IMPORTANT

DPRS OPEN SEASON INFORMATION

PLEASE READ ALL INFORMATION AND INSTRUCTIONS.

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

TABLE OF CONTENTS

Page 1 - Table of Contents, Privacy Act Statement, Public Burden Statement
Page 2 - Form DPRS-2809
Page 3 - Information and Instruction Sheet for Completing Form DPRS-2809
Page 4 - Fee for Service Plans/Health Maintenance Organization (HMO) Plans – Descriptions
Page 5 - High Deductible Health Plans and Consumer Driven Health Plans – Descriptions
Page 6 - FEHB Program Features
Page 7 - Open Season Information
Page 8 - Fee for Service Plans – Enrollment Codes and Rates
Page 9 - Fee For Service Plans – Enrollment Codes and Benefits
Page 10 - High Deductible and Consumer-Driven Health Plans – Nationwide and State Specific - Codes and Rates
Page 11 - High Deductible and Consumer-Driven Health Plans – Codes and Benefits
Page 12 - HMO and POS Plans for Your State (if applicable)

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

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

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

If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement. We 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 National Finance Center, Direct Premium Unit (DPRS) Billing Unit, P.O. Box 61780, New Orleans, LA 70161, (3206-0202). The OMB number, 3206-0202 is currently valid. NFC may not collect this information, and you are not required to respond, unless this number is displayed.
REQUEST TO CHANGE FEHB ENROLLMENT FOR 2015 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 303-274-3805.
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 5. ARE YOU MARRIED?
M F YES NO

6. HOME MAILING ADDRESS (including ZIP Code) The changes are indicated in Item 6

7. IF YOU ARE COVERED BY MEDICARE, CHECK ALL THAT APPLY

8. MEDICARE CLAIM NUMBER

9. ARE YOU COVERED BY INSURANCE OTHER THAN MEDICARE?
YES indicate in Item 10 below. NO

10. INDICATE THE TYPE(S) OF OTHER INSURANCE

TRICARE FEHB OTHER

NAME OF OTHER INSURANCE

POLICY NUMBER

An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment.

SECTION II - FEHB Plan You Are Currently Enrolled In

1. PLAN NAME 2. ENROLLMENT CODE

SECTION III - FEHB Plan You Are Changing to

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

DELETE THIS SHEET IF USING A SEPARATE SHEET FOR ADDITIONAL FAMILY MEMBERS.
You must make all changes through the National Finance Center.

Effective Date of Open Season Changes. All enrollment changes will be effective January 1, 2015. If your change is processed before January 1, 2015, the coupons received in January will reflect the new premium that will be due February 1. Otherwise, the new premium will be reflected in the coupons sent to you after the change is processed, retroactive to January 1, 2015.

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, 2015.

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, 2015 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.

Please visit the following websites for comprehensive information on FEHB. www.opm.gov/healthcare-insurance/healthcare or www.opm.gov/healthcare-insurance/healthcare/reference-materials/ or www.opm.gov/openseason. 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 National Finance Center Contact Center at 800-242-9630 from 8:00 a.m. to 4:00 p.m., CST, weekdays or write to: DPRS, P.O. Box 61760, New Orleans, LA 70161-1760 or email to NFC.DPRS@nfc.gov or fax to 303-274-3805. Visit our web site at www.nfc.usda.gov/dprs. 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 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 co-payment 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, laboratory 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 who 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 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 terms such as Level (L I, L II) or Tier (T I, T 2) to show what you pay for generic or brand name prescription drugs. The payment levels that plans use follow: L I or Tier 1 includes generic drugs, but may include some preferred brands, L II or Tier 2 includes preferred brands and may include some generics. L III or Tier 3 includes non-preferred, other covered drugs, and with some exceptions, specialty drugs. L IV or Tier 4 includes mostly preferred specialty drugs. L V or Tier 5 generally includes non-preferred specialty drugs.

Mail Order Discounts — If your plan has a Mail Order program (typically for maintenance drugs) and its response is "Yes", in general, its Mail Order program is superior to its retail pharmacy benefit (e.g., you obtain a greater quantity for less cost than retail pharmacy purchases). If your plan does not have a Mail Order program or it does not offer a superior benefit to retail pharmacy purchases, the response will be "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 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 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.
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, Tier11, Level 1, etc. The 2 to 3 payment levels that plans use follow:

- Level I includes most generic drugs, but may include some preferred brands.
- Level II may include generics and preferred brands not included in Level I.
- Level III includes all other covered drugs, with some exceptions for specialty drugs.

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

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

A Health Savings Account (HSA) allows individuals to pay for current health expenses and save for future qualified medical expenses on a 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.
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.

**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.

Minimum Essential Coverage (MEC) Healthcare Reform FEHB Fast Facts

Under the Patient Protection and Affordable Care Act, Public Law 111–148 and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (collectively, the Affordable Care Act), the Federal government, state governments, insurers, employers, and individuals are given shared responsibility to reform and improve the availability, quality, and affordability of health insurance coverage in the United States.

Beginning in January 1, 2014, the Affordable Care Act’s individual shared responsibility provision requires each individual (including children) to:

* maintain minimum essential health coverage (known as “minimum essential coverage” or “MEC”) for each month or
* qualify for an exemption; or
* make a payment when filing his or her Federal income tax return.

Does FEHB coverage qualify as minimum essential coverage (MEC)?

Yes, according to the Affordable Care Act, codified at 26 U.S.C. § 5000A(f), MEC includes an eligible employer-sponsored plan that is a Federal Governmental Plan as defined under the Public Health Service Act. All FEHB plans are eligible employer-sponsored plans and provide minimum essential coverage (MEC). Therefore, FEHB plans meet the definition of MEC.

Does coverage through the FEHB Temporary Continuation of Coverage (TCC) or Spouse Equity provisions qualify as MEC?

Yes, the requirement to maintain MEC is satisfied for individuals covered under FEHB plans through TCC or Spouse Equity provisions.
The 2014 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 10 through December 8, 2014. 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, 2014.

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, 2015 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 - 45% +  
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 - $110 MAX  
P - DAY/$875  
Q - $50 MIN  
R - NOTHING UP TO $1,200  
S - DED/25%  
T - $75 DAY-$750  
U - 30 DAY $30/50 DAY  
V - T1 - T5  
W - T2/30% T4/T2 30%/480 T3  
X - 35% +  
Y - $30 MIN  
Z - T3/$55 MIN/30 DAY  
# - T2/3OT3 50% $55 MIN  
1 - $105  
2 - $200  
3 - $400  
* OR $50

**Important**

You should carefully review the 2015 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. **This guide is only a summary of benefits. Check details with carrier.** If you do not change your enrollment during open season, you may not be eligible to change until the next open season. If you also make changes to the same 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 2015. 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 2015 premium rates.

**Plans Not Participating in the FEHB Program in 2015**

Some plans will withdraw from the FEHB Program after December 31, 2014. 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 2015, 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 2015 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, 2015. 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, 2015.

**2015 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, 2014, your new 2015 payment coupons will be mailed to you during the first two weeks of January, 2015. Your payment coupon for the month of January 2015 will be the first coupon to reflect the 2015 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.