

*Spouse Equity*

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*Cleared @ GMB in 2008*

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

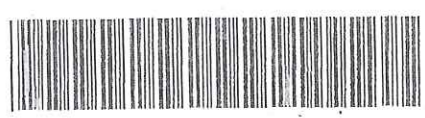
While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

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

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

**Public Burden Statement.** We think, this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, OPM Forms Officer, (3206-0202), Washington, D.C. 20415-7900. The OMB number, 3206-0480 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

*(0202)*



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

**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.

**Nationwide Fee-for-Service Plans Open to All**

- 471  APWU-Self Only
- 472  APWU-Self and Family
- 104  Blue Cross/Blue Shield-Stnd-Self Only
- 105  Blue Cross/Blue Shield-Stnd-Self and Family
- 111  Blue Cross/Blue Shield-Basic-Self Only
- 112  Blue Cross/Blue Shield-Basic-Self and Family
- 311  GEHA-High-Self Only
- 312  GEHA-High-Self and Family
- 314  GEHA-Stnd-Self Only
- 315  GEHA-Stnd-Self and Family
- 454  Mail Handlers-Stnd-Self Only
- 455  Mail Handlers-Stnd-Self and Family
- 414  Mail Handlers-Value Option-Self Only
- 415  Mail Handlers-Value Option-Self and Family
- 321  NALC-Self Only
- 322  NALC-Self and Family

**Nationwide Fee-for-Service Plans Open Only to Specific Groups**

- 401  Foreign Service-Self Only
- 402  Foreign Service-Self and Family
- 421  Association Benefit Plan-Self Only
- 422  Association Benefit Plan-Self and Family
- 431  Panama Canal Area-Self Only
- 432  Panama Canal Area-Self and Family
- 381  Rural Carriers-Self Only
- 382  Rural Carriers-Self and Family
- 441  SAMBA-High-Self Only
- 442  SAMBA-High-Self and Family
- 444  SAMBA-Stnd-Self Only
- 445  SAMBA-Stnd-Self and Family

**Nationwide High Deductible and Consumer-Driven Health Plans**

- 474  APWU-CDHP-Self Only
- 475  APWU-CDHP-Self and Family
- 341  GEHA-HDHP Self Only
- 342  GEHA-HDHP Self and Family
- 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. 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 disability that began before age 22.

Name of Family Member (last, first, middle initial)	Social Security number	Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Relationship Code
Address (if different from enrollee)		Medicare	TRICARE	Other Insurance
Name of Insurance		A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>	Insurance Policy Number	

**Section IV. Address Correction**  
 I need to correct my address. The changes are indicated in the box below.


**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.

Signature \_\_\_\_\_ Daytime Telephone Number \_\_\_\_\_ Date \_\_\_\_\_

Form has been revised by NFC

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 [www.opm.gov/insure/health](http://www.opm.gov/insure/health). To contact the carrier for a plan brochure, call the phone number provided in this package. NFC will not stock any brochures.

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

**Section II, Enrollment Codes and Plan Names.** Mark one block only in the Nationwide 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.

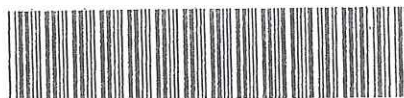
**Identification Cards.** These cards are issued by the health plans, not DPRS. You should direct questions about identification (ID) cards to your plan. It may take up to THREE months after DPRS has processed your open season change for you to receive an identification card. Should you or your family 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 [www.opm.gov/insure/health](http://www.opm.gov/insure/health) can help you choose your health plan. In addition to the info contained in this guide you will find information on:

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

**Additional Help.** If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit 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](http://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 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.

DIRECT PREMIUM REMITTANCE SYSTEM

*Not on 2011*

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

*Included in 2011*

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

Features of an HRA include:

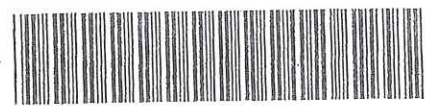
- Tax-free withdrawals for qualified medical expenses.
- Carryover of unused credits from year to year.
- Credits in an HRA do not earn interest.
- Credits in the HRA are forfeited if you leave federal employment or switch health insurance plans.

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 preventative care.

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*pg 4 of 2011 plan*

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

PLAN NAME	Telephone Number	Plan Option	Enrollment Code		Your Monthly Premium	
			Self Only	Self & Family	Self Only	Self & Family
<b>PLANS OPEN TO ALL</b>						
APWU HEALTH PLAN	800/222-2798	HIGH	471	472	416.24	941.14
BLUE CROSS AND BLUE SHIELD	LOCAL	STANDARD	104	105	448.91	1027.95
BLUE CROSS AND BLUE SHIELD	LOCAL	BASIC	111	112	339.17	794.43
GEHA HEALTH BENEFIT PLAN	800/821-6136	HIGH	311	312	512.44	1115.27
GEHA HEALTH BENEFIT PLAN	800/821-6136	STANDARD	314	315	288.41	655.40
MAIL HANDLERS BENEFIT PLAN	800/410-7778	STANDARD	454	455	427.42	954.35
MAIL HANDLERS BENEFIT VALUE OPTION	800/410-7778	VALUE OPTION	414	415	177.71	423.69
NALC HEALTH BENEFIT PLAN	888/636-6252		321	322	441.65	960.48
<b>PLANS OPEN ONLY TO SPECIFIC GROUPS</b>						
ASSOCIATION BENEFIT PLAN	800/634-0069		421	422	440.16	1013.98
FOREIGN SERVICE BENEFIT PLAN	202/833-4910		401	402	419.49	996.91
PANAMA CANAL AREA BENEFIT PLAN	800/548-8969		431	432	385.75	805.18
RURAL CARRIERS BENEFIT PLAN	800/638-8432		381	382	513.65	1045.07
SAMBA HEALTH BENEFIT PLAN	800/638-6589	HIGH	441	442	549.36	1293.76
SAMBA HEALTH BENEFIT PLAN	800/658-6589	STANDARD	444	445	397.89	908.74

DIRECT PREMIUM REMITTANCE SYSTEM

Not include in 2011 pkg

## 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 [www.opm.gov/insure](http://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:

Aetna	HIP Health Plan of New York
APWU Health Plan	HMO Health Ohio
AvMed Health Plans	Humana
Blue Cross & Blue Shield of RI	Independent Health Association, Inc.
BlueCross BlueShield	Kaiser Foundation Health Plan (except Hawaii)
Government Wide Service Benefit Plan	M.D. IPA
CareFirst BlueChoice, Inc	Medica Health Plans
ConnectiCare, Inc	MVP Health Care, Inc.
Blue Choice	NALC Health Benefit Plan
Geisinger Health Plan	PacifiCare Health Plans
Government Employees	Panama Canal Area Benefit Plan
Health Association, Inc. (GEHA)	SAMBA
Group Health Incorporated	SuperMed HMO
Health Net of Arizona, Inc.	UniCare
Health Net of California	UnitedHealthcare (except the River Valley, Inc. in Iowa and Illinois)
HealthPartners, Inc.	UPMC Health Plan
HealthPlus of Michigan	



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

Enrollment Code		Benefit Type	Medical-Surgical - Amounts You Pay				Prescription Drugs				Mail Order Discount			
			Calendar Year Per Person	Deductible Prescription Per Person	Hospital Inpatient	Primary Office Visits	Doctor Care	Hospital	Level I	Level II		Level III		
Self Only	Self & Family							Inpatient Surgery	Inpatient R&B					
PLANS OPEN TO ALL														
471	472	PPO NON PPO	\$275 \$500	A A	A	\$18 30%	10% 30%	10% 30%	10% 30%	\$8 50%	25% 50%	25% 50%	25% 50%	YES YES
104	105	PPO NON PPO	\$300 \$300	A A	H	\$15 25%	10% 25%	10% 25%	\$100 H	25% 45%+	25% 45%+	25% 45%+	25% 45%+	YES YES
111	112	PPO	A	A	K	\$20	\$100	\$100	C	\$10	\$30	\$35	L	NO
311	312	PPO NON PPO	\$350 \$350	A A	A	\$20 25%	10% 25%	10% 25%	C C	\$5 \$5	25% 25%	\$5 \$5	Q Q	NO NO
314	315	PPO NON PPO	\$350 \$350	A A	A	\$10 35%	15% 35%	15% 35%	-15% 35%	\$5 \$5	50% 50%+	50% 50%+	50% 50%+	NO NO
454	455	PPO NON PPO	\$350 \$450	A A	A	\$20 30%	10% 30%	10% 30%	C C	\$10 50%	\$40 50%	\$60 50%	50% 50%+	YES YES
414	415	PPO NON PPO	\$500 \$800	A D	A	20% 40%	20% 40%	20% 40%	20% 40%	\$10 D	50%	50%	D	YES NO
321	322	PPO NON PPO	\$250 \$300	A	A	\$20 30%	30%	I P	C	25% 50%+	25% 50%+	25% 50%+	25% 50%+	YES NO
PLANS OPEN ONLY TO SPECIFIC GROUPS														
421	422	PPO NON PPO	\$300 \$300	A A	A	\$10 30%	10% 30%	10% 30%	C C	\$5 \$5	\$25 \$25	30% 30%	30% 30%	YES YES
401	402	PPO NON PPO	\$300 \$300	A A	C	10% 30%	10% 30%	10% 30%	C C	\$10 \$10	25% 25%	25% 25%	30% 30%	YES YES
431	432	PPO FFS	A A	A A	A	\$10 50%	50%	C	C	40% 40%	40% 40%	40% 40%	40% 40%	NO NO
381	382	PPO NON PPO	\$350 \$400	\$200 \$200	A	\$20 25%	10% 20%	10% 20%	C C	30% 30%	30% 30%	30% 30%	30% 30%	YES YES
441	442	PPO NON PPO	\$250 \$250	A A	A	\$20 30%	10% 30%	10% 30%	C C	\$10 \$10	\$25 \$25	\$40 \$40	\$40 \$40	YES YES
444	445	PPO NON PPO	\$250 \$250	A A	A	\$20 30%	15% 30%	15% 30%	C C	\$10 \$10	\$30 \$30	\$45 \$45	\$45 \$45	YES YES



Nationwide High Deductible and Consumer Driven Health Plans

Plan Name	Telephone Number	Enrollment Code		Premium	
		Self	Self & Family	Self	Self & Family
APWU HEALTH PLAN-(CDHP)	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	663.91

High Deductible and Consumer Driven Health Plans for Your State

Plan Name	Telephone Number	Enrollment Code		Premium	
		Self	Self & Family	Self	Self & Family
AETNA HEALTH FUND-(CDHP)	877/459-6604	221	222	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



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

Enrollment Code	Benefit Type	Premium Contribution		CY Deductible		Catastrophic Limit		Office Visit	In-patient Surgery	Out-patient Surgery	Preventative Services	Prescription Drugs		
		HSA	HRA	Self	Self & Family	Self	Self & Family					Level I	Level II	Level III
474	IN-NETWORK OUT-NETWORK	B B	B B	\$600 \$600	\$1,200 \$1,200	\$3,000 \$9,000	\$4,500 \$9,000	15% 40%	A A	15% 40%	C E	25% D	25% D	25% D
341	IN-NETWORK OUT-NETWORK	\$60 \$60		\$1,500 \$1,500	\$3,000 \$3,000	\$5,000 \$5,000	\$10,000 \$10,000	5% 25%	5% 25%	5% 25%	C E	25% 25%+	25% 25%+	25% 25%+
481	IN-NETWORK OUT-NETWORK	\$70 \$70		\$2,000 \$2,000	\$4,000 \$4,000	\$5,000 \$7,500	\$10,000 \$15,000	\$15. 40%	G 40%	C 40%	C D	\$10 D	\$25 D	\$40 D

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

Enrollment Code		Location
Self	Self & Family	
221	222	MOST OF MASSACHUSETTS
224	225	MOST OF MASSACHUSETTS
DV1	DV2	CENTRAL/EASTERN MASSACHUSETTS

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

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

LOCATION	Total Monthly Premium		PLAN NAME	Enrollment Code		TELEPHONE NUMBER
	Self Only	Self & Family		Self Only	Self & Family	
SOUTHEASTERN MASSACHUSETTS	509.97	1351.44	BC & BS OF RHODE ISLAND - HIGH	DA1	DA2	401/459-5500
COUNTIES HAMPDEN, HAMPSHIRE, FRANKLI	492.22	1119.97	CONNECTICARE, INC - HIGH	TE1	TE2	800/251-7722
COUNTIES HAMPDEN, HAMPSHIRE, FRANKLI	438.38	997.45	CONNECTICARE, INC - STD	TE4	TE5	800/251-7722
CENTRAL/EASTERN MASSACHUSETTS	545.57	1325.96	FALLON COMMUNITY HEALTH PLAN- HIGH	JV1	JV2	800/868-5200
CENTRAL/EASTERN MASSACHUSETTS	488.78	1187.88	FALLON COMMUNITY HEALTH PLAN- STD	JV4	JV5	800/868-5200

SEE PLAN  
 BROCHURES  
 FOR BENEFIT  
 INFORMATION.

TCC

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Cleared @ OMB in 2008

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

We request that you provide your Social Security Number so that it may be used as your individual identifier in the FEHB program. Executive Order 9397 (November 22, 1943) allows Federal agencies to use the Social Security Number as an individual identifier to distinguish between people with the same or similar names. Failure to furnish the requested information may result in the U.S. Office of Personnel Management's (OPM) inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies. Agencies other than the OPM may have further routine uses for disclosure of information for the records system in which the file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

**Public Burden Statement.** We think this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, OPM Forms Officer, (3206-0202), Washington, D.C. 20415-7900. The OMB number, 3206-0180 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

LCP22



FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FEHB

OPEN SEASON

DPRS-2809

OMB 3206-0202

(Revised 11/17/07)

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.

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 Maintenance 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 at www.opm.gov/insure.health.

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.

Nationwide Fee-for-Service Plans Open to All

- 471 APWU-Self Only
472 APWU-Self and Family
104 Blue Cross/Blue Shield-Stnd-Self Only
105 Blue Cross/Blue Shield-Stnd-Self and Family
111 Blue Cross/Blue Shield-Basic-Self Only
112 Blue Cross/Blue Shield-Basic-Self and Family
311 GEHA-High-Self Only
312 GEHA-High-Self and Family
314 GEHA-Stnd-Self Only
315 GEHA-Stnd-Self and Family
454 Mail Handlers-Stnd-Self Only
455 Mail Handlers-Stnd-Self and Family
414 Mail Handlers-Value Option-Self Only
415 Mail Handlers-Value Option-Self and Family
321 NALC-Self Only
322 NALC-Self and Family

Nationwide Fee-for-Service Plans Open Only to Specific Groups

- 401 Foreign Service-Self Only
402 Foreign Service-Self and Family
421 Association Benefit Plan-Self Only
422 Association Benefit Plan-Self and Family
431 Panama Canal Area-Self Only
432 Panama Canal Area-Self and Family
381 Rural Carriers-Self Only
382 Rural Carriers-Self and Family
441 SAMBA-High-Self Only
442 SAMBA-High-Self and Family
444 SAMBA-Stnd-Self Only
445 SAMBA-Stnd-Self and Family

Nationwide High Deductible and Consumer-Driven Health Plans

- 474 APWU-CDHP-Self Only
475 APWU-CDHP-Self and Family
341 GEHA-HDHP Self Only
342 GEHA-HDHP Self and Family
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, 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 disability that began before age 22.

Table with columns: Name of Family Member, Social Security number, Date of birth, Sex, Relationship Code, Medicare, TRICARE, Other Insurance, Name of Insurance, Insurance Policy 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.

Signature

Daytime Telephone Number

Date

## 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 [www.opm.gov/insure/health](http://www.opm.gov/insure/health). To contact the carrier for a plan brochure, call the phone number provided in this package. NFC will not stock any brochures.

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

**Section II, Enrollment Codes and Plan Names.** Mark one block only in the Nationwide 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 [www.opm.gov/insure/health](http://www.opm.gov/insure/health) can help you choose your health plan. In addition to the info contained in this guide you will find information on:

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

**Additional Help.** If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit 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](http://www.nfc.usda.gov) and scroll down to the DPRS web site.

Visit our web site at [www.nfc.usda.gov](http://www.nfc.usda.gov) and scroll down to the DPRS web site.



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 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**

Not on pg 7

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.



DIRECT PREMIUM REMITTANCE SYSTEM

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

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

Features of an HRA include:

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

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.



2008 DPRS OPEN SEASON INFORMATION TCC ENROLLEES (102% PREMIUM)  
 FEE FOR SERVICE PLANS - ENROLLMENT CODES AND RATES

PLAN NAME	Telephone Number	Plan Option	Enrollment Code		Your Monthly Premium	
			Self Only	Self & Family	Self Only	Self & Family
APWU HEALTH PLAN	800/222-2798	HIGH	471	472	424.56	959.96
BLUE CROSS AND BLUE SHIELD	LOCAL	STANDARD	104	105	457.89	1048.51
BLUE CROSS AND BLUE SHIELD	LOCAL	BASIC	111	112	345.95	810.32
GEHA HEALTH BENEFIT PLAN	800/821-6136	HIGH	311	312	522.69	1137.58
GEHA HEALTH BENEFIT PLAN	800/821-6136	STANDARD	314	315	294.18	668.51
MAIL HANDLERS BENEFIT PLAN	800/410-7778	STANDARD	454	455	435.97	973.44
MAIL HANDLERS BENEFIT VALUE OPTION	800/410-7778	VALUE OPTION	414	415	181.26	432.16
NALC HEALTH BENEFIT PLAN	888/636-6252		321	322	450.48	979.69
<b>PLANS OPEN ONLY TO SPECIFIC GROUPS</b>						
ASSOCIATION BENEFIT PLAN	800/634-0069		421	422	448.96	1034.26
FOREIGN SERVICE BENEFIT PLAN	202/833-4910		401	402	427.88	1016.85
PANAMA CANAL AREA BENEFIT PLAN	800/548-8969		431	432	393.47	821.28
RURAL CARRIERS BENEFIT PLAN	800/638-8432		381	382	523.92	1065.97
SAMBA HEALTH BENEFIT PLAN	800/638-6589	HIGH	441	442	560.35	1319.64
SAMBA HEALTH BENEFIT PLAN	800/658-6589	STANDARD	444	445	405.85	926.91

DIRECT PREMIUM REMITTANCE SYSTEM

Not in 2011 pkg.

## 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

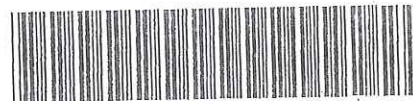
The health plans listed here have also made a commitment to offer you and your family access to healthcare quality and price/cost information so you can make more informed choices on which providers to use to receive care. The website information available includes online decision tools with cost estimators 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 [www.opm.gov/insure](http://www.opm.gov/insure) before you make your healthcare decisions. *102*

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 TCC ENROLLEES (102% PREMIUM)  
 FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

Enrollment Code		Benefit Type	Medical-Surgical - Amounts You Pay				Prescription Drugs				Mail Order Discount	
Self Only	Family		Calendar Year Per Person	Deductible Prescription Per Person	Hospital Inpatient	Primary Office Visits	Inpatient Surgery	Hospital Inpatient R&B	Level I	Level II		Level III
PLANS OPEN TO ALL												
471	472	PPO NON PPO	\$275 \$500	A A	A \$300	\$18 30%	10% 30%	10% 30%	\$8 50%	25% 50%	25% 50%	YES YES
104	105	PPO NON PPO	\$300 \$300	A A	\$100 H	\$15 25%	10% 25%	\$100 H	25% 45%+	25% 45%+	25% 45%+	YES YES
111	112	PPO	A	A	\$100 K	\$20	\$100	C	\$10	\$30	\$35 L	NO
311	312	PPO NON PPO	\$350 \$350	A A	\$100 \$300	\$20 25%	10% 25%	C C	\$5 \$5	25% 25%	\$5 \$5 Q	NO NO NO
314	315	PPO NON PPO	\$350 \$350	A A	A A	\$10 35%	15% 35%	15% 35%	\$5 \$5	50% 50%+	50% 50%+	NO NO
454	455	PPO NON PPO	\$350 \$450	A A	\$200 \$400	\$20 30%	10% 30%	C	\$10 50%	\$40 50%	\$60 50%	YES YES
414	415	PPO NON PPO	\$500 \$800	A D	A A	20% 40%	20% 40%	20% 40%	\$10 D	50% D	50% D	YES NO
321	322	PPO NON PPO	\$250 \$300	A	\$100	\$20 30%	I P	C	25% 50%+	25% 50%+	25% 50%+	YES NO
PLANS OPEN ONLY TO SPECIFIC GROUPS												
421	422	PPO NON PPO	\$300 \$300	A A	\$100 \$300	\$10 30%	10% 30%	C C	\$5 \$5	\$25 \$25	30% 30% M	YES YES
401	402	PPO NON PPO	\$300 \$300	A A	\$200 C	10% 30%	10% 30%	C C	\$10 \$10	25% 25% N	30% 30% D	YES YES
431	432	PDS FFS	A A	A A	\$50 \$125	\$10 50%	50% C	C	40% 40%	40% 40%	40% 40%	NO NO
381	382	PPO NON PPO	\$350 \$400	\$200 \$200	\$100 \$300	\$20 25%	10% 20%	C C	30% 30%	30% 30%	30% 30%	YES YES
441	442	PPO NON PPO	\$250 \$250	A A	\$200 \$300	\$20 30%	10% 30%	C	\$10 \$10	\$25 \$25	\$40 \$40	YES YES
444	445	PPO NON PPO	\$250 \$250	A A	\$200 \$300	\$20 30%	15% 30%	C	\$10 \$10	\$30 \$30 +J	\$45 \$45 +J	YES YES

## Nationwide High Deductible and Consumer Driven Health Plans

Plan Name	Telephone Number	Enrollment Code		Premium	
		Self	Self & Family	Self	Self & Family
APWU HEALTH PLAN-(CDHP)	800/222-2798	474	475	343.43	772.62
GEHA-(HDHP)	800/821-6136	341	342	388.43	887.19
MAILHANDLERS-(HDHP)	800/410-7778	481	482	298.84	677.19

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

Plan Name	Telephone Number	Enrollment Code		Premium	
		Self	Self & Family	Self	Self & Family
AETNA HEALTH FUND-(CDHP)	877/459-6604	221	222	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	YN2	531.31	1,205.24
HEALTHAMERICA-(HDHP)	866/351-5946	YW1	YW2	402.73	909.60
HEALTHAMERICA-(HDHP)	866/351-5946	9N1	9N2	392.67	885.94
UPMC HEALTH PLAN-(HDHP)	888/876-2756	8W4	8W5	481.43	1,160.87

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

Enrollment Code	Benefit Type	Premium Contribution		CY Deductible		Catastrophic Limit		Office Visit	In-patient Surgery	Out-patient Surgery	Preventative Services	Prescription Drugs		
		HSA	HRA	Self	Self & Family	Self	Self & Family					Level I	Level II	Level III
474	IN-NETWORK OUT-NETWORK	B B	B B	\$300 \$600	\$1,200 \$1,200	\$3,000 \$9,000	\$4,500 \$9,000	15% 40%	A A	15% 40%	C E	25% D	25% D	25% D
341	IN-NETWORK OUT-NETWORK	\$60 \$60		\$1,500 \$1,500	\$3,000 \$3,000	\$5,000 \$5,000	\$10,000 \$10,000	5% 25%	5% 25%	5% 25%	C E	25% 25%+	25% 25%+	25% 25%+
481	IN-NETWORK OUT-NETWORK	\$70 \$70		\$2,000 \$2,000	\$4,000 \$4,000	\$5,000 \$7,500	\$10,000 \$15,000	\$15 40%	G 40%	C 40%	C D	\$10 D	\$25 D	\$40 D

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

Enrollment Code	Location
221	PHIL/PITTS/LEHIGH VLLY/CENT/NE/SE PA
224	PHIL/PITTS/LEHIGH VLLY/CENT/NE SE PA
Y61	GREATER PITTSBURGH AREA
YN1	NORTHEAST PENNSYLVANIA
YW1	CENTRAL PENNSYLVANIA
9N1	SOUTHEASTERN PA
8W4	WESTERN PENNSYLVANIA AREA

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

ON page 4 of  
2011 pkg



2008 DPRS OPEN SEASON INFORMATION TCC ENROLLEES (102% PREMIUM)  
HMO AND POS PLANS FOR PENNSYLVANIA

LOCATION	Total Monthly Premium		PLAN NAME	Enrollment Code		TELEPHONE NUMBER
	Self Only	Self & Family		Self Only	Self & Family	
PITTSBURGH AREA AND WESTERN PA	294.22	811.29	AETNA OPEN ACCESS PITTS- HIGH	YE1	YE2	877/459-6604
PHILADELPHIA/CENTRAL/SOUTHEASTERN PA	533.65	1287.62	AETNA OPEN ACCESS- HIGH	P31	P32	877/459-6604
PHILADELPHIA/CENTRAL/SOUTHEASTERN PA	407.08	974.21	AETNA OPEN ACCESS- BASIC	P34	P35	877/459-6604
PENNSYLVANIA	645.08	1483.66	GEISINGER HEALTH PLAN- HIGH	GG1	GG2	800/447-4000
PENNSYLVANIA	534.93	1230.35	GEISINGER HEALTH PLAN- STD	GG4	GG5	800/447-4000
NORTHEAST PENNSYLVANIA	639.51	1470.89	HEALTHAMERICA NE- HIGH	4N1	4N2	866/351-5946
NORTHEAST PENNSYLVANIA	511.06	1175.48	HEALTHAMERICA NE- STD	4N4	4N5	866/351-5946
CENTRAL PENNSYLVANIA	602.23	1385.12	HEALTHAMERICA PA CENTRAL- HIGH	SW1	SW2	866/351-5946
CENTRAL PENNSYLVANIA	433.96	998.08	HEALTHAMERICA PA CENTRAL- STD	SW4	SW5	866/351-5946
GREATER PITTSBURGH AREA	490.40	1250.57	HEALTHAMERICA PA PITTS- HIGH	261	262	866/351-5946
GREATER PITTSBURGH AREA	351.75	896.98	HEALTHAMERICA PA PITTS- STD	264	265	866/351-5946
SOUTHEASTERN PENNSYLVANIA	605.03	1389.16	HEALTHAMERICA SE- HIGH	PN1	PN2	866/351-5946
SOUTHEASTERN PENNSYLVANIA	410.79	943.14	HEALTHAMERICA SE- STD	PN4	PN5	866/351-5946
PHILADELPHIA AREA	491.40	1296.17	KEYSTONE HLTHPLAN EAST- HIGH	ED1	ED2	800/227-3115
PHILADELPHIA AREA	427.20	1127.48	KEYSTONE HLTHPLAN EAST- STD	ED4	ED5	800/227-3115
HARRISBURG/NORTHERN REGION/LEHIGH VA	560.67	1337.34	KEYSTONE- HIGH	S41	S42	800/622-2843
HARRISBURG/NORTHERN REGION/LEHIGH VA	515.91	1230.95	KEYSTONE- STD	S44	S45	800/622-2843
WESTERN PENNSYLVANIA	484.96	1237.05	UPMC HEALTH PLAN- HIGH	8W1	8W2	888/876-2756
WESTERN PENNSYLVANIA	427.48	1090.41	UPMC HEALTH PLAN- STD	UW4	UW5	888/876-2756

SEE PLAN

BROCHURES

FOR BENEFIT

INFORMATION.



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Cleared at OMB in 2008

**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 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/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

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

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

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

**Public Burden Statement.** We 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.

40202



**REQUEST TO CHANGE FEHB ENROLLMENT FOR 2008 PLAN YEAR**

Read the enclosed instructions before completing this form. Return this form to: USDAO/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.**

**FEHB**

**OPEN SEASON**

**DPRS-2809**

OMB 3206-0202

(Revised 11/07)

**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 Maintenance 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 at [www.opm.gov/insure.health](http://www.opm.gov/insure.health).

**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.

**Nationwide Fee-for-Service Plans Open to All:**

- 471  APWU-Self Only
- 472  APWU-Self and Family
- 104  Blue Cross/Blue Shield-Stnd-Self Only
- 105  Blue Cross/Blue Shield-Stnd-Self and Family
- 111  Blue Cross/Blue Shield-Basic-Self Only
- 112  Blue Cross/Blue Shield-Basic-Self and Family
- 311  GEHA-High-Self Only
- 312  GEHA-High-Self and Family
- 314  GEHA-Stnd-Self Only
- 315  GEHA-Stnd-Self and Family
- 454  Mail Handlers-Stnd-Self Only
- 455  Mail Handlers-Stnd-Self and Family
- 414  Mail Handlers-Value Option-Self Only
- 415  Mail Handlers-Value Option-Self and Family
- 321  NALC-Self Only
- 322  NALC-Self and Family

**Nationwide Fee-for-Service Plans Open Only to Specific Groups**

- 401  Foreign Service-Self Only
- 402  Foreign Service-Self and Family
- 421  Association Benefit Plan-Self Only
- 422  Association Benefit Plan-Self and Family
- 431  Panama Canal Area-Self Only
- 432  Panama Canal Area-Self and Family
- 381  Rural Carriers-Self Only
- 382  Rural Carriers-Self and Family
- 441  SAMBA-High-Self Only
- 442  SAMBA-High-Self and Family
- 444  SAMBA-Stnd-Self Only
- 445  SAMBA-Stnd-Self and Family

**Nationwide High Deductible and Consumer-Driven Health Plans**

- 474  APWU-CDHP-Self Only
- 475  APWU-CDHP-Self and Family
- 341  GEHA-HDHP Self Only
- 342  GEHA-HDHP Self and Family
- 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, 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 disability that began before age 22.

Name of Family Member (last, first, middle initial)	Social Security number	Date of Birth	Sex	Relationship Code
			M <input type="checkbox"/> F <input type="checkbox"/>	TRICARE <input type="checkbox"/> Other insurance <input type="checkbox"/>
			A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>	Medicare <input type="checkbox"/> Insurance Policy Number <input type="checkbox"/>

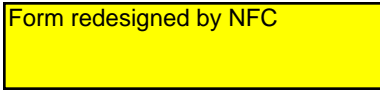
Address (if different from enrolled)

**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.

Signature

Daytime Telephone Number

Date



## 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 [www.opm.gov/insure/health](http://www.opm.gov/insure/health). To contact the carrier for a plan brochure, call the phone number provided in this package. NFC will not stock any brochures.

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

**Section II, Enrollment Codes and Plan Names.** Mark one block only in the Nationwide 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 [www.opm.gov/insure/health](http://www.opm.gov/insure/health) can help you choose your health plan. In addition to the info contained in this guide you will find information on:

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

**Additional Help.** If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit 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](http://www.nfc.usda.gov) and scroll down to the DPRS web site.

Visit our web site at [www.nfc.usda.gov](http://www.nfc.usda.gov) and scroll down to the DPRS web site.



page 1 of 2011 PKG.

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
- O - \$30 MINIMUM
- P - 15% OR 30%
- Q - PLUS DIFFERENCE

**PRESCRIPTION DRUG PAYMENT LEVELS** *Not on page 7 of 2011 PKG.*

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.

*See pgs 4 & 5 of 2011 PKG.*

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.

DIRECT PREMIUM REMITTANCE SYSTEM*ps 4 of 2011 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.

*at top of 2011 pkg.*  
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 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 HSA.
- Tax-deferred interest earned on the account.
- Tax-free withdrawals for qualified medical expenses
- Carryover of unused funds and interest from year to year.
- Portability; the account is owned by you and yours to keep – even when you retire, leave government service or change plans.

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

Features of an HRA include:

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

*at top of 2011 pkg.*  
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 preventative care.



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

PLAN NAME	Telephone Number	Plan Option	Enrollment Code		Your Monthly Premium	
			Self Only	Self & Family	Self Only	Self & Family
<b>PLANS OPEN TO ALL</b>						
APWU HEALTH PLAN	800/222-2798	HIGH	471	472	104.06	235.28
BLUE CROSS AND BLUE SHIELD	LOCAL	STANDARD	104	105	134.66	314.47
BLUE CROSS AND BLUE SHIELD	LOCAL	BASIC	111	112	84.79	198.61
GEHA HEALTH BENEFIT PLAN	800/821-6136	HIGH	311	312	198.19	401.79
GEHA HEALTH BENEFIT PLAN	800/821-6136	STANDARD	314	315	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	414	415	44.43	105.92
NALC HEALTH BENEFIT PLAN	888/636-6252		321	322	127.40	247.00
<b>PLANS OPEN ONLY TO SPECIFIC GROUPS</b>						
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		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	HIGH	441	442	235.11	580.28
SAMBA HEALTH BENEFIT PLAN	800/658-6589	STANDARD	444	445	99.47	227.18

Not in 2011 PKG

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 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](http://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:

- |                                      |   |
|--------------------------------------|---|
| Aetna                                | HIP Health Plan of New York   |
| APWU Health Plan                     | HMO Health Ohio   |
| AvMed Health Plans                   | Humana  |
| Blue Cross & Blue Shield of RI       | Independent Health Association, Inc.                                  |
| BlueCross BlueShield                 | Kaiser Foundation Health Plan (except Hawaii)                         |
| Government Wide Service Benefit Plan | M.D. IPA  |
| CareFirst BlueChoice, Inc            | Medica Health Plans   |
| ConnectiCare, Inc                    | MVP Health Care, Inc.   |
| Blue Choice                          | NALC Health Benefit Plan  |
| Geisinger Health Plan                | PacifiCare Health Plans   |
| Government Employees                 | Panama Canal Area Benefit Plan  |
| Health Association, Inc. (GEHA)      | SAMBA   |
| Group Health Incorporated            | SuperMed HMO  |
| Health Net of Arizona, Inc.          | UniCare   |
| Health Net of California             | UnitedHealthcare (except the River Valley, Inc. in Iowa and Illinois) |
| HealthPartners, Inc.                 | UPMC Health Plan  |
| HealthPlus of Michigan               |   |



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

Enrollment Code	Benefit Type	Medical-Surgical - Amounts You Pay				Prescription Drugs			Mail Order Discount	
		Calendar Year Per Person	Deductible	Primary Office Visits	Inpatient Surgery	Hospital Inpatient R&B	Level I	Level II		Level III
<b>PLANS OPEN TO ALL</b>										
471	PPO NDN PPO	\$275 \$500	A A	\$18 30%	10% 30%	10% 30%	\$8 50%	25% 50%	25% 50%	YES YES
104	PPO NDN PPO	\$300 \$300	A A	\$15 25%	10% 25%	\$100 H	25% 45%+	25% 45%+	25% 45%+	YES YES
111	PPO	A	A	\$20	\$100	C	\$10	\$30	\$35 L	NO
311	PPO NDN PPO	\$350 \$350	A A	\$20 25%	10% 25%	C C	\$5 \$5	25% 25%	\$5 Q \$5 Q	NO NO
314	PPO NDN PPO	\$350 \$350	A A	\$10 35%	15% 35%		\$5 \$5	50% 50%+	50% 50%+	NO NO
454	PPO NDN PPO	\$350 \$450	A A	\$20 30%	10% 30%	C	\$10 50%	\$40 50%	\$60 50%	YES YES
414	PPO NDN PPO	\$500 \$800	A D	20% 40%	20% 40%	A A	\$10 D	50% D	50% D	YES NO
321	PPO NDN PPO	\$250 \$300	A \$25	\$20 30%	I P	C	25% 50%+	25% 50%+	25% 50%+	YES NO
<b>PLANS OPEN ONLY TO SPECIFIC GROUPS</b>										
421	PPO NDN PPO	\$300 \$300	A A	\$10 30%	10% 30%	C C	\$5 \$5	\$25 \$25	30% M 30% M	YES YES
401	PPO NDN PPO	\$300 \$300	A A	10% 30%	10% 30%	C C	\$10 \$10	25% N 25% N	30% O 30% O	YES YES
431	PDS FFS	A A	A A	\$10 50%	50% C	C	40% 40%	40% 40%	40% 40%	NO NO
381	PPO NDN PPO	\$350 \$400		\$20 25%	10% 20%	C C	30% 30%	30% 30%	30% 30%	YES YES
441	PPO NDN PPO	\$250 \$250	A A	\$20 30%	10% 30%	C C	\$10 \$10	\$25 \$25	\$40 \$40	YES YES
444	PPO NDN PPO	\$250 \$250	A A	\$20 30%	15% 30%	C C	\$10 \$10	\$30 +U \$30 +U	\$45 +U \$45 +U	YES YES



Nationwide High Deductible and Consumer Driven Health Plans

Plan Name	Telephone Number	Enrollment Code		Premium	
		Self	Self & Family	Self	Self & Family
APWU HEALTH PLAN-(CDHP)	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

High Deductible and Consumer Driven Health Plans for Your State

Plan Name	Telephone Number	Enrollment Code		Premium	
		Self	Self & Family	Self	Self & Family
AETNA HEALTH FUND-(CDHP)	877/459-6604	221	222	82.06	188.75
AETNA HEALTH FUND-(HDHP)	877/459-6604	224	225	67.00	146.72
AULTCARE HMO-(HDHP)	330/363-6360	3A4	3A5	91.29	182.91
BLUE CROSS AND BLUE SHIELD-(HDHP)	LOCAL PHONE	114	115	84.79	198.61
HUMANA COVERAGEFIRST-(CDHP)	888/393-6765	L81	L82	75.94	174.67
UNITED HEALTHCARE INS CO-(HDHP)	877/835-9861	E91	E92	89.55	198.03

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

Enrollment Code	Benefit Type	Premium Contribution		CY Deductible		Catastrophic Limit		Office Visit	In-patient Surgery	Out-patient Surgery	Preventative Services	Prescription Drugs		
		HSA	HRA	Self	Self & Family	Self	Self & Family					Level I	Level II	Level III
474	IN-NETWORK OUT-NETWORK	B B	B B	\$600 \$600	\$1,200 \$1,200	\$3,000 \$9,000	\$4,500 \$9,000	15% 40%	A A	15% 40%	C E	25% D	25% D	25% D
341	IN-NETWORK OUT-NETWORK	\$60 \$60		\$1,500 \$1,500	\$3,000 \$3,000	\$5,000 \$5,000	\$10,000 \$10,000	5% 25%	5% 25%	5% 25%	C E	25% 25%+	25% 25%+	25% 25%+
481	IN-NETWORK OUT-NETWORK	\$70 \$70		\$2,000 \$2,000	\$4,000 \$4,000	\$5,000 \$7,500	\$10,000 \$15,000	\$15 40%	G 40%	C 40%	C D	\$10 D	\$25 D	\$40 D

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

Enrollment Code	Location	SEE PLAN BROCHURES FOR BENEFIT INFORMATION		
		Self	Self & Family	
221	CINCINNATI/CLEVELAND/COLUMBUS/TOLEDO			
224	CINCINNATI/CLEVELAND/COLUMBUS/TOLEDO			
3A4	STARK/CARROLL/HOLMES/TUSCARAWAS/WAYNE			
114	OHIO			
L81	CINCINNATI			
E91	CLEVELAND AND COLUMBUS AREAS			

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

page 4 of 2011 pkg.



2008 DPRS OPEN SEASON INFORMATION - ENROLLEES  
 HMO AND POS PLANS FOR OHIO

LOCATION	Total Monthly Premium		PLAN NAME	Enrollment Code		TELEPHONE NUMBER
	Self Only	Self & Family		Self Only	Self & Family	
COLUMBUS AREA	98.28	237.26	AETNA OPEN ACCESS- HIGH	ND1	ND2	877/459-6604
GREATER CINCINNATI AREA	172.95	491.12	AETNA OPEN ACCESS- HIGH	RD1	RD2	877/459-6604
CLEVELAND AND TOLEDO AREAS	107.08	289.34	AETNA OPEN ACCESS- HIGH	7D1	7D2	877/459-6604
STARK/CARROLL/HOLMES/TUSCARAWAS/WAYN	181.16	502.80	AULTCARE HMO- HIGH	3A1	3A2	330/363-6360
EASTERN OHIO	103.46	238.38	HEALTH PLAN UPPER OH VLY- HIGH	U41	U42	800/524-6961
NORTHEAST OHIO	168.53	521.48	HMO HEALTH OHIO- HIGH	L41	L42	800/522-2066
CLEVELAND/AKRON AREAS	150.63	427.36	KAISER PERMANENTE- HIGH	641	642	800/686-7100
CLEVELAND/AKRON AREAS	76.98	188.88	KAISER PERMANENTE- STD	644	645	800/686-7100
NORTHWEST/NORTH CENTRAL OHIO	103.38	278.96	PARAMOUNT HEALTH CARE- HIGH	U21	U22	800/462-3589
CLEVELAND, AKRON AND CANTON AREAS	159.84	376.94	SUMMACARE HEALTH PLAN- HIGH	5W1	5W2	330/996-8700
NORTHEAST OHIO	339.28	958.23	SUPER MED HMO- HIGH	5M1	5M2	800/522-2066
CLEVELAND	133.58	325.46	UNITED HEALTHCARE OF OH- HIGH	AK1	AK2	877/835-9861
COLUMBUS	156.11	371.83	UNITED HEALTHCARE OF OH- HIGH	CA1	CA2	877/835-9861

SEE PLAN  
 BROCHURES  
 FOR BENEFIT  
 INFORMATION.

Law 4

Direct Pay

Cleared @ OMB in 2008

**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 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/or your family's eligibility for payment of a claim for health benefits-services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

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

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

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

**Public Burden Statement.** We think this form takes an average of 45 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, OPM Forms Officer, (3206-0202), Washington, D.C. 20415-7900. The OMB number, 3206-0160 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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**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 Maintenance 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 at [www.opm.gov/insure/health](http://www.opm.gov/insure/health).

**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.

- |   |   |
|---|---|
| Nationwide Fee-for-Service Plans Open to All                              | Nationwide Fee-for-Service Plans Open Only to Specific Groups         |
| 471 <input type="checkbox"/> APWU-Self Only                               | 401 <input type="checkbox"/> Foreign Service-Self Only                |
| 472 <input type="checkbox"/> APWU-Self and Family                         | 402 <input type="checkbox"/> Foreign Service-Self and Family          |
| 104 <input type="checkbox"/> Blue Cross/Blue Shield-Stnd-Self Only        | 421 <input type="checkbox"/> Association Benefit Plan-Self Only       |
| 105 <input type="checkbox"/> Blue Cross/Blue Shield-Stnd-Self and Family  | 422 <input type="checkbox"/> Association Benefit Plan-Self and Family |
| 111 <input type="checkbox"/> Blue Cross/Blue Shield-Basic-Self Only       | 431 <input type="checkbox"/> Panama Canal Area-Self Only              |
| 112 <input type="checkbox"/> Blue Cross/Blue Shield-Basic-Self and Family | 432 <input type="checkbox"/> Panama Canal Area-Self and Family        |
| 311 <input type="checkbox"/> GEHA-High-Self Only                          | 381 <input type="checkbox"/> Rural Carriers-Self Only                 |
| 312 <input type="checkbox"/> GEHA-High-Self and Family                    | 382 <input type="checkbox"/> Rural Carriers-Self and Family           |
| 314 <input type="checkbox"/> GEHA-Stnd-Self Only                          | 441 <input type="checkbox"/> SAMBA-High-Self Only                     |
| 315 <input type="checkbox"/> GEHA-Stnd-Self and Family                    | 442 <input type="checkbox"/> SAMBA-High-Self and Family               |
| 454 <input type="checkbox"/> Mail Handlers-Stnd-Self Only                 | 444 <input type="checkbox"/> SAMBA-Stnd-Self Only                     |
| 455 <input type="checkbox"/> Mail Handlers-Stnd-Self and Family           | 445 <input type="checkbox"/> SAMBA-Stnd-Self and Family               |
| 414 <input type="checkbox"/> Mail Handlers-Value Option-Self Only         |   |
| 415 <input type="checkbox"/> Mail Handlers-Value Option-Self and Family   |   |
| 321 <input type="checkbox"/> NALC-Self Only                               |   |
| 322 <input type="checkbox"/> NALC-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. 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 disability that began before age 22.

Name of Family Member (last, first, middle initial)	Social Security Number	Date of Birth	Sex	Relationship Code
Address (if different from enrollee)	Medicare	M <input type="checkbox"/> F <input type="checkbox"/>		TRICARE
	A <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/>		Other Insurance	
	Name of Insurance		Insurance Policy Number	

**Section IV. Address Correction**

I need to correct my address. The changes are indicated in the box below.

[Empty box for address correction]

**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.

Signature \_\_\_\_\_ Daytime Telephone Number \_\_\_\_\_ Date \_\_\_\_\_

DR25A (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 may not be eligible to change later, even if you do not wish to pay an increased premium cost for your enrollment.

**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 [www.opm.gov/insure/health](http://www.opm.gov/insure/health). To contact the carrier for a plan brochure, call the phone number provided in this package. NFC will not stock any brochures.

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

**Section II, Enrollment Codes and Plan Names.** Mark one block only in the Nationwide 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 [www.opm.gov/insure/health](http://www.opm.gov/insure/health) can help you choose your health plan. In addition to the info contained in this guide you will find information on:

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

**Additional Help.** If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit 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](http://www.nfc.usda.gov) and scroll down to the DPRS web site.

Visit our web site at [www.nfc.usda.gov](http://www.nfc.usda.gov) and scroll down to the DPRS web site.



DIRECT PREMIUM REMITTANCE SYSTEM

OPEN SEASON INFORMATION

*This is on page 7 of the 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
- 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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DIRECT PREMIUM REMITTANCE SYSTEM

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

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

Features of an HRA include:

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

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

PLAN NAME PLANS OPEN TO ALL	Telephone Number	Plan Option	Enrollment Code		Your Monthly Premium	
			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	105	134.66	314.47
BLUE CROSS AND BLUE SHIELD	LOCAL	BASIC	111	112	84.79	198.61
GEHA HEALTH BENEFIT PLAN	800/821-6136	HIGH	311	312	198.19	401.79
GEHA HEALTH BENEFIT PLAN	800/821-6136	STANDARD	314	315	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	414	415	44.43	105.92
NALC HEALTH BENEFIT PLAN	888/636-6252		321	322	127.40	247.00
<b>PLANS OPEN ONLY TO SPECIFIC GROUPS</b>						
ASSOCIATION BENEFIT PLAN	800/634-0069		421	422	125.91	300.50
FOREIGN SERVICE BENEFIT PLAN	202/833-4910		401	402	105.24	259.43
PANAMA CANAL AREA BENEFIT PLAN	800/548-8969		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	HIGH	441	442	235.11	580.28
SAMBA HEALTH BENEFIT PLAN	800/658-6589	STANDARD	444	445	99.47	227.18

Not in 2011 pkg

## 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 [www.opm.gov/insure](http://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:

Aetna	HIP Health Plan of New York
APWU Health Plan	HMO Health Ohio
AvMed Health Plans	Humana
Blue Cross & Blue Shield of RI	Independent Health Association, Inc.
BlueCross BlueShield	Kaiser Foundation Health Plan (except Hawaii)
Government Wide Service Benefit Plan	M.D. IPA
CareFirst BlueChoice, Inc	Medica Health Plans
ConnectiCare, Inc	MVP Health Care, Inc.
Blue Choice	NALC Health Benefit Plan
Geisinger Health Plan	PacificCare Health Plans
Government Employees	Panama Canal Area Benefit Plan
Health Association, Inc. (GEHA)	SAMBA
Group Health Incorporated	SuperMed, HMO
Health Net of Arizona, Inc.	UniCare
Health Net of California	UnitedHealthcare (except the River Valley, Inc. in Iowa and Illinois)
HealthPartners, Inc.	UPMC Health Plan
HealthPlus of Michigan	



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

Enrollment Code		Medical-Surgical - Amounts You Pay										Prescription Drugs					
Self Only	Self & Family	Benefit Type	Deductible		Calendar Year Per Person		Hospital		Doctor Care		Hospital		Level I	Level II	Level III	Mail Order Discount	
			Prescription Per Person	Per Person	Hospital Inpatient	Hospital Inpatient	Primary Office Visits	Inpatient Surgery	Inpatient R&B	Inpatient R&B							
PLANS OPEN TO ALL																	
471	472	PPO NON PPO	\$275 \$500	A A	A A	\$300 \$300	A A	\$18 30%	10% 30%	10% 30%	10% 30%	10% 30%	\$8 50%	25% 50%	25% 50%	YES YES	
104	105	PPO NON PPO	\$300 \$300	A A	A A	\$100 \$100	H H	\$15 25%	10% 25%	10% 25%	\$100	H	25% 45%+	25% 45%+	25% 45%+	YES YES	
111	112	PPO	A	A	A	\$100	K	\$20	\$100	\$100	C	C	\$30	\$35	L	NO	
311	312	PPO NON PPO	\$350 \$350	A A	A A	\$100 \$300	A A	\$20 25%	10% 25%	10% 25%	C C	C C	\$5 \$5	25% 25%	\$5 \$5	NO NO	
314	315	PPO NON PPO	\$350 \$350	A A	A A	A A	A A	\$10 35%	15% 35%	15% 35%	.15% 35%		50% 50%+	50% 50%+	50% 50%+	NO NO	
454	455	PPO NON PPO	\$350 \$450	A A	A A	\$200 \$400	A A	\$20 30%	10% 30%	10% 30%	30%	C	\$40 50%	\$60 50%	\$60 50%	YES YES	
414	415	PPO NON PPO	\$500 \$800	A D	A D	A A	A A	20% 40%	20% 40%	20% 40%	20% 40%		50% D	50% D	50% D	YES NO	
321	322	PPO NON PPO	\$250 \$300	A A	A A	\$100	A	\$20 30%	I P	30%	30%	C	25% 50%+	25% 50%+	25% 50%+	YES NO	
PLANS OPEN ONLY TO SPECIFIC GROUPS																	
421	422	PPO NON PPO	\$300 \$300	A A	A A	\$100 \$300	A C	\$10 30%	10% 30%	10% 30%	10% 30%	C C	\$5 \$5	\$25 \$25	30% 30%	30% 30%	YES YES
401	402	PPO NON PPO	\$300 \$300	A A	A A	\$200	C	10% 30%	10% 30%	10% 30%	C C	C C	\$10 \$10	25% 25%	N N	30% 30%	YES YES
431	432	POS FFS	A A	A A	A A	\$50 \$125	A A	\$10 50%	50%	50%	C	C	40% 40%	40% 40%	40% 40%	NO NO	
381	382	PPO NON PPO	\$350 \$400	A A	A A	\$100 \$300	A A	\$20 25%	10% 20%	10% 20%	C C	C C	30% 30%	30% 30%	30% 30%	YES YES	
441	442	PPO NON PPO	\$250 \$250	A A	A A	\$200 \$300	A A	\$20 30%	10% 30%	10% 30%	30%	C	\$10 \$10	\$25 \$25	\$40 \$40	\$40 \$40	YES YES
444	445	PPO NON PPO	\$250 \$250	A A	A A	\$200 \$300	A A	\$20 30%	15% 30%	15% 30%	30%	C	\$10 \$10	\$30 \$30	\$45 \$45	\$45 \$45	YES YES

### Nationwide High Deductible and Consumer Driven Health Plans

Plan Name	Telephone Number	Enrollment Code		Premium	
		Self	Self & Family	Self	Self & Family
APWU HEALTH PLAN-(CDHP)	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

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

Plan Name	Telephone Number	Enrollment Code		Premium	
		Self	Self & Family	Self	Self & Family
AETNA HEALTH FUND-(CDHP)	877/459-6604	221	222	82.06	188.75
AETNA HEALTH FUND-(HDHP)	877/459-6604	224	225	67.00	146.72
BLUE CROSS AND BLUE SHIELD-(HDHP)	LOCAL PHONE	114	115	84.79	198.61
HUMANA COVERAGEFIRST-(CDHP)	888/393-6765	BT1	BT2	83.54	192.14
HUMANA COVERAGEFIRST-(CDHP)	888/393-6765	L61	L62	83.54	192.14
UNITED HEALTHCARE INS CO-(HDHP)	877/835-9861	E91	E92	89.55	198.03

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

Enrollment Code	Benefit Type	Premium Contribution		CY Deductible		Catastrophic Limit		Office Visit	In-patient Surgery	Out-patient Surgery	Preventative Services	Prescription Drugs		
		HSA	HRA	Self	Self & Family	Self	Self & Family					Level I	Level II	Level III
474	IN-NETWORK OUT-NETWORK	B	B	\$600	\$1,200	\$3,000	\$4,500	15%	A	15%	C	25%	25%	25%
341	IN-NETWORK OUT-NETWORK	\$60	\$60	\$1,500	\$3,000	\$5,000	\$10,000	5%	5%	5%	C	25%	25%	25%+
481	IN-NETWORK OUT-NETWORK	\$70	\$70	\$2,000	\$4,000	\$5,000	\$10,000	\$15	G	C	C	\$10	\$25	\$40

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

Enrollment Code	Location
221	MOST OF TENNESSEE
224	MOST OF TENNESSEE
114	TENNESSEE
BT1	NASHVILLE
L61	MEMPHIS
E91	TENNESSEE

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

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2008 DPRS OPEN SEASON INFORMATION DIRECT PAY ENROLLEES  
 HMO AND POS PLANS FOR TENNESSEE

LOCATION	Total Monthly Premium		PLAN NAME	Enrollment Code		TELEPHONE NUMBER
	Self Only	Self & Family		Self Only	Self & Family	
MEMPHIS AREA NASHVILLE AREA	94.32	248.65	AETNA OPEN ACCESS-	UB1	UB2	877/459-6604 877/459-6604
	247.22	566.59	AETNA OPEN ACCESS-	6U1	6U2	

SEE PLAN  
 BROCHURES  
 FOR BENEFIT  
 INFORMATION.