to you during the first two weeks of January, 2008. Your payment coupon for the month of January 2008 will be the first coupon to reflect the 2008 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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Nationwide Fee for Service Health Plans (Page 6 & 8)

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 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 can choose medical providers who are not contracted 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) offered discounted charges. 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. Lab work and radiology services from independent practitioners within the hospital are frequently not covered by the hospital's 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 the 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.

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 9 & 10)

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.

When you enroll, your plan establishes for you either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). The plan automatically deposits the monthly "premium pass through" into your HSA. The plan credits an amount into the HRA. (This is the "Premium Contribution to HSA/HRA column in the chart.)

Preventative care is often covered in full, usually with no or only a small deductible or copayment. Preventative care expenses may also be payable up to an annual maximum dollar amount. As you receive other non-preventative medical care, you must meet the plan deductible before the plan pays benefits. You can choose to pay your deductible with funds

from your HSA or you can choose instead to pay for your deductible out-of-pocket, allowing your savings to continue to grow.

The HDHP features higher annual deductibles (a minimum of \$1,100 for Self Only and \$2,200 for Self and Family coverage) and annual out-of-pocket limits (not to exceed \$5,600 for Self and \$11,200 for Family coverage) than other insurance plans. Depending on the HDHP you choose, you may have the choice of using in-network and out-of-network providers. Using in-network providers will save you money.

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 HAS.
- 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 haveMedicare. HRAs are similar to HSAs except an enrollee cannotmake 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.

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.

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2008 DPRS OPEN SEASON INFORMATION DIRECT PAY ENROLLEES FEE FOR SERVICE PLANS - ENROLLMENT CODES AND RATES

						B. C. L.
			100	Code	TOU.	Premium
PLAIN INAIVIE		rian Option	Self Only.	Self & Family	Self Only	Self & Family
APWU HEALTH PLAN	800/222-2798	HIGH	471	472	104.06	235 28
BLUE CROSS AND BLUE SHIELD	LOCAL	STANDARD	104	1055	134.66	6. 7.
BLUE CROSS AND BLUE SHIELD	. LOCAL	BASIC	111	112	84.79	198.61
GEHA HEALTH BENEFIT PLAN	800/821-6136	HIGH	11	9,12	000	701
GEHA HEALTH BENEPIT PLAN	800/821-6136	STANDARD	ω 41	. e.	72.10	163 85
MAIL HANDLERS BENEFIT PLAN	800/410-7778	STANDARD	454	455	113.17	240.87
MAIL HANDLERS BENEFIT VALUE OPTION	800/410-7778	VALUE OPTION	4	415	44.43	105.92
NALC HEALTH BENEFIT PLAN	888/636-6252		321	325	127.40	247.00
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PLANS UPEN UNLY TO SPECIFIC GROUPS				_		
ASSOCIATION BENEFIT PLAN	800/634-0069		421	422	125.91	300.50
FOREIGN SERVICE BENEFIT PLAN	202/833-4910		401	402	105.24	283.43
PANAMA CANAL AREA BENEFIT PLAN	800/548-8969	Car	431	432	96.44	201.29
RURAL CARRIERS BENEFIT PLAN	800/638-8432		381	382	199.40	331.59
SAMBA HEALTH BENEFIT PLAN	800/638-6589	H.	*		11 00	
SAWBA HEALTH BENEFIT PLAN	800/658-6589	GOVORDA	- 7	V L	1	280.78
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#### DIRECT PREMIUM REMITTANCE SYSTEM

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## Federal Employees Health Benefits (FEHB) Program Health Information Technology and Price/Cost Transparency Leaders

Over the past few years, OPM has encouraged FEHB health benefits plans to increase their use of health information technology (HIT) to create efficient care delivery and to develop tools to help you determine the quality of the doctors, hospitals and other providers that you and your family use for day-to-day healthcare needs.

HIT based on broadly accepted standards allows patients, healthcare providers, and health plans to share information securely, driving down costs by avoiding duplicate procedures and manual transactions. More importantly, HIT reduces medical errors from, for instance, misread handwritten prescriptions, and emergency care medical decisions made without complete and accurate information. HIT can also help you find appropriate health information to aid you and your doctor in making appropriate clinical decisions regarding your care. Since privacy and security considerations are vitally important, safeguards are being established to keep your records safe from inappropriate disclosure.

#### Health Information Technology

The health plans listed below have made a commitment to offer you and your family access to internet based personal health records (PHR). PHRs come in a variety of forms but what they all have in common is that they give you a convenient way to track, view, and manage your personal health information. PHRs also allow you to share your health information with your healthcare providers so they have a better picture of your health history. When providers know your health history they can make more accurate diagnoses and provide you with safer, more efficient care.

#### Quality and Price/Cost Transparency On-line Tools

The health plans listed here have also made a commitment to offer you and your family access to healthcare quality and price/cost information so you can make more informed choices on which providers to use to receive care. The website information available includes online decision tools with cost estimators and quality indicators for physician and hospital services and prescription drugs used to treat common illnesses and conditions. These health plans describe the sources of this health information and any limitations so you can understand what the information means. Some examples of the types of surgical procedures for which you can obtain cost and quality information include: arthroscopy knee/shoulder, breast biopsy, cataract repair, cesarean delivery, colonoscopy, corneal surgery, gall bladder removal, heart catheterization, hysterectomy, inguinal hernia repair, knee replacement, and tonsillectomy. This information helps you understand the true price/cost and quality of your healthcare and enhances your ability to compare hospital, physician, prescription and other provider value as you make healthcare choices. FEHB health plans are working to expand the price/cost and quality information they provide to you.

The health plans listed on the following page met OPM's HIT, quality and price/cost transparency standards at the time this Guide went to press. As other plans bring these tools on line, we will add them to the list on our website. So, please check the updated information at <a href="https://www.opm.gov/insure">www.opm.gov/insure</a> before you make your healthcare decisions.

The following health plans have demonstrated their commitment to efficiency, safety and quality through computer system enhancements that offer PHRs and quality and price/cost transparency decision support tools:

Aetna APWU Health Plan AvMed Health Plans Blue Cross & Blue Shield of RI BlueCross BlueShield Government Wide Service Benefit Plan CareFirst BlueChoice, Inc ConnectiCare, Inc. Blue Choice Geisinger Health Plan Government Employees Health Association, Inc. (GEHA) Group Health Incorporated Health Net of Arizona, Inc. Health Net of California HealthPartners, Inc. HealthPlus of Michigan

HIP Health Plan of New York HMO Health Ohio Humana Independent Health Association, Inc. Kaiser Foundation Health Plan (except Hawaii) M.D. IPA Medica Health Plans MVP Health Care, Inc. NALC Health Benefit Plan PacifiCare Health Plans Panama Canal Area Benefit Plan SAMBA SuperMed HMO UniCare UnitedHealthcare (except the River Valley, Inc. in Iowa and Illinois)

UPMC Health Plan



2008 DPRS OPEN SEASON INFORMATION DIRECT PAY ENROLLEES FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

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### Nationwide High Deductible and Consumer Driven Health Plans

Plan Name	Telephone Number	Enrollme	ent Code	Premi	um
		Self	Self & Family	Self	Self & Family
APWU HEALTH PLAN-(CDHP)	800/222-2798	474	475	84 . 17	189.37
GEHA-(HDHP)	800/821-6136	341	342	95 20	217.45
MAILHANDLERS-(HDHP)	800/410-7778	481	482	73.24	165.98
a.					

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

Telephone	Enrollme	ent Code	Premiu	ım
Number	Self	Self & Family	Self	Self & Family
877/459-6604	221	222	82 :06	188.75
877/459-6604	224	225	67.00	146.72
LOCAL PHONE	114	115	84.79	198.61
888/393-6765	ВТ1	ВТ2	83.54	192.14
888/393-6765	LĢ 1	L62	83.54	192.14
877/835-9861	· E91	E92	89.55	198.03
	Ž.			
	Number  877/459-6604  877/459-6604  LOCAL PHONE  888/393-6765  888/393-6765	Number Self	Number Self Self & Family  877/459-6604 221 222  877/459-6604 224 225  LOCAL PHONE 114 115  888/393-6765 BT1 BT2  888/393-6765 L61 L62	Number         Self         Self & Family         Self           877/459-6604         221         222         82 06           877/459-6604         224         225         67.00           LOCAL PHONE         114         115         84.79           888/393-6765         BT1         BT2         83.54           888/393-6765         L61         L62         83.54

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

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19 19 19 19 19 19 19 19 19 19 19 19 19 1	riescription prugs	Level !!	25%	25%	\$25 D	
		Level	25% D	25%	\$10 D	
	Preventative Services		ÓШ	ОШ	UД	
-tri0	patient	ל ייי שני א	40% 40%	25%	o %04	
-ui	# 2	5000	A A	5% 25%	40%	1
	Visit		15% 40%	5%	\$15 40%	
Catatrophic Limit	Self &	Family	\$4,500	\$10,000 \$10,000	\$10,000 \$15,000	
Catatrop	Q,		0000 8 8	\$ 22,000 \$ 52,000	\$5,000	,
uctible	Self &	ramily	\$600 \$1,200	\$3,000	\$4,000	
CY Deductible	Self	15	009\$	\$1,500 \$1,500 \$3,000	\$2,000 \$4,000 \$2,000 \$4,000	
Premium	HRA	۵	<u>a</u> œ			
	-	a	o m	\$60	\$70	
Benefit Type	L .	IN-NETWORK	OUT-NETWORK	IN-NETWORK OUT-NETWORK	IN-NETWORK OUT-NETWORK	
Enrollment Code	Self & Family	475		342	482	·
Enrollme	Self	474		341	188	

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

	Location	MOST OF TENNESSEE	MOST OF TENNESSEE	TENNESSEE	NASHVILLE	MEMPHIS	TENNESSEE				
Enrollment Code	Self & Family	222	225	112	B72	L62	E92			-	~
Enrollme	Self	221	224	114	BT1	L61	ш 0				

#### DIRECT PREMIUM REMITTANCE SYSTEM

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 for 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 not 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 are (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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ENROLLEES 2008 DPRS OPEN SEASON INFORMATION DIRECT PAY HWO AND POS PLANS FOR TENNESSEE

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