Spouse Equity

how I

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.

TABLE OF CONTENTS

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

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

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

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

Public Burden Statement. We 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, 3206-0460 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

0202

HEALTH BENEFITS PROGRAM

FEHB

OPEN SEASON

DPRS-2809

OMB 3206-0202

(Revised 11/07)

REQUEST TO CHANGE FEHB ENROLLMENT FOR 2008 PLAN YEAR

Read the enclosed instructions before completing this form. Return this form to: USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161

Do not take any action to maintain your present coverage.

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

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

☐ **Change Enrollment.** I want to change my FEHB enrollment. I have indicated my selection in Section II. I have either: (1) marked the block of a Nationwide plan, or (2) entered the enrollment code and plan name of an Health Maintenace Organization (HMO) plan, Regional High Deductible Health Plan (HDHP), or Consumer Driven Health Plan (CDHP).

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the 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

HMO Plan or HDHP or CDHP

Enrollment Code	Name of Plan

Note: If changing Plans to an HMO Plan or HDHP or CDHP, please use the box above to request the change.

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 ☐F	
Address (if different from enrollee)		Medicare	TRICARE	Other Insurance
		☐A ☐B ☐D		☐
		Name of Insurance		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

DR25A (revised 11/07)

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. 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 can help you choose your health plan. In addition to the info contained in this guide you will find information on:

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

Additional Help. If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit from 7:45 a.m. to 4:00 p.m., CST, weekdays or write to: DPRS, P.O. Box 61760, New Orleans, LA. 70161-1760.Visit our web site at www.nfc.usda.gov and scroll down to the DPRS web site.

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

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

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

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 haveMedicare. HRAs are similar to HSAs except an enrollee cannotmake deposits into an HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

Features of an HRA include:

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

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

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
PLANS OPEN TO ALL						
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
PLANS OPEN ONLY TO SPECIFIC GROUPS						
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 before you make your healthcare decisions. N.O

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 SPOUSE EQUITY ENROLLEES (100% PREMIUM)
FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

Enrollment Code		Benefit Type	Medical-Surgical - Amounts You Pay						Prescription Drugs			
			Deductible			Doctor Care		Hospital				
Self Only	Self & Family		Calendar Year Per Person	Prescription Per Person	Hospital Inpatient	Primary Office Visits	Inpatient Surgery	Inpatient R&B	Level I	Level II	Level III	Mail Order Discount
PLANS OPEN TO ALL												
471	472	PPO	$275	A	A	$18	10%	10%	$8	25%	25%	YES
		NON PPO	$500	A	$300	30%	30%	30%	50%	50%	50%	YES
104	105	PPO	$300	A	$100	$15	10%	$100	25%	25%	25%	YES
		NON PPO	$300	A	H	25%	25%	H	45%+	45%+	45%+	YES
111	112	PPO	A	A	$100 K	$20	$100	C	$10	$30	$35 L	NO
311	312	PPO	$350	A	$100	$20	10%	C	$5	25%	$5 Q	NO
		NON PPO	$350	A	$300	25%	25%	C	$5	25%	$5 Q	NO
314	315	PPO	$350	A	A	$10	15%	15%	$5	50%	50%	NO
		NON PPO	$350	A	A	35%	35%	35%	$5	50%+	50%+	NO
454	455	PPO	$350	A	$200	$20 C	10%	C	$10	$40	$60	YES
		NON PPO	$450	A	$400	30%	30%	30%	50%	50%	50%	YES
414	415	PPO	$500	A	A	20%	20%	20%	$10	50%	50%	YES
		NON PPO	$800	D	A	40%	40%	40%	D	D	D	NO
321	322	PPO	$250	A	A	$20	I	C	25%	25%	25%	YES
		NON PPO	$300	$25	$100	30%	P	30%	50%+	50%+	50%+	NO
PLANS OPEN ONLY TO SPECIFIC GROUPS												
421	422	PPO	$300	A	$100	$10	10%	C	$5	$25	30% M	YES
		NON PPO	$300	A	$300	30%	30%	C	$5	$25	30% M	YES
401	402	PPO	$300	A	C	10%	10%	C	$10	25% N	30% O	YES
		NON PPO	$300	A	$200	30%	30%	C	$10	25% N	30% O	YES
431	432	POS	A	A	$50	$10	C	C	40%	40%	40%	NO
		FFS	A	A	$125	50%	50%	50%	40%	40%	40%	NO
381	382	PPO	$350	$200	$100	$20	10%	C	30%	30%	30%	YES
		NON PPO	$400	$200	$300	25%	20%	C	30%	30%	30%	YES
441	442	PPO	$250	A	$200	$20 C	10%	C	$10	$25	$40	YES
		NON PPO	$250	A	$300	30%	30%	30%	$10	$25	$40	YES
444	445	PPO	$250	A	$200	$20 C	15%	C	$10	$30 +J	$45 +J	YES
		NON PPO	$250	A	$300	30%	30%	30%	$10	$30 +J	$45 +J	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		Catatrophic Limit		Office Visit	In-patient Surgery	Out-patient Surgery	Preventative Services	Prescription Drugs		
Self	Self & Family		HSA	HRA	Self	Self & Family	Self	Self & Family					Level I	Level II	Level III
474	475	IN-NETWORK	B	B	$600	$1,200	$3,000	$4,500	15%	A	15%	C	25% D	25% D	25% D
		OUT-NETWORK	B	B	$600	$1,200	$9,000	$9,000	40%	A	40%	E			
341	342	IN-NETWORK	$60		$1,500	$3,000	$5,000	$10,000	5%	5%	5%	C	25%	25%	25%
		OUT-NETWORK	$60		$1,500	$3,000	$5,000	$10,000	25%	25%	25%	E	25%+	25%+	25%+
481	482	IN-NETWORK	$70		$2,000	$4,000	$5,000	$10,000	$15.	G	C	C	$10 D	$25 D	$40 D
		OUT-NETWORK	$70		$2,000	$4,000	$7,500	$15,000	40%	40%	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 or providers in a designated service are (like an HMO), or (2) out-of-network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non– HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

page 4 of 2011 pkg

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

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 haw2
Cleared @ OND 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.

TABLE OF CONTENTS

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

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

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

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

Public Burden Statement. We 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, 3206-0160 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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FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FEHB

OPEN SEASON

DPRS-2809

OMB 3206-0202

(Revised (11/07)

REQUEST TO CHANGE FEHB ENROLLMENT FOR 2008 PLAN YEAR

Read the enclosed instructions before completing this form. Return this form to: USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161

Do not take any action to maintain your present coverage.

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

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

☐ **Change Enrollment.** I want to change my FEHB enrollment. I have indicated my selection in Section II. I have either: (1) marked the block of a Nationwide plan, or (2) entered the enrollment code and plan name of an Health Maintenace Organization (HMO) plan, Regional High Deductible Health Plan (HDHP), or Consumer Driven Health Plan (CDHP).

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the 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

HMO Plan or HDHP or CDHP

Enrollment Code	Name of Plan

Note: If changing Plans to an HMO Plan or HDHP or CDHP, please use the box above to request the change.

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 ☐F	
Address (if different from enrollee)		Medicare	TRICARE	Other Insurance
		☐A ☐B ☐D		☐
		Name of Insurance		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

R25A (revised (11/07)

Form redesigned 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. 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 can help you choose your health plan. In addition to the info contained in this guide you will find information on:

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

Additional Help. If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit from 7:45 a.m. to 4:00 p.m., CST, weekdays or write to: **DPRS, P.O. Box 61760, New Orleans, LA. 70161-1760.** Visit our web site at www.nfc.usda.gov and scroll down to the DPRS web site.

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

DIRECT PREMIUM REMITTANCE SYSTEM

OPEN SEASON INFORMATION

page 7 of 2011 pkg.

The 2007 Open Season for Spouse Equity/Temporary Continuation of Coverage Enrollees/Direct Pay Annuitants under the Federal Employees Health Benefits (FEHB) Program will be from November 12 through December 10, 2007. During Open Season you may change from one plan to another, from one option to another in the same plan, or from self only to self and family. Certain former spouses are excluded from self and family. Refer to our office for eligibility. Coverage under your current enrollment will continue **automatically** unless you request a change or unless your current plan will no longer be participating in the FEHB Program after December 31, 2007.

This Open Season package contains information tailored especially for you. The plan comparison chart on the following pages shows the benefits and premiums effective as of January 1, 2008 for Nationwide Fee-for-Service Plans (Page 6 & 8), the Nationwide High Deductible and Consumer Driven Health Plans (Page 9 & 10) and the Health Maintenance Organizations (HMOs) and Point of Service (POS) Plans available in your state (Page 12). When comparing HMOs please note that, generally, you may only enroll in an HMO that services the area you live in. In some cases, the HMO may allow you to enroll if you work within its service area even though you live outside of the service area. Check with the HMO for questions concerning your specific eligibility to enroll. If no HMOs or plans are available in your area, page 12 is omitted from your package.

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

Please use the following letter codes to determine the benefit explanations for plans on page 8 and page 10:

A – NONE

B – N/A

C – NOTHING

D – NOT COVERED

E – NOTHING UP TO $1200

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 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.

See pg 4 & 5 of 2011 pkg

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

pg 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.

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

Not In 2011 doc pg 5

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.

Not In 2011

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

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

Features of an HSA include:

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

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

Features of an HRA include:

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

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

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

PLAN NAME	Telephone Number	Plan Option	Enrollment Code		Your Monthly Premium	
			Self Only	Self & Family	Self Only	Self & Family
PLANS OPEN TO ALL						
APWU HEALTH PLAN	800/222-2798	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
PLANS OPEN ONLY TO SPECIFIC GROUPS						
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 before you make your healthcare decisions. IV 12

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

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

Enrollment Code		Benefit Type	Premium Contribution		CY Deductible		Catatrophic Limit		Office Visit	In-patient Surgery	Out-patient Surgery	Preventative Services	Prescription Drugs		
Self	Self & Family		HSA	HRA	Self	Self & Family	Self	Self & Family					Level I	Level II	Level III
474	475	IN-NETWORK	B	B	$600	$1,200	$3,000	$4,500	15%	A	15%	C	25%	25%	25%
		OUT-NETWORK	B	B	$600	$1,200	$9,000	$9,000	40%	A	40%	E	D	D	D
341	342	IN-NETWORK	$60		$1,500	$3,000	$5,000	$10,000	5%	5%	5%	C	25%	25%	25%
		OUT-NETWORK	$60		$1,500	$3,000	$5,000	$10,000	25%	25%	25%	E	25%+	25%+	25%+
481	482	IN-NETWORK	$70		$2,000	$4,000	$5,000	$10,000	$15	G	C	C	$10	$25	$40
		OUT-NETWORK	$70		$2,000	$4,000	$7,500	$15,000	40%	40%	40%	D	D	D	D

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

Enrollment Code		Location
Self	Self & Family	
221	222	PHIL/PITTS/LEHIGH VLLY/CENT/NE/SE PA
224	225	PHIL/PITTS/LEHIGH VLLY/CENT/NE SE PA
Y61	Y62	GREATER PITTSBURGH AREA
YN1	YN2	NORTHEAST PENNSYLVANIA
YW1	YW2	CENTRAL PENNSYLVANIA
9N1	9N2	SOUTHEASTERN PA
8W4	8W5	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 or providers in a designated service are (like an HMO), or (2) out-of-network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non- HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

ON page 4 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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IMPORTANT

DPRS OPEN SEASON INFORMATION

PLEASE READ ALL INFORMATION AND INSTRUCTIONS.

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

TABLE OF CONTENTS

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

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

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

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

Public Burden Statement. We 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, 3206-0160 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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FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

FEHB

OPEN SEASON

DPRS-2809

OMB 3206-0202

(Revised 11/07)

REQUEST TO CHANGE FEHB ENROLLMENT FOR 2008 PLAN YEAR

Read the enclosed instructions before completing this form. Return this form to: USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161

Do not take any action to maintain your present coverage.

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

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

☐ **Change Enrollment.** I want to change my FEHB enrollment. I have indicated my selection in Section II. I have either: (1) marked the block of a Nationwide plan, or (2) entered the enrollment code and plan name of an Health Maintenace Organization (HMO) plan, Regional High Deductible Health Plan (HDHP), or Consumer Driven Health Plan (CDHP).

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the 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

HMO Plan or HDHP or CDHP

Enrollment Code	Name of Plan

Note: If changing Plans to an HMO Plan or HDHP or CDHP, please use the box above to request the change.

Section IV. Address Correction

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

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 ☐ F	
Address (if different from enrollee)		Medicare	TRICARE	Other Insurance
		☐ A ☐ B ☐ D		☐
		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 _____

DR25A (revised 11/07)

Form redesigned 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. 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 can help you choose your health plan. In addition to the info contained in this guide you will find information on:

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

Additional Help. If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit from 7:45 a.m. to 4:00 p.m., CST, weekdays or write to: **DPRS, P.O. Box 61760, New Orleans, LA. 70161-1760.** Visit our web site at www.nfc.usda.gov and scroll down to the DPRS web site.

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

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DIRECT PREMIUM REMITTANCE SYSTEM

OPEN SEASON INFORMATION

The 2007 Open Season for Spouse Equity/Temporary Continuation of Coverage Enrollees/Direct Pay Annuitants under the Federal Employees Health Benefits (FEHB) Program will be from November 12 through December 10, 2007. During Open Season you may change from one plan to another, from one option to another in the same plan, or from self only to self and family. Certain former spouses are excluded from self and family. Refer to our office for eligibility. Coverage under your current enrollment will continue **automatically** unless you request a change or unless your current plan will no longer be participating in the FEHB Program after December 31, 2007.

This Open Season package contains information tailored especially for you. The plan comparison chart on the following pages shows the benefits and premiums effective as of January 1, 2008 for Nationwide Fee-for-Service Plans (Page 6 & 8), the Nationwide High Deductible and Consumer Driven Health Plans (Page 9 & 10) and the Health Maintenance Organizations (HMOs) and Point of Service (POS) Plans available in your state (Page 12). When comparing HMOs please note that, generally, you may only enroll in an HMO that services the area you live in. In some cases, the HMO may allow you to enroll if you work within its service area even though you live outside of the service area. Check with the HMO for questions concerning your specific eligibility to enroll. If no HMOs or plans are available in your area, page 12 is omitted from your package.

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

Please use the following letter codes to determine the benefit explanations for plans on page 8 and page 10:

A – NONE

B – N/A

C – NOTHING

D – NOT COVERED

E – NOTHING UP TO $1200

F – DEDUCTIBLE PLUS 25%

G – $75 PER DAY UP TO $750

H – DEDUCTIBLE + 30%

I – NOTHING TO 10%

J – PER DAY x 5

K – 1 REFILL

L – OR 50%

M – OR $45

N – $25 MINIMUM

O – $30 MINIMUM

P – 15% OR 30%

Q – PLUS DIFFERENCE

PRESCRIPTION DRUG PAYMENT LEVELS

Not on page 7 of 2011 plcy.

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.

See pgs 4 & 5 & 2011 plcy

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 g 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.

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)

at top of 2011 pkg.

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

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

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

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

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

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

Features of an HSA include:

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

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

Features of an HRA include:

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

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

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

PLAN NAME	Telephone Number	Plan Option	Enrollment Code		Your Monthly Premium	
			Self Only	Self & Family	Self Only	Self & Family
PLANS OPEN TO ALL						
APWU HEALTH PLAN	800/222-2798	HIGH	471	472	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
PLANS OPEN ONLY TO SPECIFIC GROUPS						
ASSOCIATION BENEFIT PLAN	800/634-0069		421	422	125 91	300.50
FOREIGN SERVICE BENEFIT PLAN	202/833-4910		401	402	105.24	283.43
PANAMA CANAL AREA BENEFIT PLAN	800/548-8969		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 before you make your healthcare decisions.

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

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

2008 DPRS OPEN SEASON INFORMATION - ENROLLEES

FEE FOR SERVICE PLANS - ENROLLMENT CODES AND BENEFITS

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

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

Enrollment Code		Benefit Type	Premium Contribution		CY Deductible		Catatrophic Limit		Office Visit	In-patient Surgery	Out-patient Surgery	Preventative Services	Prescription Drugs		
Self	Self & Family		HSA	HRA	Self	Self & Family	Self	Self & Family					Level I	Level II	Level III
474	475	IN-NETWORK	B	B	$600	$1,200	$3,000	$4,500	15%	A	15%	C	25%	25%	25%
		OUT-NETWORK	B	B	$600	$1,200	$9,000	$9,000	40%	A	40%	E	D	D	D
341	342	IN-NETWORK	$60		$1,500	$3,000	$5,000	$10,000	5%	5%	5%	C	25%	25%	25%
		OUT-NETWORK	$60		$1,500	$3,000	$5,000	$10,000	25%	25%	25%	E	25%+	25%+	25%+
481	482	IN-NETWORK	$70		$2,000	$4,000	$5,000	$10,000	$15	G	C	C	$10	$25	$40
		OUT-NETWORK	$70		$2,000	$4,000	$7,500	$15,000	40%	40%	40%	D	D	D	D

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

Enrollment Code		Location
Self	Self & Family	
221	222	CINCINNATI/CLEVELAND/COLUMBUS/TOLEDO
224	225	CINCINNATI/CLEVELAND/COLUMBUS/TOLEDO
3A4	3A5	STARK/CARROLL/HOLMES/TUSCARAWAS/WAYNE
114	115	OHIO
L81	L82	CINCINNATI
E91	E92	CLEVELAND AND COLUMBUS AREAS

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

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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	800/624-6961	
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.

TABLE OF CONTENTS

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

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, 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

(3206-0202

HEALTH BENEFITS PROGRAM

FEHB

OPEN SEASON

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

REQUEST TO CHANGE FEHB ENROLLMENT FOR 2008 PLAN YEAR

Read the enclosed instructions before completing this form. Return this form to: USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161

Do not take any action to maintain your present coverage.
COMPLETE THIS FORM *ONLY* IF YOU ARE MAKING CHANGES.

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

☐ **Change Enrollment.** I want to change my FEHB enrollment. I have indicated my selection in Section II: I have either: (1) marked the block of a Nationwide plan, or (2) entered the enrollment code and plan name of an Health Maintenace Organization (HMO) plan, Regional High Deductible Health Plan (HDHP), or Consumer Driven Health Plan (CDHP).

All plan brochure requests must be made through the carrier from whom you wish to receive the brochure or from the 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

HMO Plan or HDHP or CDHP

Enrollment Code	Name of Plan

Note: If changing Plans to an HMO Plan or HDHP or CDHP, please use the box above to request the change.

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 ☐ F	
Address (if different from enrollee)		Medicare	TRICARE	Other Insurance
		☐ A ☐ B ☐ D		☐
		Name of Insurance		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 _____

DR25A (revised 11/07)

Form redesigned 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. 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 can help you choose your health plan. In addition to the info contained in this guide you will find information on:

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

Additional Help. If you need assistance in completing your form, or for questions regarding who is eligible to enroll in FEHB, periods of eligibility, changing, or canceling enrollment, conversion to a non-group plan with your carrier after TCC expires, you may call the DPRS Billing Unit from 7:45 a.m. to 4:00 p.m., CST, weekdays or write to: DPRS, P.O. Box 61760, New Orleans, LA. 70161-1760. Visit our web site at www.nfc.usda.gov and scroll down to the DPRS web site.

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

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.

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

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

Features of an HRA include:

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

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

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

PLAN NAME	Telephone Number	Plan Option	Enrollment Code		Your Monthly Premium	
			Self Only	Self & Family	Self Only	Self & Family
PLANS OPEN TO ALL						
APWU HEALTH PLAN	800/222-2798	HIGH	471	472	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
PLANS OPEN ONLY TO SPECIFIC GROUPS						
ASSOCIATION BENEFIT PLAN	800/634-0069		421	422	125.91	300.50
FOREIGN SERVICE BENEFIT PLAN	202/833-4910		401	402	105.24	283.43
PANAMA CANAL AREA BENEFIT PLAN	800/548-8969		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 before you make your healthcare decisions.

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

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

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

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

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

Enrollment Code		Benefit Type	Premium Contribution		CY Deductible		Catatrophic Limit		Office Visit	In-patient Surgery	Out-patient Surgery	Preventative Services	Prescription Drugs		
Self	Self & Family		HSA	HRA	Self	Self & Family	Self	Self & Family					Level I	Level II	Level III
474	475	IN-NETWORK	B	B	$600	$1,200	$3,000	$4,500	15%	A	15%	C	25%	25%	25%
		OUT-NETWORK	B	B	$600	$1,200	$9,000	$9,000	40%	A	40%	E	D	D	D
341	342	IN-NETWORK	$60		$1,500	$3,000	$5,000	$10,000	5%	5%	5%	C	25%	25%	25%
		OUT-NETWORK	$60		$1,500	$3,000	$5,000	$10,000	25%	25%	25%	E	25%+	25%+	25%+
481	482	IN-NETWORK	$70		$2,000	$4,000	$5,000	$10,000	$15	G	C	C	$10	$25	$40
		OUT-NETWORK	$70		$2,000	$4,000	$7,500	$15,000	40%	40%	40%	D	D	D	D

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

Enrollment Code		Location
Self	Self & Family	
221	222	MOST OF TENNESSEE
224	225	MOST OF TENNESSEE
114	115	TENNESSEE
BT1	BT2	NASHVILLE
L61	L62	MEMPHIS
E91	E92	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 or providers in a designated service are (like an HMO), or (2) out-of-network providers (like an FFS plan). When you use the POS network of providers, you usually pay a copayment for services and do not have to file claims or other paperwork. If you use non– HMO or non-POS providers, you pay a deductible, coinsurance, or the balance of the billed charge. In any case, your out-of-pocket costs are higher and you file your own claims for reimbursement.

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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	94.32	248.65	AETNA OPEN ACCESS- HIGH	UB1	UB2	877/459-6604
NASHVILLE AREA	247.22	566.59	AETNA OPEN ACCESS- HIGH	6J1	6J2	877/459-6604

SEE PLAN BROCHURES FOR BENEFIT INFORMATION.