

IMPORTANT

DPRS OPEN SEASON INFORMATION

PLEASE READ ALL INFORMATION AND INSTRUCTIONS.

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

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

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

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

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

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

REQUEST TO CHANGE FEHB ENROLLMENT FOR 2013 PLAN YEAR

Read the enclosed instructions before completing this form. Return this form to:
USDA/NFC, DPRS Billing Unit, P.O. Box 61760, New Orleans, LA 70161
You may fax your form to 888-212-8734.

Do not take any action to maintain your present coverage.

COMPLETE THIS FORM ONLY IF YOU ARE MAKING CHANGES.

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

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

| | | | | | |
|--|--|--|-------------------------------|---|---|
| 1. ENROLLEE NAME (last, first, middle initial) | | 2. SOCIAL SECURITY NUMBER | 3. DATE OF BIRTH (mm/dd/yyyy) | 4. SEX <input type="checkbox"/> M <input type="checkbox"/> F | 5. ARE YOU MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6. HOME MAILING ADDRESS (including ZIP Code) | | 7. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D | | 8. MEDICARE CLAIM NUMBER | |
| | | 9. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? <input type="checkbox"/> YES, indicate in item 10 below. <input type="checkbox"/> NO | | | |
| 10. INDICATE THE TYPE(S) OF OTHER INSURANCE <input type="checkbox"/> TRICARE <input type="checkbox"/> OTHER <input type="checkbox"/> FEHB | | NAME OF OTHER INSURANCE | | POLICY NUMBER | |

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

| | | | | | |
|--|--|---|--------------------------------|--|-----------------------|
| 11. NAME OF FAMILY MEMBER (last, first, middle initial) | | 12. SOCIAL SECURITY NUMBER | 13. DATE OF BIRTH (mm/dd/yyyy) | 14. SEX <input type="checkbox"/> M <input type="checkbox"/> F | 15. RELATIONSHIP CODE |
| 16. ADDRESS (if different from enrollee) | | 17. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D | | 18. MEDICARE CLAIM NUMBER | |
| | | 19. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? <input type="checkbox"/> YES, indicate in item 20 below. <input type="checkbox"/> NO | | | |
| 20. INDICATE THE TYPE(S) OF OTHER INSURANCE <input type="checkbox"/> TRICARE <input type="checkbox"/> OTHER <input type="checkbox"/> FEHB | | NAME OF OTHER INSURANCE | | POLICY NUMBER | |
| 21. EMAIL ADDRESS (if home address is different from enrollee's) | | 22. PREFERRED TELEPHONE NUMBER (if home address is different from enrollee's) | | | |

| | | | | | |
|--|--|---|--------------------------------|--|-----------------------|
| 23. NAME OF FAMILY MEMBER (last, first, middle initial) | | 24. SOCIAL SECURITY NUMBER | 25. DATE OF BIRTH (mm/dd/yyyy) | 26. SEX <input type="checkbox"/> M <input type="checkbox"/> F | 27. RELATIONSHIP CODE |
| 28. ADDRESS (if different from enrollee) | | 29. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> D | | 30. MEDICARE CLAIM NUMBER | |
| | | 31. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE? <input type="checkbox"/> YES, indicate in item 32 below. <input type="checkbox"/> NO | | | |
| 32. INDICATE THE TYPE(S) OF OTHER INSURANCE <input type="checkbox"/> TRICARE <input type="checkbox"/> OTHER <input type="checkbox"/> FEHB | | NAME OF OTHER INSURANCE | | POLICY NUMBER | |
| 33. EMAIL ADDRESS (if home address is different from enrollee's) | | 34. PREFERRED TELEPHONE NUMBER (if home address is different from enrollee's) | | | |

| | | | |
|---|--------------------|--|--------------------|
| SECTION II - FEHB Plan You Are Currently Enrolled In | | Section III - FEHB Plan You Are Changing to | |
| 1. PLAN NAME | 2. ENROLLMENT CODE | 1. PLAN NAME | 2. ENROLLMENT CODE |

SECTION IV - Signature

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

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

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 2013. If your plan is not listed, you must select another plan during this Open Season period (November 12 through December 10, 2012) to be assured of continued health benefits coverage.

Important. You should also carefully review the 2013 premium cost shown in the plan comparison charts for your plan and option of coverage. There are only limited opportunities, which permit you to change your enrollment outside of the Open Season. If you do not change your enrollment during the Open Season, you may not be eligible to change later, even if you do not wish to pay an increased premium cost for your enrollment.

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

Section I, Enrollee and Family Member Information. Please complete all information in blocks 1-34 for the primary enrollee and your dependents. If your address is incorrect on the enclosed form, enter the changes in Box 6 and check the box indicating a change. 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.

Section II, Enrollment Codes and Plan Names. Please complete the plan name and enrollment code for the plan you are currently enrolled in 2012.

Section III, Enrollment Codes and Plan Names. Please complete the plan name and enrollment code for the plan you choose to enroll in 2013.

Section IV, Authorization. You must sign and date the form. No changes will be made unless the enrollee signs and dates the form. Enter the daytime area code and phone number and email address 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, 2013. If your change is processed before January 1, 2013, 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, 2013.

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, 2013.

Identification Cards. These cards are issued by the health plans, not DPRS. You should direct questions about identification (ID) cards to your plan. Cards are usually issued within 30 days from the date the plan receives notice of your enrollment change. Should you or your family require medical attention after the January 1, 2013 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:

- Open Season Resources
- Comparing Plans
- FEHB Handbook
- Frequently Asked Questions
- Medicare and FEHB
- Health Care Reform/Affordable Care Act

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

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

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

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

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

Fee-for-Service plans open only to specific groups Several Fee-for-Service plans that are sponsored or underwritten by an employee organization strictly limit enrollment to persons who are members of that organization. If uncertain of eligibility, check with your human resources office first.

How to read the Fee-for-Service Chart

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

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

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

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

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

Doctors are what you pay for surgical services and for office visits.

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

Prescription Drug Payment Levels

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

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

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

Level III includes all other covered drugs, with some exceptions for specialty drugs. Many plans are basing how much you pay for prescription drugs on what they are charged.

Mail Order Discounts – If your plan has a Mail Order program and that program is superior to the purchase of medications at the pharmacy (e.g., you get a greater quantity or pay less through Mail Order) your plan's response is "yes." If the plan does not have a Mail Order program or it is not superior to its pharmacy benefit, the plan's response is "no."

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

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

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

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

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

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

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

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

DIRECT PREMIUM REMITTANCE SYSTEM

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

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

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

A **Consumer-Driven Health Plan (CDHP)** provides you with freedom in spending health care dollars the way you want. The typical plan has features such as: member responsibility for certain up-front medical costs, an employer-funded account that you may use to pay these up-front costs, and catastrophic coverage with a high deductible. You and your family receive full coverage for In-Network preventative care.

How to Read the HDHP/CDHP Charts:

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

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

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

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

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

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

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

Prescription Drug Payment Levels

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

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

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

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

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

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

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

Features of an HSA include:

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

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

Features of an HRA include:

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

DIRECT PREMIUM REMITTANCE SYSTEM

FEHB Program Features

- **No Waiting Periods.** You can use your benefits as soon as your coverage becomes effective. There are no pre-existing condition limitations even if you change plans.
- **A Choice of Coverage.** Choose between Self Only or Self and Family.
- **Group Benefits.** Under Spouse Equity coverage, you pay the total monthly premium. Under TCC, you pay the total monthly premium plus a 2 percent administrative charge.
- **A Choice of Plans and Options.** Select from Fee-for-Service (with the option of a Preferred Provider Organization) Health Maintenance Organization, Point-of-Service plans, Consumer-Driven Plans, or High Deductible Health Plans.
- **Annual Enrollment Opportunity.** Each year you can enroll or change your health plan enrollment. The Open Season runs from the Monday of the second full work week in November through the Monday of the second full work week in December.
- **Continued Group Coverage.** Eligibility for you or your family members may continue following your retirement, divorce or death. See your human resources office or retirement system for more information.
- **Coverage after FEHB Ends.** You or your family members may be eligible for conversion to non-group (private) coverage when FEHB coverage ends. See your Human Resources Office for more information.
- **Consumer Protections.** Go to www.opm.gov/insure/health/consumers to see your appeal rights to OPM if you and your plan have a dispute over a claim; read the Patients Bill of Rights and the FEHB Program; and learn about your privacy protections with it comes to your medical information.

When Can I enroll in TCC?

- **Individuals eligible for TCC** generally must enroll within 60 days after the qualifying event permitting enrollment, or after receiving notice of eligibility, whichever is later. However, the opportunity to elect TCC ends 60 days after the qualifying event if: (1) you do not notify your human resources office or retirement system within 60 days of your child's loss of coverage, or (2) you or your former spouse do not notify your human resources office or retirement system within 60 days of your divorce.
- **Former Spouses under the Spouse Equity provision** can enroll at any time after the employing office establishes that the former spouse has met both the eligibility and application time limitation requirements. To determine eligibility, the former spouse must apply to the employing office or retirement system within 60 days after:
 - The date of dissolution of the marriage, or
 - The date of the retirement systems notice of eligibility to enroll based on entitlement to a former spouse annuity benefit, whichever is later.

Pre-Existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition.
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.)
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY: 1-866-561-1604).

Medicaid and the Childrens Health Insurance Program (CHIP)

Offer Free or Low-Cost Health Coverage to Children and Families

- If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.
- If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.
- Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employers health plan is required to permit you and your dependents to enroll in the plan as long as you and your dependents are eligible, but not already enrolled in the employers plan. This is called a special enrollment opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

DIRECT PREMIUM REMITTANCE SYSTEM**OPEN SEASON INFORMATION**

The 2012 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, 2012. 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, 2012.

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, 2013 for Nationwide Fee-for-Service Plans (Pages 8 & 9), the Nationwide High Deductible and Consumer Driven Health Plans, (Pages 10 & 11) and the Health Maintenance Organizations (HMOs) and Point of Service (POS) Plans available in your state (Page 12). When comparing HMOs please note that, generally, you may only enroll in an HMO that services the area you live in. In some cases, the HMO may allow you to enroll if you work within its service area even though you live outside of the service area. Check with the HMO for questions concerning your specific eligibility to enroll. If no HMO or POS plans are available in your area, page 12 is omitted from your package.

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

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

- A - NONE
- B - N/A
- C - 15% MCare B
- D - DAY x 5
- E - NOTHING
- F - +DIFF.
- G - \$200 MAX
- H - NOT COVERED
- I - UP TO \$450
- J - MAX \$150
- K - UP TO &600
- L - \$55 MAX
- M - \$70 MAX
- N - \$100 MAX
- O - \$90 MAX
- P - OR \$62.50
- Q - \$50 MIN
- R - NOTHING UP TO \$1,200
- S - DED/25%
- T - \$75 DAY-\$750
- U - MAX \$150+
- V - MAX \$200+
- W - OR \$50
- X - 35% +
- Y - \$30 MIN

Important

You should carefully review the 2013 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 2013. 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 2013 premium rates.

Plans Not Participating in the FEHB Program in 2013

Some plans will withdraw from the FEHB Program after December 31, 2012. 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 2013, 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 2013 unless you are a Federal retiree or survivor annuitant. If you are a Federal retiree or survivor annuitant and you don't select another plan, we will enroll you in the Blue Cross and Blue Shield Service Benefit Plan option that is most similar to your current plan's cost and benefits. The effective date of your enrollment will be January 1, 2013. If Blue Cross and Blue Shield is the plan you want, don't wait for us to enroll you. If you elect them now, you will receive your plan card sooner.

Effective Dates of Open Season Changes

All changes to new plans will be effective January 1, 2013.

2013 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, 2012, your new 2013 payment coupons will be mailed to you during the first two weeks of January, 2013. Your payment coupon for the month of January 2013 will be the first coupon to reflect the 2013 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, and to verify that we have your current address, so we will be able to send you a reprinted set of coupons.