FEDDESK GUIDE

2017 Health Insurance Guide

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2017 Health Insurance Guide

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Contents

Introduction

This **2017 Health Insurance Guide** is designed to help Federal employees – just like you – understand the Federal Employees Health Benefits (FEHB) Program.

Started in 1960, FEHB is the largest employer-sponsored group health insurance program in the world, covering over 9 million Federal employees, retirees, former employees, family members, and former spouses. There are over 350 health plans offered under the FEHB Program!

Every year, an Open Season is held for FEHB Program enrollees to change health plans and/or the type of enrollment they have. Eligible employees may also enroll during this time. Outside of this Open Season, there are very limited opportunities to enroll, cancel enrollment, or change your enrollment. So you need to understand the rules. That's where this unique WAEPA Guide can help!

The **2017 Health Insurance Guide** will help you – and your family – understand the ins and outs of the FEHB Program and help you take full advantage of all the opportunities it presents!

We hope that you find this **2017 Health Insurance Guide** helpful.

– *John D. Whitney*

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Federal Employees Health Benefits

General Overview

The Federal Employees Health Benefits (FEHB) Program became effective in 1960 and is the largest employer-sponsored group health insurance program in the world, covering over 9 million Federal employees, retirees, former employees, family members, and former spouses.

As a Federal employee, you are entitled to enroll yourself and any eligible family members in a health plan offered under the FEHB Program, unless your position is excluded from coverage by law or regulation. If you meet the requirements, you will be eligible to continue group coverage into retirement.

There are three types of enrollment:

- Self Only
- Self and Family
- Self Plus One.

Each health plan carrier under the FEHB Program charges a different premium. The Government pays up to 75% of the cost of your health benefits coverage, and you pay the remainder, based on a formula set by law.

Over 350 health plans are offered under the FEHB Program. Of the 14 available fee-for-service plans, seven are open to all enrollees, while another seven are available only to specific categories of employees. In addition, health maintenance organizations (HMOs) are available in most areas of the United States; you must live or work within a defined area to be eligible to enroll in a particular HMO.

Each year, an Open Season is held for FEHB Program enrollees to change health plans and/or the type of enrollment they have. Eligible employees may also enroll during this time. Open Season runs from the Monday of the second full workweek in November through the Monday of the second full workweek in December.

There are limited opportunities to enroll, cancel enrollment, or change your enrollment outside of an Open Season.

OPM Responsibilities

OPM has the overall responsibility for the administration of the FEHB Program including:

- approving or disapproving carriers for participation in the FEHB Program;
- contracting for, and approving or disapproving plans;
- negotiating benefit and rate changes with carriers;
- approving the certified text on benefits for the brochures;
- publishing FEHB regulations, instructions, forms, and documents;
- receiving and depositing premium withholdings and contributions, remitting premiums to carriers, and accounting for the Employees Health Benefits Fund;

- making final determinations of the applicability of the FEHB law to specific employees or groups of employees;
- studying and evaluating the operation and administration of the FEHB law and the plans offered under it, and reporting findings to Congress;
- ordering corrections of administrative errors if it would be against equity and good conscience not to do so;
- providing guidance to agencies;
- auditing carriers' operations under the law;
- resolving disputed health insurance claims between the enrollee and the carrier;
- conducting employing agency FEHB responsibilities for retired employees and survivor annuitants.

Enrollee Responsibilities

Your responsibilities include:

- being aware of your plan's benefit package and premium charges;
- being aware of your plan's exclusions and limitations;
- reviewing the benefit and rate changes made to your plan during Open Season;
- during Open Season, determining whether your plan will still meet your needs in the upcoming year;
- filing the appropriate forms with your employing office on a timely basis to enroll, change, or cancel enrollment;
- ensuring that the proper deduction has been recorded on your earnings and leave statement;
- examining plan provider directories or checking directly with a health care provider to see if that provider participates or will continue to participate in any plan networks or preferred provider arrangements;
- being aware of and following plan precertification and preauthorization requirements;
- filing claims on a timely basis with the necessary documentation;
- being aware of requirements for continuing your enrollment into retirement;
- promptly asking your employing office for information about temporary continuation of coverage if a family member ceases to be eligible under your enrollment;
- promptly requesting conversion to an individual contract when FEHB eligibility ends;
- notifying the carrier of your plan when your address changes;
- notifying the carrier of your plan when a new family member is added to yourself and family enrollment.

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Types of Enrollment

There are three types of enrollment:

1. Self Only. A self only enrollment provides benefits only for you as the enrollee. You may enroll for self only even though you have a family, but they will not be eligible for FEHB coverage (even upon your death or disability).

2. Self and Family. A self and family enrollment provides benefits for you and your eligible family members. All of your eligible family members are automatically covered, even if you didn't list them on your Health Benefits Election Form (SF 2809) or other appropriate request. You cannot exclude any eligible family member and you cannot provide coverage for anyone who is not an eligible family member.

3. Self Plus One. A Self Plus One enrollment covers the enrollee and one designated eligible family member. The definition of eligible family members has not changed. Your eligible family member can include either a spouse OR a child up to age 26. A child age 26 or over who is incapable of self-support because of a mental or physical disability that existed before age 26 is also an eligible family member.

You may enroll for self and family coverage before you have any eligible family members. Then, a new eligible family member (such as a newborn child or a new spouse) will be automatically covered by your family enrollment from the date he/she becomes a family member. When a new family member is added to your existing self and family enrollment, you do not have to complete a new SF 2809 or other appropriate request, but your carrier may ask you for information about your new family member. You will send the requested information directly to the carrier. Exception: if you want to add a foster child to your coverage, you must provide eligibility information to your employing office.

General Eligibility for Coverage. Family members eligible for coverage under your Self and Family enrollment are your spouse (including a valid common law marriage) and children under age 26, including legally adopted children, recognized natural (born out of wedlock) children and stepchildren (including children of same-sex domestic partners). A child is eligible for coverage under your Self and Family enrollment, if a state-issued birth certificate lists you as a parent of that child.

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Eligibility for Health Benefits

As a Federal employee, you are eligible to elect FEHB coverage, unless your position is excluded by law or regulation. Your agency applies these rules and determines your eligibility.

Employee Coverage

Cooperative Employees. You are eligible for FEHB coverage if you are:

- appointed by a Federal agency for service in cooperation with a non-Federal agency,
- paid in whole or in part from non-Federal funds (such as certain employees of the Agriculture Extension Service), and
- your position is not excluded from coverage.

Withholdings and contributions for your coverage must be made from Federally-controlled funds and must be timely paid, or the cooperating non-Federal agency must agree in writing with your agency to make and timely remit the required withholdings and contributions from non-Federal funds. The withholdings and contributions arrangement must be approved by OPM.

Agricultural Stabilization and Conservation County Committee Employees. If you are employed by a county committee established under section 8(b) of the Soil Conservation and Domestic Allotment Act, you are eligible for FEHB coverage (unless your position is excluded from coverage).

Employees Transferred to Public International Organizations. If you transfer to a public international organization under the Federal Employees International Organization Service Act, you may elect to retain your FEHB coverage. To keep your coverage, all necessary withholdings and contributions during your service with the international organization must be currently paid.

U.S. Commissioners. If you are a United States Commissioner subject to the Civil Service Retirement law or the Federal Employees Retirement law, you are eligible for FEHB coverage.

Personal Services Contractors of the U.S. Department of the Treasury. Effective September 30, 1996, if you are a personal services contractor of the U.S. Department of the Treasury, you are eligible for FEHB coverage.

Presidential Appointee. You are eligible for FEHB coverage if you are a Presidential appointee appointed to fill an unexpired term.

Provisional Appointee. You are eligible for FEHB coverage if you are a temporary employee who receives a provisional appointment as defined in 5 CFR 316.401 and 316.403.

Acting Postmaster. You are eligible for FEHB coverage if you are an acting postmaster.

Temporary Employees

Eligibility to Enroll at Own Cost. If your position is excluded from coverage because your appointment is limited to one year or less, you will be eligible to enroll under 5 U.S.C. 8906a when you have completed one year of current continuous employment, excluding any break in service of 5 days or less. You must pay both the employee and the

Government shares of the premium.

The one-year requirement may be met at the end of a one-year appointment in a single agency or it may be based on a series of shorter appointments served in one or more agencies, as long as you have not had a break in service of more than 5 days.

In many cases, a temporary appointment lasts one year. If your appointment is renewed at the end of that year, you are eligible to enroll.

Student Employees. If you are a student employee (for example, a student aide or Stay-in-School Program participant), you generally serve on temporary appointments limited to 1 year or less. You typically work part-time during the school year and full-time during summers and vacations and become eligible to participate after completing one year on the employment rolls, provided you pay the full premium cost.

Intermittent Employment. If you are an intermittent employee (you do not have a prearranged regular tour of duty), you are not eligible for coverage. Seasonal or occasional employment for one calendar year that amounted to less than 6 months of work does not meet the one year of current continuous employment requirement.

> Exception. You are eligible for FEHB coverage if your appointment follows, with a break in service of no more than 3 days, a position in which you were insured.

Mixed Tour of Duty. If you work, under an appointment limited to one year or less, a mixed tour of duty (combining periods of full-time, part-time, and intermittent tours of duty during the year), you may be eligible to enroll as a temporary employee. You must be on a full-time or prearranged part-time work schedule at the beginning of the one-year period of current continuous employment and at the time you enroll under this provision. When counting the one year of current continuous employment, include any periods of intermittent service. If you change to an intermittent tour of duty after your enrollment begins, your enrollment will continue as long as you didn't have a break in service of more than three calendar days.

Employees Excluded From Coverage

District of Columbia Employees. You are excluded from FEHB coverage if you were first employed by the District of Columbia government on or after October 1, 1987.

> Exceptions. You are eligible for FEHB coverage if you are:

- an employee of St. Elizabeth's Hospital, who accepts employment with the District of Columbia government following Federal employment without a break in service, as provided in Pub. L. 98-621;
- an employee of the D.C. Control Board (District of Columbia Financial Responsibility and Management Assistance Authority), who makes an election under the Technical Corrections to Financial Responsibility and Management Assistance Act (section 153 of P. L. 104-134) to be considered a Federal employee for FEHB coverage and other benefits purposes;
- effective August 5, 1997, the Corrections Trustee and the Pretrial Services, Defense Services, Parole, Adult Probation, and Offender Supervision Trustee and employees of these Trustees who accept employment with the District of Columbia Government within 3 days after separating from the Federal government, as provided by P. L. 105-33; and
- effective October 1, 1997, a judge or nonjudicial employee of the District of Columbia Courts, as provided by Pub. L. 105-33.

Noncitizens. You are excluded from FEHB coverage if you are not a citizen or national of the United States and your permanent duty station is located outside the United States and its territories and possessions.

Exception. You are eligible for FEHB coverage if you met the definition of employee on September 30, 1979, by service in an Executive agency (as defined in 5 U.S.C. 105), the United States Postal Service, or the Smithsonian Institution in the area which was then known as the Canal Zone.

TVA Employees. You are excluded from FEHB coverage if you are an employee of the Tennessee Valley Authority.

Employees of Farm Credit Administration-Supervised Corporations. You are excluded from FEHB coverage if you are an employee of a corporation supervised by the Farm Credit Administration, if private interests elect or appoint a member of the board of directors. The corporations are Regional Banks for Cooperatives, Federal Intermediate Credit Banks, Federal Land Banks, Production Credit Corporations, and the Central Bank for Cooperatives.

Temporary Employees. You are excluded from FEHB coverage if you are:
serving under an appointment limited to one year or less and you have not completed at least one year of current
continuous employment, excluding any break in service of 5 days or less; or
expected to work less than 6 months in each year.

Exceptions. You are eligible for FEHB coverage if:

- your full-time or part-time temporary appointment has a regular tour of duty and follows a position in which you were insured, with a break in service of no more than 3 days;
- you are an acting postmaster;
- you are a Presidential appointee appointed to fill an unexpired term;
- you are a temporary employee who receives a provisional appointment as defined in 5 CFR 316.401 and 316.403;
- you are employed under an OPM-approved career-related work-study program under Schedule B lasting at least one year and in pay status for at least one-third of the total period of time from the date of your first appointment to the completion of the work-study program; or
- your appointment follows, with a break in service of no more than 3 days, a position in which you were insured.

Patient Employees. You are excluded from FEHB coverage if you are a beneficiary or patient employee in a Government hospital or home.

Employees Paid on a Contract or Fee Basis. You are excluded from FEHB coverage if you are paid on a contract or fee basis.

Exception. You are eligible for FEHB coverage when you are a:

- United States citizen, appointed by a contract between you and the Federal employing authority which requires your personal service, and paid on the basis of units of time; or
- Personal Service Contractor employed by the Department of the Treasury.

Employees Paid on a Piecework Basis. You are excluded from FEHB coverage if you are paid on a piecework basis.

> Exception. You are eligible for FEHB coverage when your work schedule provides for full-time or part-time service with a regularly scheduled tour of duty.

OPM Determination. OPM makes the final determination about whether the above categories apply to a specific employee or group of employees.

Part-time career employment or certain interim appointments are not excluded from FEHB coverage.

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Types of Plans

Types of Plans

- Fee-for-Service Plans
- Health Maintenance Organizations

Two types of plans participate in the FEHB Program: fee-for-service plans and health maintenance organizations (HMOs).

Fee-for-Service Plans

These plans reimburse you or your health care provider for the cost of covered services. You may choose your own physician, hospital, and other health care providers. Most fee-for-service plans have preferred provider (PPO) arrangements. If you receive services from a preferred provider, you usually have lower out-of-pocket expenses (i.e., a smaller copayment and/or a reduced or waived deductible). All fee-for-service plans require precertification of inpatient admissions and preauthorization of certain procedures.

Fee-For-Service (FFS) plans generally use two approaches.

> Fee-for-Service (FFS) Plans (non-PPO). A traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse you after you have filed an insurance claim for each covered medical expense. When you need medical attention, you visit the doctor or hospital of your choice. This approach may be more expensive for you and require extra paperwork.
>
> Fee-for-Service (FFS) Plans with a Preferred Provider Organization (PPO). An FFS option that allows you to see medical providers who reduce their charges to the plan; you pay less money out-of-pocket when you use a PPO provider. When you visit a PPO you usually won't have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. For instance, lab work and radiology services from independent practitioners within the hospital may not be covered by the PPO agreement. Most networks are quite wide, but they may not have all the doctors or hospitals you want. This approach usually will save you money.

Generally enrolling in a FFS plan does not guarantee that a PPO will be available in your area. PPOs have a stronger presence in some regions than others, and in areas where there are regional PPOs, the non-PPO benefit is the standard benefit. In "PPO-only" options, you must use PPO providers to get benefits.

Health Maintenance Organization (HMO). A health plan that 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. Some HMOs are affiliated with or have arrangements with HMOs in other service areas for non-emergency care if you travel or are away from home for extended periods. Plans that offer reciprocity discuss it in their brochure. HMOs limit your out-of-pocket costs to the relatively low amounts shown in the benefit brochures.

The HMO provides a comprehensive set of services - as long as you use the doctors and hospitals affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and generally no deductible or coinsurance for in-hospital care.

Most HMOs ask you to choose a doctor or medical group to be 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 most appropriate to your condition.

Care received from a provider not in the plan's network is not covered unless it's emergency care or the plan has a reciprocity arrangement.

HMO Plans Offering a Point of Service (POS) Product. In an HMO, the POS product lets you use providers who are not part of the HMO network. However, you pay more for using these non-network providers. You usually pay higher deductibles and coinsurances than you pay with a plan provider. You will also need to file a claim for reimbursement, like in a FFS plan. The HMO plan wants you to use its network of providers, but recognizes that sometimes enrollees want to choose their own provider.
Some plans are Point Of Service (POS) plans and have features similar to both FFS plans and HMOs.

Consumer-Driven Health Plans (CDHP). Describes a wide range of approaches to give you more incentive to control the cost of either your health benefits or health care. You have greater freedom in spending health care dollars up to a designated amount, and you receive full coverage for in-network preventive care. In return, you assume significantly higher cost sharing expenses after you have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

Health Reimbursement Arrangement (HRA). Health Reimbursement Arrangements are a common feature of Consumer-Driven Health Plans. They may be referred to by the health plan under a different name, such as Personal Care Account. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA. HRAs are similar to HSAs except an enrollee cannot make deposits into and 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.

Health Savings Account (HSA). A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pretax basis. Funds deposited into an HSA 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 an HSA, you must be covered under a High Deductible Health Plan and cannot be eligible for Medicare or covered by another plan that is not a High Deductible Health Plan or a general purpose HCFSA or be dependent on another person's tax return. HSAs are subject to a number of rules and limitations established by the Department of Treasury. Visit www.ustreas.gov/offices/public-affairs/hsa/ for more information.

High Deductible Health Plan (HDHP). A High Deductible Health Plan is a health insurance plan in which the enrollee pays a deductible of at least $1,300 (Self Only coverage) or $2,600 (family coverage). The annual out-of-pocket amount (including deductibles and copayments) the enrollee pays cannot exceed $7,150 (Self Only coverage) or $14,300 (family coverage). HDHPs can have first dollar coverage (no deductible) for preventive care and higher out-of-pocket copayments and coinsurance for services received from non-network providers. HDHPs offered by the FEHB Program establish and partially fund HSAs for all eligible enrollees and provide a comparable HRA for enrollees who are eligible for an HSA. The HSA premium funding or HRA credit amounts vary by plan.

Opportunities to Enroll or Change Enrollment

Effective Date. Unless otherwise specified, enrollments or changes in enrollment become effective on the first day of the first pay period that begins after your employing office receives your enrollment request and that follows a pay period during any part of which you were in pay status.

If You Participate in Premium Conversion, Can I Still Change My Enrollment? Yes, you can still make changes to your enrollment as detailed in this section with two exceptions. You must have a qualifying life event to change from self and family to self only or to cancel your FEHB coverage outside of Open Season.

New Appointment. If you are a new employee, you may enroll in any available plan, option, and type of enrollment within 60 days after your date of appointment, unless your position is excluded from coverage. If you were employed in a position that was excluded from coverage and then appointed to a position that conveys coverage, you may enroll within 60 days after the change.

If you are a Nonappropriated Fund (NAF) employee who moves to Federal employment, you are eligible for coverage just as any other new employee, even if you have continued coverage under the NAF retirement system.

Change to Self Only. If you participate in premium conversion, you may change your enrollment from self and family to self only:

- During the annual Open Season; or
- Within 60 days after you have a qualifying life event. Your change in enrollment must be consistent with and correspond to your qualifying life event.

  Example. Joel gets divorced, and since he doesn't have any children, he wants to change to a self only enrollment. He can make this enrollment change outside of Open Season since it is consistent with and corresponds to his qualifying life event (divorce).

  If you do not participate in premium conversion, you may change your enrollment from self and family to self only at any time.

  Note: Different rules apply for some U.S. Postal Service employees. Check with your employing office if you want to change to a self only enrollment.

A change from self and family to self only becomes effective on the first day of the first pay period that begins after the employing office receives your enrollment request.

Your spouse's death, your divorce, a child's marriage or a child's reaching age 22, may leave you as the only person covered by a self and family enrollment. If you are the only person left in a self and family enrollment, you should change to a self only enrollment promptly so that you are not unnecessarily paying premiums for a family enrollment.

Your employing office can make a change to self only retroactive to the first day of the pay period after the pay period in which you have no remaining eligible family members. Your employing office will make a retroactive change only upon your written request stating the event and date when you became the only person covered by the family enrollment. There will be an adjustment in your health benefits withholdings and contributions.

Qualifying Life Event. A qualifying life event (QLE) is a term defined by OPM to describe events deemed acceptable by the IRS that may allow premium conversion participants to change their participation election for premium conversion outside of an open season.

The qualifying life events that may allow you to change your premium conversion election are:

Changes in entitlement to Medicare or Medicaid for you, your spouse or dependent	Your Spouse or dependent first becomes eligible for coverage under Medicare or Medicaid You, your Spouse or dependent loses entitlement to Medicare or Medicaid
Employment Status	Change in your employment status or that of your spouse or dependent from either full-time to part-time, or the reverse Start of your spouse's employment Your Spouse or dependent is employed in a position that offers health insurance Start or end of an unpaid leave of absence by you, your spouse or your dependent
Other	Significant change in the cost or conditions of your spouse's health care coverage related to your spouse's employment that affects you

Open Season. You may enroll during the open season if you are an eligible employee. If you are enrolled, you may change plans, options, type of enrollment, or premium conversion status. If you are a non-enrolled annuitant, you are not permitted to enroll during an open season unless you had suspended your FEHB enrollment to join an Medicare managed care plan or because of your eligibility under Medicaid or a similar State-sponsored program of medical assistance for the needy.

The effective dates of the annual Open Season enrollments and changes in enrollment are as follows:

- A new enrollment is effective the first day of the first pay period that begins in the following year and that follows a pay period during any part of which you are in pay status.
- A change in enrollment is effective the first day of the first pay period that begins in the following year, regardless of whether you are in pay status.
- When your employing office accepts a late open season enrollment or change in enrollment, it is effective retroactive to the same date that it would have been effective if it had been received on time.

Change in Family Status. You may enroll or change enrollment from self only to self and family, from one plan or option to another, or make any combination of these changes during the period beginning 31 days before and ending 60 days after a change in your family status. You can change your enrollment only once during this time period (unless there is another event during this time that would permit an enrollment change). You can also change your premium conversion status as long as the change in enrollment is on account of and consistent with a qualifying life event.

If you change from self only to self and family because of the birth or addition of a child, the effective date of your enrollment change is the first day of the pay period in which the child becomes a family member.

If you and your spouse each are enrolled for self only and you want a self and family enrollment because of a change in family status, one of you may change to a self and family enrollment if the other cancels the self only enrollment.

New Spouse. If you want to provide immediate coverage for your new spouse, you may submit an enrollment request during the pay period before the anticipated date of your marriage. If the effective date of the change is before your marriage, your new spouse does not become eligible for coverage until the actual day of your marriage.

If you enroll or change your enrollment before the date of your marriage and intend to change your name, you must

note on your request: "Now: [Current Name] will be: [Married Name]." The reason for the change and the date of the marriage must be given in your request.

If you enrolled or changed your enrollment before your anticipated marriage date and you do not get married, your employing office must void the request. If you changed plans, your employing office must be sure to notify both the old and the new carrier that your change was voided.

Divorce or Separation. Even if you are legally separated, your spouse is still considered a family member and eligible for coverage under your self and family enrollment. To continue to provide health benefits coverage for your children, you must continue your self and family enrollment. Upon a final divorce decree, your spouse is no longer an eligible family member and is not covered under your enrollment.

When two Federal employees divorce, one person usually continues a self and family enrollment to provide coverage for the children, while the other enrolls for self only. When the enrollment covering the children is canceled or changed to self only, you may change to a self and family enrollment to provide immediate coverage for your children.

Former Spouse. If you are a former spouse who has coverage under the spouse equity or temporary continuation of coverage (TCC) provisions of FEHB law, you may change from self only to self and family or from one plan or option to another, or both, within 60 days after the birth or acquisition of an eligible child. To be eligible, the child must be that of both you and the employee or annuitant on whose service your coverage is based.

Change in Employment Status. Generally, you may enroll or change enrollment from self only to self and family, from one plan or option to another, or make any combination of these changes within 60 days after a change in your employment status. You can also change your premium conversion status if the enrollment change is on account of and consistent with a qualifying life event. Various changes in employment status and the allowable enrollment changes that you may make are described below.

Return to Pay Status after 365 Days in Leave Without Pay. If your enrollment terminated:

- after you had been in leave without pay status for 365 days; or
- when you entered leave without pay status; or
- at any time during the first 365 days in leave without pay status, you may enroll for self only or self and family in any available plan or option when you return to pay status. If you were not enrolled at the time leave without pay status began, you may enroll upon return to pay status only if a qualifying event occurred while you were on leave without pay.

Reemployment after More than 3-Day Break in Service. If you move from one employing office to another (other than by retirement) with a break in service of more than 3 days, you may enroll the same as a new employee. If you are a Nonappropriated Fund (NAF) employee who returns to Federal employment, you are eligible for coverage, even when you have continued coverage under the NAF retirement system.

Return from Military Service. If you are restored to a civilian position after serving in the uniformed services under conditions that entitle you to benefits under 5 CFR part 353, or similar authority, you may enroll in any option of any available plan after returning to civilian duty. If your enrollment was terminated on entry into military service, you will have the same enrollment reinstated effective on the day of restoration to duty in a civilian position. In addition, you may change your enrollment based on your return to civilian duty.

Change from Temporary Appointment to Another Type of Covered Appointment. When you are eligible to enroll as a temporary employee under 5 U.S.C. 8906a and you change to an appointment that makes you eligible for FEHB coverage with a Government contribution, you may change plans, options, and types of enrollment.

Your change in health benefits status is effective either:

- on the same date as your change in employment status, if the change is on the first day of a pay period, or
- at the beginning of the pay period following your change in employment status, if the change is after the first day of the pay period.

If there is a break in service of more than 3 days, your old enrollment terminates at the end of the pay period in which your temporary appointment ends. You have a new opportunity to enroll based on the new appointment.

Separating from Service. If you are separating from service and you or your spouse is pregnant, you may enroll or change your enrollment during your final pay period. You must provide medical documentation of the pregnancy to your employing office.

The effective date of the change is the first day of the pay period in which your employing office receives your appropriate request.

Although you can usually enroll for family coverage under temporary continuation of coverage (TCC) provisions, it does not become effective until the day after the 31-day extension of coverage. An enrollment election prior to separation will ensure that the baby's health care costs will be covered if he/she is born during the 31-day extension of coverage. If you are not eligible for TCC, a change to a self and family enrollment during your final pay period will allow you to convert to an individual policy for the whole family.

Transfer To or From Overseas Employment. You may enroll or change enrollment when you transfer from a duty post within the United States to a duty post outside the United States or the reverse. You have 31 days before the date you are expected to leave your former duty post and 60 days after your arrival at the new duty post to enroll or change enrollment.

If you are at an overseas duty post at the time of your retirement, you may change your enrollment within 60 days after your retirement.

Change To or From Part-Time Career Employment. When you change to part-time career employment (16 to 32 hours a week under 5 U.S.C. 3401(2)) with a break in service of 3 days or less, you may enroll or change your enrollment within 60 days from the change in your employment status. Similarly, when you change from part-time employment under 5 U.S.C. 3401(2) to full-time employment, you may enroll or change enrollment. This does not apply to part-time appointments of other than 16 to 32 hours per week (or 32 to 64 hours biweekly in the case of a flexible or compressed work schedule) nor to any noncareer appointment.

You Lose Coverage under FEHB or Another Group Insurance Plan. If you are an employee eligible for FEHB coverage, you may enroll or change your enrollment from self only to self and family, from one plan or option to another, or make any combination of these changes when you or an eligible family member lose coverage under FEHB or any other group health benefits plan (including coverage under another Federally-sponsored health benefits program or under Medicaid). Except as otherwise provided below, you must enroll or change your enrollment within the period beginning 31 days before and ending 60 days after the loss of coverage. You can also change your premium conversion status if the enrollment change is on account of and consistent with a qualifying life event.

If you are eligible for FEHB coverage in your own right and you become a survivor annuitant, you have the option to continue the current enrollment with withholdings made from your survivor annuity. If you elect to enroll as an employee, and you later separate or your employment status changes so that your enrollment terminates, you may continue the enrollment as a survivor annuitant.

If you are an eligible employee under age 22 and covered under your parent's self and family enrollment, you are

eligible to enroll if you are no longer dependent on your parent. Your employing office will permit you to enroll when it receives a statement from your parent that you are no longer a dependent. Your parent must also submit this statement to his/her employing office, which will notify the carrier that you are no longer an eligible family member. Your employing office will note in your appropriate request that you are no longer a dependent and not eligible for benefits under your parent's enrollment.

Former Spouse Loses Regular FEHB Coverage. If you are entitled to health benefits coverage as a former spouse, but you are instead enrolled as an employee or family member, you may enroll or resume enrollment under spouse equity when your coverage as an employee or family member ends (as long as you still meet the spouse equity requirements).

Former TCC Enrollee Loses Regular FEHB Coverage. If you were enrolled under temporary continuation of coverage (TCC) provisions and you acquired regular FEHB coverage (either as an employee or family member), you may reenroll in TCC if the regular coverage ends before the original TCC enrollment would have expired. You may reenroll in the same plan and option as your original TCC enrollment. If you are not eligible to enroll in the plan you had when your TCC enrollment ended, you may enroll in the same option of any available plan. The second TCC enrollment cannot extend beyond the date the original TCC enrollment would otherwise have stopped.

Termination of Membership in Employee Organization. If you are enrolled in a plan sponsored by a union or employee organization and you stop being a member of that organization, your plan can ask your employing office to terminate your enrollment, subject to a 31-day extension of coverage.

Your plan will send a notice to your employing office and a copy to you. Your employing office will terminate your enrollment on a Notice of Change in Health Benefits Enrollment (SF 2810), effective at the end of the pay period in which it receives the notice. You may then enroll for self only or self and family in any available plan or option. If you reenroll within 60 days after termination, you are considered to have been continuously enrolled (for purposes of continuing enrollment after retirement) even though there actually may have been a break between the effective date of termination of your enrollment in the employee organization plan and the effective date of your new enrollment.

You are Enrolled in a Plan that is Discontinued. You may change to another plan when you are enrolled in a plan that is discontinued in whole or in part. You may enroll in the new plan for either self only or self and family coverage. If your plan is discontinued at the end of a contract year, you must change your enrollment during open season unless OPM establishes a different time. If the whole plan is discontinued and you do not change to another plan, you are considered to have canceled your enrollment. If one option of a two-option plan is discontinued and you do not change to another plan, you are considered to have enrolled in the remaining option of the plan.

Normally, a plan that terminates its participation in the FEHB Program will terminate as of December 31 of a given year. The plan will continue to provide benefits until the new coverage takes effect. When a plan is discontinued at any time other than at the end of a contract year, OPM will announce a special enrollment period and give instructions about the proration of premiums and the effective date of enrollment changes.

Change to Position out of Commuting Area. When your or your spouse's loss of non-Federal coverage is due to a move outside of the commuting area, you must enroll or change enrollment within the period beginning 31 days before the date you leave employment in the old commuting area and ending 180 days after you enter on duty at the place of employment in the new commuting area.

Loss of Coverage under Spouse's Non-Federal Plan. Your spouse may elect to temporarily continue the employer-provided group insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You may choose to enroll either at the time your spouse or child loses coverage through the non-Federal employer or whenever the COBRA coverage terminates for any reason.

Move from an HMO's Service Area. If you are enrolled in an HMO and you move or become employed outside the HMO's service area (or, if you are already living or working outside this area, you move or become employed further

away), you may change your enrollment. Also, you may change your enrollment if an enrolled family member moves outside the service area (or moves further away). You must notify your employing office of the move.

The effective date of the change is the first day of the pay period that begins after your employing office receives your appropriate request.

You become Eligible for Medicare. You may change your enrollment to any option of any available plan at any time beginning on the 30th day before you become eligible for Medicare. You may make an enrollment change under this event only once.

Salary of Temporary Employee Insufficient to Pay Withholdings. If you are temporary employee eligible under 5 U.S.C. 8906a and your salary is not sufficient to pay your plan's premiums, your employing office must notify you of the plans available at a cost that does not exceed your available salary. You may enroll in another plan where the cost is no greater than your available salary within 60 days after receiving notification from your employing office.

Coverage under your new plan is effective immediately upon termination of your old plan's coverage.

Continuation of Old Plan during Confinement. If you changed your enrollment from one plan or option to another and you or a covered family member are an inpatient in a hospital or other institution on the last day of your enrollment under the prior plan or option, the benefits of the prior plan or option will continue for the confined person for the length of the inpatient stay, up to 91 days from the last day of enrollment in the prior plan or option. This provision does not apply when a plan is discontinued or when OPM orders an enrollment change.

Your new plan or option does not pay benefits for you while you are receiving continued inpatient benefits from your old plan or option. The new plan or option will begin coverage on the earlier of:

- the day of your discharge;
- the day after maximum inpatient benefits available under the old plan or option have been paid or provided; or
- the 92nd day after the last day of enrollment in the old plan or option.

Coverage for other family members (who are not confined in a hospital or other institution) under the new plan begins on the normal effective date of coverage.

Dual Enrollment

Dual Enrollment Prohibited. Dual enrollment is when you or an eligible family member under your self and family enrollment are covered under more than one FEHB enrollment. Generally, dual enrollment is prohibited except when you or a family member would otherwise lose coverage.

Your stepchildren that live with you in a regular parent-child relationship are eligible for coverage under your self and family enrollment. When all of either your children or your spouse's children live with you, only one self and family enrollment is needed. If both you and your spouse are enrolled for self and family, you must eliminate the dual enrollment.

Employing Office Actions. Your carrier must contact the employing offices involved when it discovers an unauthorized dual enrollment case. One of the enrollments must be voided or canceled from the date that dual enrollment began. The health benefits premiums you paid during the unallowable enrollment will be refunded, and your employing office must make a corresponding adjustment in the Government's contribution. The carrier of the enrollment that is voided or canceled may require that you refund any benefits it paid under the unallowable enrollment, although these benefits may be payable under the allowable enrollment.

If you and your spouse are unable to agree on which enrollment to continue, the enrollment of the spouse with a court order to provide coverage for the children will be continued. Otherwise, the second (later) enrollment must be voided or canceled.

When Dual Enrollment is Allowed. Dual enrollment must be authorized by your employing office(s) and will only be allowed when you or an eligible family member would otherwise lose coverage. Some examples of allowable dual enrollment include when:

- you and your spouse legally separate and both of you retain custody of your children by prior marriages;
- you and your spouse have children from prior marriages who don't live with you;
- you and your spouse legally separate and you or your children would lose full health benefits coverage (e.g., you move outside your HMO's service area and your spouse refuses to change health plans; your spouse refuses to pass along reimbursements for health benefits claims filed);
- you and your spouse divorce;

No enrollee or family member may receive benefits under more than one FEHB enrollment. If your employing office authorizes a dual enrollment, you may be covered and receive benefits only under your own enrollment. You must inform the carriers involved which family members will be covered and receive benefits under which enrollment. If you or a family member receive benefits under more than one plan, it is considered fraud and you are subject to disciplinary action.

Dates for Open Season. Each year OPM provides an open season from the Monday of the second full workweek in November through the Monday of the second full workweek in December. The Director of OPM may modify the dates of open season or announce additional open seasons. Your open season election generally will take effect the following January.

Notification to Agencies. OPM notifies agencies of each regular open season by a Benefits Administration Letter (BAL). We give specific instructions on the coordination of open season, and let the agencies know of any changes in materials to be issued or procedures to be followed during that period.
If your employing office's health benefits official needs additional open season information or assistance, he/she may contact the headquarters benefits officer. The headquarters benefits officer may contact OPM with questions.

Employee Express. Your agency may allow or require you to make open season changes through "Employee Express," or another electronic method, instead of using a Health Benefits Election form (SF 2809). Check with your employing office to see if this method is available for your use.

Other Enrollment Actions During Open Season. While new enrollments and other permissible enrollment changes can be made as usual during the open season, these should not be identified as open season changes on the appropriate request because open season changes do not take effect until January. You should make sure that you specify the reason for your enrollment change on your enrollment request.

Timely Election. Your employing office must receive your open season election no later than the last day of open season to be considered timely filed.

Your employing office may accept and process a late election if it determines that you were unable to submit it timely for reasons beyond your control (e.g., your employing office did not distribute open season literature until after open season). Your failure to read the available material is not considered a reason beyond your control.

If your employing office decides to accept a late election, it enters "belated open season enrollment/change" in the

Remarks section of your enrollment request. You or your employing office must explain why you could not make a timely election and attach the statement to the file copy of your enrollment request.

If your employing office decides that your late election was not beyond your control, it must explain to you in writing why it did not accept your late request and give you notice of your reconsideration rights.

Deductibles. If you change plans, any covered expenses you incur between January 1 and the effective date of coverage under your new plan count towards the prior year's deductible of your old plan.

If You Don't Want to Make an Open Season Change. You do not need to do anything if you want to continue your current enrollment (unless your plan is dropping out of the FEHB Program). If you do not change your enrollment, any benefit or rate changes apply beginning January 1.

Processing Open Season Changes. OPM provides employing offices with instructions for processing open season enrollments and enrollment changes each year via a Benefits Administration Letter (BAL).

Continuation of Enrollment

Upon Transfer. When you move from one employing office to another, your enrollment continues without interruption (see Employees Excluded from Coverage for the only exceptions to this) as long as you do not have a break in service of more than three calendar days. This is regardless of whether or not your move is designated as a transfer. You do not need to do anything to ensure your continued enrollment, but the gaining employing office must transfer your enrollment.

If you are enrolled in an HMO and transfer to a location outside of the HMO's service area, your enrollment continues. However, you will be covered only for emergency care, Point of Service (POS) benefits (if applicable), or care that you travel back to an HMO participating provider to receive. You may change to another plan before or after the move.

If you are enrolled in a plan sponsored by a union or employee organization and you transfer to another agency, you do not have the right to enroll in another plan because of your transfer. Your current enrollment will continue until:

- you change plans when you have an opportunity (such as an open season), or
- the plan terminates your enrollment because you are no longer a member of the organization.

  Example. Vincent is employed by the FBI and is enrolled in the Special Agents Mutual Benefits Association (SAMBA) plan. He transfers to another agency where its employees are not eligible to join SAMBA. His enrollment in SAMBA will continue, and the gaining agency must make withholdings and contributions for SAMBA, until he changes his enrollment or SAMBA takes steps to terminate his enrollment.

Effective Date. The effective date of the enrollment transfer for the gaining employing office is the first day you enter on its rolls.

Transfers to or from the District of Columbia Government. If you are a Federal employee with D.C. Government service prior to October 1, 1987, and you move back to D.C. Government without a break in service, your enrollment must be transferred in by the D.C. Government on the Notice of Change in Health Benefits Enrollment form (SF 2810). Since your personnel files are not transferred, the D.C. Government must request copies of your health benefits forms when it requests other employment information from the losing Federal employing office.

If you move from the D.C. Government to a Federal agency, the gaining office must transfer your enrollment in on SF 2810 and ask the D.C. Government for the personnel folder copies of health benefits forms at the same time it asks for a transcript of personnel records.

The two personnel offices must verify your health insurance status so that withholdings can begin with the initial pay period even if documentation has not yet arrived from the losing office.

If you do not have D.C. Government service prior to October 1, 1987, and you transfer to the D.C. Government, your enrollment is terminated because you are no longer an eligible employee. If you were first employed by the D.C. Government on or after October 1, 1987, and you transfer to a Federal agency, you may enroll in the FEHB Program if you are otherwise eligible.

Transfers to or from the U.S. Senate and House of Representatives. If you leave a Federal agency and become employed by the U.S. Senate or House of Representatives without a break in service of more than three calendar days, your health benefits enrollment is transferred.

If you leave employment with the U.S. Senate or House of Representatives and become employed by a Federal agency without a break in service of more than three calendar days, your enrollment will terminate effective at the end of the month that you separate. Withholdings and contributions will be made for that entire month. The gaining employing office will ask you for a copy of the termination Notice of Change in Health Benefits Enrollment (SF 2810), verify your eligibility for continued enrollment, and ask the losing office for the employing office copies of your health benefits forms. The gaining office will reinstate your enrollment on the SF 2810 effective the first day of the following month, so you will not have to pay double premiums.

Continuation upon Retirement. When you retire and are eligible to continue FEHB coverage into retirement, your enrollment is transferred in by the retirement system and automatically continued.

Continuation for Family Members upon Your Death. If you die in service while enrolled for self and family, enrollment for your family members automatically continues when they meet the requirements for continuation.

Leave Without Pay Status. Generally, your enrollment may continue for up to 365 days of leave without pay. You must pay the employee share of premiums for every pay period that your enrollment continues.

Restoration to Duty After Erroneous Removal or Suspension

Election. If you are suspended without pay, your enrollment may continue for up to 365 days in leave without pay status. If you are removed from service, your enrollment terminates at the end of the pay period in which you are removed. If your enrollment terminated and you are ordered restored to duty because the suspension or removal was unwarranted or unjustified, you may elect either to:

- have your prior enrollment reinstated retroactive to the date it was terminated, or
- enroll the same as a new employee.

Your employing office must notify you of the health benefits coverage choices available.

Reinstatement of Enrollment. If you elect to have your prior enrollment reinstated retroactively, premium withholdings and contributions must also be made retroactively as if the erroneous suspension or removal had not taken place. The amount of the retroactive withholdings due may be withheld from your backpay award. Your health benefits coverage is considered to have been continuously in effect and you and your covered family members are retroactively entitled to full plan benefits. If you had converted to an individual contract, you may get a refund of the premiums you paid for that coverage.

New Enrollment. If you elect to enroll the same as a new employee instead of having your prior enrollment reinstated, your enrollment is effective the first day of the first pay period that begins after your employing office receives your appropriate request. You are not retroactively entitled to plan benefits and no retroactive premium withholdings and

contributions will be made.

The period of suspension or removal (during which the enrollment was not in effect) is not considered when determining your eligibility to continue coverage into retirement, as long as you enroll within 60 days after the date you are ordered restored to duty.

If you lose health benefits coverage because you separate from Federal service, whether voluntary or involuntary (except for removal due to gross misconduct), you may elect temporary continuation of coverage (TCC).

During an Interim Appointment

If you have an interim appointment under the Whistleblower Protection Act of 1989 [5 U.S.C. 7701(b)(2)(A)], you are entitled to the same coverage provisions as other employees with appointments that entitle them to coverage under the FEHB Program.

If your interim appointment is terminated and your prior separation still stands, you have the same rights under the FEHB Program as any other employee whose appointment terminates. These rights are based on the termination from the interim appointment - the prior separation has no bearing. If you were ineligible for temporary continuation of coverage (TCC) based on your prior separation, this has no effect on your eligibility for TCC based on the separation from your interim appointment.

If you are eligible for retirement and you receive an interim appointment, your annuity will be suspended. Your employing office must notify the retirement system to transfer your enrollment back to your employing office. If your interim appointment ends and your prior separation still stands, your enrollment will be transferred back to the retirement system.

If you are restored to duty and your interim appointment terminates, you may choose retroactive reinstatement of your health benefits coverage. If you continued health benefits coverage under TCC between your prior separation and your interim appointment, a retroactive reinstatement terminates your TCC enrollment retroactively. You are due a refund for the premiums you paid for the TCC enrollment. This amount may be applied to the premiums you owe for the retroactive reinstatement. If your backpay award and TCC enrollment refund will not cover the amount you owe for the retroactive reinstatement, you must pay the balance due directly to your employing office.

Can I Choose Not to Participate in Premium Conversion? Yes, but you need to opt-out or waive participation in premium conversion. You should obtain, complete and return a waiver/election form to your employing office. If your employing office receives that form before the beginning of the first pay period that begins on or after October 1, 2000, the waiver will be effective.

Who Should Not Participate? Regardless of your marital status, and the number of dependents you have, if you:

- pay no federal income tax, or
- earn less than $6,400 per year

you should give serious consideration to waiving participation in premium conversion.

Can I Change My Premium Conversion Participation Status? Yes, but your opportunities to do so are limited. You may waive participation:

- During Open Season. The effective date of the change is the first day of the first pay period that begins in the following calendar year.

- When you make a change in FEHB enrollment that is on account of and consistent with a qualifying life event.

- When you have a qualifying life event and the change is on account of and consistent with that event (even when you don't change your enrollment). You have 60 days after the qualifying life event to file your change with your employing office. The waiver is effective on the first day of the pay period following the date your employing office received your change request.

You may cancel your waiver and participate:

- Open Season. The effective date of the change is the first day of the first pay period that begins in the following calendar year.

- When you have a qualifying life event; the change in FEHB coverage is consistent with the qualifying life event; and you complete an election form to participate within 60 days from the qualifying life event.

Does Premium Conversion Affect My Other Federal Benefits? No. All Federal retirement, thrift savings and life insurance benefits are based on gross salary and are not affected by participation in premium conversion.

What's the Impact of Premium Conversion on my Social Security Benefits? Premium conversion may slightly reduce the Social Security benefit you will receive upon retirement. The extent of the impact depends on several factors:

- The retirement system that you participate in;

- Whether your salary exceeds the social Security wage base; and

- The number of years left until your retirement.

CSRS. If you are covered under CSRS, you are generally better off with premium conversion. Your tax savings are slightly less, since you don't pay social security taxes. However, a reduction in Social Security benefits is not an issue for you since Social Security is not a component of your Civil Service Retirement.

Even if you have Social Security coverage as a result of a non-Federal job, premium conversion would not change your Social Security benefit.

CSRS Offset. Under CSRS offset, your Social Security benefits would be slightly reduced, but your CSRS Offset benefits would be increased by almost the same amount. Participating in premium conversion is most likely a benefit to you.

FERS. Your Social Security benefits are calculated on your taxable earnings, so any reduction in your taxable income will affect your Social Security calculation

The small reduction in Social Security benefits is greatly outweighed by the much larger tax savings. Here is a simple formula you can use to estimate the difference in your Social Security benefit:

- Take the number of years you will participate in premium conversion (from now until your estimated retirement) and divide by 35.

- Multiply this by your current annual FEHB premium

- Multiply the result of Step 2 by the marginal SSA rate (15% for most Federal employees)

The result is the annual loss of Social Security benefits.

(# of Years of Premium Conversion /35) X Annual FEHB Premium X marginal SSA rate = Annual Loss

Example: Antonio participates in FERS. He's had a full career of FICA contributions, with an ending salary (today) of $50,000 and projected retirement at age 66 in January 2016. His estimated Social Security benefit equals $1,414 per month.

He begins participating in premium conversion and reduces his taxable income by $2,000, the amount of his FEHB premium. By changing his salary to $48,000, his monthly Social Security benefit is now $1,403, an $11.00 per month difference in today's dollars. 15/35= .4286 X 2000 = 857 X .15 = 128/12 = 10.71 or 11

Compare that to the estimated $67 increase in take home pay per month.

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Cost of Insurance

Generally, if you are a Federal employee or annuitant, you share the cost of your health benefits coverage with the Government as your employer. Temporary employees enrolled under 5 U.S.C. 8906(a), former spouses enrolled under spouse equity provisions, and most persons covered under temporary continuation of coverage (TCC) do not receive a Government contribution towards the cost of their health benefits.

Government's Share

The Government's share of premiums paid is set by law. Amendments to the FEHB law under the Balanced Budget Act of 1997 (Public Law 105-33, approved August 5, 1997) authorized a new formula for calculating the Government contribution effective with the contract year that begins in January 1999. This formula is known as the "Fair Share" formula because it will maintain a consistent level of Government contributions, as a percentage of total program costs, regardless of which health plan enrollees elect.

For most employees and annuitants, the Government contribution equals the lesser of:

- 72 percent of amounts OPM determines are the program-wide weighted average of premiums in effect each year, for self only and for self and family enrollments, respectively, or
- 75 percent of the total premium for the particular plan an enrollee selects.

Government Contribution for Part-Time Employees

If you are a part-time career employee, the Government contribution toward your health benefits is prorated in proportion to the percentage of full-time service you are regularly scheduled to perform.

If you became a part-time career employee (working 16 to 32 hours a week or 32 to 64 hours biweekly) on or after April 8, 1979, you are entitled to a partial Government contribution in proportion to the number of hours you are scheduled to work in a pay period.

Employees who served on a part-time basis before April 8, 1979, and who have continued to serve on a part-time basis without a break in service (in that or any other position) are eligible for the full Government contribution, as are part-time employees who work less than 16 hours or more than 32 hours per week.

The amount of the Government contribution is determined by dividing the number of hours you are scheduled to work during the pay period by the number of hours worked by a full-time employee serving in the same or comparable position (normally 80 hours per biweekly pay period). That percentage is then applied to the Government contribution made for full-time employees enrolled in that plan.

The amount of the Government contribution is then deducted from the total premium (Government plus employee shares), and the remaining amount is withheld from your pay.

Your Share

During each pay period in which your FEHB enrollment is in effect, you are responsible for paying all premiums in excess of the Government contribution, usually 25% of the total premium.

If your pay (after retirement, FICA tax, Medicare and Federal income tax deductions) will cover the full employee share of your health benefits premiums, the withholding is taken from your salary. Group life insurance withholdings follow health benefits withholdings in the order of precedence set forth in the Treasury Fiscal Manual.

Premium Conversion

What is Premium Conversion? Premium conversion is a tax benefit. It allows you to allot a portion of your pay to your employer, who will in turn use that amount to pay your contribution for FEHB coverage. This allotment is made on a pre-tax basis, which means that the money is not subject to Federal income, Medicare, or Social Security taxes, and in most cases, state and local taxes. The allotment reduces your taxable income, so less tax is withheld, and your paycheck is larger.

Am You Eligible? You are eligible to have your FEHB premiums paid under the premium conversion plan when:

- you are an employee of the Executive Branch of the Federal Government;
- your pay is issued by an Executive Branch agency; and
- you participate in the FEHB Program.

If you are enrolled in the FEHB Program and are employed outside the Executive Branch, or your pay is not issued by an agency of the Executive Branch, you may be eligible if your employer agrees to offer participation in the plan.

If you are an employee paying both your and the Government's share of the premiums, the entire amount deducted from your pay qualifies for premium conversion.

Does Premium Conversion Apply Only to Employees? Yes. At the present time, annuitants and compensationers whose FEHB premiums are deducted from annuities and benefits are not eligible to participate in premium conversion. There are special rules for reemployed annuitants; see below.

Persons enrolled through Temporary Continuation of Coverage and Spouse Equity are not eligible for premium conversion.

Does Premium Conversion Apply to Reemployed Annuitants? Yes, if you are reemployed in a position that conveys FEHB eligibility, you may participate in premium conversion. See "Reemployed Annuitants" for more information.

How do You Enroll? You are automatically enrolled in premium conversion starting with the first pay period that begins on or after October 1, 2000.

Once you participate in premium conversion, your participation continues automatically unless you elect not to participate. Each year during FEHB Open Season you may decide whether or not to participate for the following year.

Making Withholdings and Contributions

General. Your employing office must make the appropriate health benefits premium withholdings and contributions beginning with the first pay period that your enrollment is effective. It must submit the full cost of your enrollment to OPM on a current basis for each pay period that your enrollment continues, even if you are paid for only part of the period (except in transfer and reinstatement cases) or you are in leave without pay status.

You should check your pay statement to verify that the health benefits premium withholding is correct and report any discrepancy to your employing office immediately. You are obligated to make the correct payment, regardless of any error in withholding made by your employing office. When too little or no money has been withheld from your pay for

health benefits, you incur a debt due the U.S. Government for the proper withholdings for each pay period that your enrollment continues.

Terminated and Cancelled Enrollments. Generally, if your enrollment terminates (other than for entry into military service), the effective date is the last day of the pay period in which the terminating event occurred. If you cancel your enrollment, the effective date is the last day of the pay period in which your employing office receives your cancellation request. Withholdings and contributions for the full pay period are required.

If your coverage terminates because you are in leave without pay status or you have insufficient pay to make the withholding, and you do not elect other payment options, the effective date is the last day of the pay period that you paid your share of the premiums.

Your coverage continues at no cost for 31 days after your enrollment terminates for any reason except when you voluntarily cancel your enrollment or your plan is discontinued.

When You Transfer to a Different Payroll Office (Daily Proration Rule) Effective March 1, 1997, the Daily Proration Rule applies when you transfer to a position serviced by a different payroll office at a time other than at the beginning of the pay period. Each payroll office (gaining and losing) is responsible for withholdings and contributions for the actual time you occupied a position each office services.

If you owe a debt for health benefits withholdings to your former employing office, the gaining office must make arrangements for withholding your indebtedness and forward the amount collected to your former employing office.

Daily Rate. A daily rate must be computed as follows:

Daily withholding and contribution rate = Biweekly withholding and contribution rate x 26 ÷ 364

Note: The denominator of 364 is always used, even during a leap year.

Active Employees. The formula for determining the amount of withholdings and contributions for which the losing and gaining payroll offices are responsible is:

Daily Rate x Days on Payroll

Example. During a pay period beginning August 4 and ending August 17, Henry transfers to a different agency, with his new appointment effective August 10. The biweekly employee share of his health benefits plan premium is $21.46 and the biweekly Government share is $61.51.

The daily withholding rate is $1.53 ($21.46 x 26 ÷ 364) and the daily contribution rate is $4.39 ($61.51 x 26 ÷ 364).

The losing agency is responsible for withholdings and contributions for 6 days (August 4 through 9), calculated as follows:

Withholdings: $1.53 daily rate x 6 days = $9.18

Contributions: $4.39 daily rate x 6 days = $26.34

The gaining agency is responsible for withholdings and contributions for 8 days (August 10 through 17), calculated as follows:

Withholdings: $1.53 daily rate x 8 days = $12.24

Contributions: $4.39 daily rate x 8 days = $35.12

When You Retire. When you retire, your employing office's responsibility for withholdings and contributions depends on when your annuity starts.

- If your annuity starts after the end of your final pay period, your employing office will make withholdings and contributions for the entire final pay period.

- If your annuity starts before the end of your final pay period, your employing office will make withholdings and contributions through the day before the starting date of your annuity, using the Daily Proration Rule.

(For information about determining when your annuity starts, see the CSRS/FERS Handbook for Personnel and Payroll Offices.)

Example. Mary Helen is retiring on May 31. The pay period begins on May 25 and ends on June 7. The biweekly employee share of her health benefits plan premium is $32.26 and the biweekly Government share is $61.51.

The daily withholding rate is $2.30 ($32.26 x 26 ÷ 364) and the daily contribution rate is $4.39 ($61.51 x 26 ÷ 364).

Her employing office will make withholdings and contributions for the period from May 25 through May 31 (7 days), calculated as follows:

Withholdings: $2.30 daily rate x 7 days = $16.10

Contributions: $4.39 daily rate x 7 days = $30.73

When You Die. The daily proration rule applies when you die and you have a survivor annuitant eligible to continue your enrollment. If there is no survivor annuity or if you had a Self Only enrollment, your employing office must make full withholdings and contributions for the pay period in which you die.

Upon Termination or Reinstatement for Military Service. The daily proration rule applies if your enrollment is terminated or reinstated because of entry into, or return from, military service. The effective date of the action is the date you entered into or returned from military service.

Retroactive Restoration. If you are retroactively restored to duty after an erroneous suspension or removal, you may either have your enrollment reinstated retroactively, or you may enroll in the plan and option of your choice, the same as a new employee. If you elect to have the enrollment reinstated retroactively, withholdings for the period of suspension or removal must be made, and your employing office must make contributions from the appropriate fund, as though the suspension or removal had not occurred.

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Coordination of Benefits

If you, or a covered family member, are entitled to benefits from a source other than your FEHB plan, such as a spouse's health insurance coverage, Medicare, Medicaid, or no-fault automobile insurance, coordination of benefits will take place. You must disclose information about the other source of benefits to your plan's Carrier.

Coordination with health care furnished by Uniformed Services Facilities (USF) and the Department of Veterans Affairs (DVA)

These Government agencies are entitled to seek reimbursement from FEHB plans for certain services and supplies furnished to you or a family member. Generally, FEHB benefits are payable for (1) inpatient hospital costs at a Uniformed Services facility, and (2) services and supplies provided by a DVA facility for treatment of a non-service connected disability.

Coordination with TRICARE (formerly CHAMPUS)

TRICARE provides health care for active-duty military personnel whose orders do not specify a period of 30 days or less, and their dependents; retired and former military personnel currently entitled to retired or retainer pay, or equivalent pay, and their dependents; and dependents of deceased military personnel. If you are covered by both an FEHB plan and TRICARE, the FEHB plan pays benefits first as the primary payer and TRICARE is the secondary payer. (All provisions applicable to CHAMPUS now apply to TRICARE.)

Coordination with MEDICARE

Basic Medicare Provisions. Medicare is generally for persons age 65 or over. It has two parts:

- Part A (Hospital Insurance) helps pay for inpatient hospital care, skilled nursing facility care, home health care, and hospice care. You are entitled to Part A without having to pay premiums if you or your spouse worked for at least 10 years in Medicare-covered employment. (You automatically qualify if you were a Federal employee on January 1, 1983.) A percentage of your salary, up to a maximum determined by the Social Security Administration, is deducted from your pay for this coverage.

- B (Medical Insurance) helps pay for doctors' services, outpatient hospital care, x-rays and laboratory tests, medical equipment and supplies, home health care (if you don't have Part A), certain preventive care, ambulance transportation, other outpatient services, and some other medical services Part A doesn't cover, such as physical and occupational therapy. You must pay premiums for Part B, which are withheld from your monthly social security payment or your Civil Service Retirement System (CSRS) annuity.

You should contact the Social Security Administration for detailed information on Medicare eligibility and benefits.

FEHB Plans and Medicare. Generally, plans under the FEHB Program provide protection against the same kind of expenses as Medicare, plus all FEHB plans provide prescription drug coverage, routine physicals, and a wider range of preventive services than Medicare. Whether your FEHB plan or Medicare is the primary payer depends on your current employment or health status, as shown in the following table.

When Either You or Your Covered Spouse are Age 65 and over, Have Medicare and FEHB, and You are:	**The Primary Payer is:**
An active employee with Federal Government (including when you or a family member are eligible for Medicare solely because of a disability)	FEHB
An annuitant	Medicare
A reemployed annuitant with Federal Government	FEHB, if position not excluded from FEHB(ask your employing office)
A Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (Or your covered spouse is this type of judge)	Medicare
Enrolled in Part B only, regardless of your employment status	Medicare, for Part B services
A former Federal employee receiving workers' compensation and the Office of Workers' Compensation has determined that you are unable to return to duty	Medicare, except for claims related to the workers' compensation injury or illness
When You or a Covered Family Member Have Medicare based on End Stage Renal Disease (ESRD) and FEHB, and:	**The Primary Payer is:**
Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD	FEHB
Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD	Medicare
Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision	Medicare
When You or a Covered Family Member have FEHB, and:	**The Primary Payer is:**
Eligible for Medicare based on disability	Medicare, if you are an annuitant. FEHB, if you are an active employee

When Your FEHB Plan is Primary. When your FEHB Plan is primary (see the table above), you should submit claims for benefits to your FEHB plan first. If a balance remains after the FEHB plan makes payment on the claim, you can then submit the claim and a copy of the FEHB plan's explanation of benefits (EOB) to Medicare.

When Medicare is Primary. When Medicare is primary (see the table above), you should submit claims for benefits to Medicare first. If a balance remains after Medicare pays the claim, you can then submit the claim and a copy of Medicare's Medicare Summary Notice (MSN) or explanation of benefits (EOB) to your FEHB plan. As the secondary payer , the FEHB plan won't process your claim without the Medicare MSN or EOB.

FEHB plan carriers have made arrangements with Medicare that automatically transfer claims information to it once Medicare processes your claim, so you generally don't need to file with both.

Enrollment Change Permitted. You may change your FEHB enrollment to any available plan or option at any time beginning on the 30th day before you become eligible for Medicare. You may use this enrollment change opportunity

only once, and is in addition to any other event (such as the annual open season) permitting enrollment changes.

You may discover that your current plan doesn't meet your needs once you start receiving Medicare benefits. You should review your plan's benefits and costs and determine if a different plan would be better for you.

Payment of Benefits in Medically Underserved Areas. If you live in a medically underserved area and are enrolled in a fee-for-service plan, your plan must pay benefits up to its contractual limits, for covered health services provided by any medical practitioner properly licensed under applicable State law.

Each year, before the FEHB open season begins, OPM determines which states qualify as medically underserved areas for the next calendar year. OPM announces the results of this determination before each open season in a public notice in the Federal Register. The medically underserved areas are listed in each fee-for-service plan's brochure.

For a list of designated states, please visit www.hrsa.gov/shortage.

Your Health Plan Choice. The right plan for you depends on many factors, including your family composition, your family's health, your ability to meet out-of-pocket medical expenses, and your ability to pay the required insurance premiums. What may be a good choice for one person may not be so for another. Only you can decide which plan is best for you.

Initial Decision and Reconsideration

Initial Decision. Your employing office has the responsibility for determining whether you are eligible to enroll or change your enrollment in the FEHB Program or in the premium conversion plan. Its initial decision that you can not enroll is given in writing and will inform you of the right to an independent level of review (reconsideration) by the appropriate agency office. The written initial decision will include the address of the office making reconsideration decisions, the time limit for requesting reconsideration, and a statement that you should include a copy of the initial decision with your reconsideration request.

Reconsideration Right. You have the right to ask your employing office to reconsider its initial decision denying FEHB enrollment or the opportunity to change your enrollment, or your participation in the premium conversioin plan. The reconsideration determines whether your employing office properly applied law and regulations in making its initial decision. This reconsideration is your final level of administrative review for enrollment decisions under the FEHB Program.

Who Does the Reconsideration? The office that makes the reconsideration decision must be at either a higher level or in a different office than the office that made the initial decision. Employing offices that make initial decisions must be made aware of the identity of the agency office making reconsideration decisions because they must include that information with the initial decision.

How to Request Reconsideration. You must request reconsideration in writing. The request must include:

- Your name and address
- Your date of birth
- Your Social Security Number
- The reason(s) for the request
- A copy of the initial decision.

Time Limit. You must request reconsideration within 30 calendar days from the date of the initial decision. Exception: you must request reconsideration of a carrier's disenrollment decision within 60 calendar days after the date of a carrier's disenrollment notice.

This time limit may be extended when you show that you were not notified of the time limit and were not otherwise aware of it or that you were unable to make the request within the time limit for reasons beyond your control.

Final Decision. The reconsidering office will issue a final decision. This decision will be in writing and fully state the findings. Initial decisions that comply with law and regulations cannot be overturned by reconsideration.

> Example 1. Henry lists parents who live with and are dependent on him as family members under his family enrollment. His employing office denies coverage of his parents. This initial decision cannot be overturned by reconsideration because the FEHB law does not provide for coverage of an employee's parents.
>
> Example 2. John marries. Three months later he requests a change of enrollment from Self Only to Self and Family based on the marriage. The employing office denies his request because the time frame for making a change due to marriage is 31 days before to 60 days after the marriage. This initial decision cannot be overturned because the time frame is a regulatory requirement.
>
> (If John claimed that he didn't make the change timely for reasons beyond his control, his employing office could allow a late election on that basis either at the initial decision level or at the reconsideration level.)

Effective Date of Reconsideration Enrollment. If on reconsideration your employing office decides that you should have been allowed to enroll or change enrollment, it accepts a Health Benefits Election Form (SF 2809) from you making the change. Generally, changes made upon reconsideration are effective prospectively. Under FEHB regulations, the change is normally effective on the first day of the first pay period beginning after the employing office receives the SF 2809.

In some cases, the law or regulations provide for retroactive effective dates, so your employing office doesn't need to decide whether a retroactive effective date is appropriate.

When the late election was the result of an administrative error, you may request that your employing office make the change retroactive to an earlier date, generally the date it would have been effective if you had been able to make a timely election.

If on reconsideration your employing office decides that you are entitled to continued enrollment in a plan from which you were disenrolled by the carrier, the disenrollment is void and coverage is reinstated retroactively.

Correction of Errors

Employing Office. Your employing office can make corrections of administrative errors regarding eligibility to enroll or changes in enrollment at any time. Your employing office may retroactively correct an enrollment code error if you report the error by the end of the second pay period after you received written documentation showing the error (for example, a pay statement or enrollment change confirmation).

When retroactive corrections are made, your employing office must determine whether the proper amount of health benefits deductions were made from your pay. Your employing office must submit any uncollected deductions and Government contributions to OPM for deposit in the Employees Health Benefits Fund.

Exception: If the administrative error was made before January 1, 1995, your employing office does not have the authority to make a retroactive correction. Instead, you must request a retroactive correction from OPM, Retirement

and Insurance Service, Office of Insurance Programs, P.O. Box 436, Washington, D.C. 20044.

OPM. OPM can order correction of an administrative error after reviewing evidence that it would be against equity and good conscience not to do so. A request for review should be sent to OPM, Retirement and Insurance Service, Office of Insurance Programs, P.O. Box 436, Washington, D.C. 20044.

Impaired Relationship. OPM may order a change in your enrollment from a particular HMO when you can show that you cannot receive adequate medical care because you (or a family member) and your HMO's health care providers have a seriously impaired relationship. You should submit your request and documentation of the impaired relationship to OPM, Retirement and Insurance Service, Office of Insurance Programs, P.O. Box 436, Washington, DC 20044.

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Leave Without Pay Status & Insufficient Pay

Coverage

Continued Coverage. Generally, your enrollment may continue for up to 365 days of leave without pay unless you want it to terminate or do not respond to your employing office's notice about continuing coverage during a period in leave without pay status. You must pay the employee share of premiums for every pay period that your enrollment continues.

Termination. Your enrollment will terminate at the end of the pay period which includes the 365th day in consecutive leave without pay status. You will have a 31-day extension of coverage and conversion rights.

4-Month Rule. The 365 days of continued enrollment during leave without pay status is not considered to be broken by any period(s) in pay status of less than 4 consecutive months. If you are in leave without pay status and return to pay status for less than 4 consecutive months, then return to leave without pay status, you do not begin a new 365-day period of continued enrollment. Instead, the second (and any other) period in leave without pay status is treated as continuation of the first. If you are in a pay status during any part of a pay period, the entire pay period is not counted toward the 365-day limit.

If you return to pay status for at least 4 consecutive months during which you are paid for at least part of each pay period, you are entitled to begin a new 365-day period of continued enrollment while in leave without pay status.

> Example 1. Arthur is in leave without pay status on January 1, 1999; returns to pay status on July 1, 1999; returns to leave without pay status on September 1, 1999; returns to pay status on January 1, 2000; and then back to leave without pay status on March 1, 2000. Since each return to pay status was for less than 4 months, his enrollment terminates at the end of the pay period that includes May 1, 2000, the 365th day in continuous leave without pay status.
>
> Example 2. Francine is in leave without pay status and returns to work on one occasion. The period in pay status is over 4 months. She is in leave without pay status on January 1, 1999; pay status on July 1, 1999; and leave without pay status on January 1, 2000 (a new 365-day eligibility period begins).
>
> Her enrollment terminates at the end of the pay period that includes December 31, 2000, the 365th day in continuous leave without pay status.

Return to Pay Status After 365 Days in Leave Without Pay Status. If your enrollment terminated because you exhausted the 365 days continuation of coverage while in leave without pay status, you must elect to enroll when you return to pay status (if you are eligible). If you enroll, and then work less than 4 months, your enrollment must again be terminated on the last day of your last pay period in pay status. You are not eligible for another 365-day period of continued coverage unless you are in pay status for at least 4 months.

Your employing office should have a follow-up system that will trigger an enrollment termination at the end of the pay period that includes the 365th day of leave without pay status.

When You Enter Leave Without Pay or Sufficient Pay Status

Employing Office Notification. Employing offices must be able to identify through timekeeping/payroll data all employees in leave without pay status and employees with insufficient pay to cover the premiums. Tracking such employees via the SF 50 is not reliable since one is not issued when an employee enters leave without pay status for less than 30 days or when an employee has insufficient pay.

Your employing office must give you a written notice as soon as it becomes aware that premium payments cannot be withheld from your salary because you are in leave without pay status or your pay is insufficient to cover your premiums. Your employing office may use the sample notice provided here or any other notice that adequately explains your options. This notice constitutes due process.

The notice:

- informs you of your options regarding continuing or terminating your enrollment;
- explains the effect of a termination;
- explains that if you decide to continue coverage, you must agree to pay the premium directly, incur a debt, or it may give you the option to pre-pay premiums;
- provides a space for you to continue or terminate your enrollment;
- states that if you do not return the notice within 31 days after receiving the notice (45 days if you live overseas), your enrollment will automatically terminate.

If your employing office cannot give you the written notice in person, it must send the notice by first class mail. Electronic mail cannot be used to give the written notice because you may not be at your desk to receive it. Your receipt is especially important because if you do not timely respond, your coverage will be terminated.

Your employing office must keep track of whether you signed and returned the notice within the required time frame. A notice that is mailed is considered to be received by you 5 days after the date of the notice. When you mail the signed form, the date of the postmark is considered to be the date the notice is returned to your employing office.

When You Choose to Continue Your Enrollment

If you elect to continue coverage during leave without pay status or insufficient pay, you can choose either to pay the premiums directly or to incur a debt. Your employing office may also offer a pre-pay option.

You Must Pay the Employee Share. You must still pay the employee share of health benefits premiums if you are in leave without pay status for an entire pay period, or if your pay during a pay period doesn't cover the full amount of withholdings due, unless you want your enrollment to terminate. Your employing office must notify you of the choices available to you and provide you with a method to make direct premium payments.

If you elect to continue your enrollment but you don't make direct premium payments, your employing office must advance you enough pay to cover the employee share of the premiums, as explained below.

Pay-As-You-Go Option. Under this option, you pay your share of FEHB premiums directly to your employing agency while on leave without pay. These payments generally will be made with after-tax monies, since there is no pay from which to make deductions.

If you choose this option, you are agreeing that if you do not pay the premiums, you will be incurring a debt to your employing office. You will have to repay this amount once you return to pay status. If you do not return to work or your employing office cannot recover the debt in full from your salary, it may recover the debt from:

- a lump sum payment of accrued leave;
- income tax refunds;

- amounts payable under the Civil Service Retirement System or Federal Employees Retirement System; or
- any other source normally available for the recovery of a debt due the United States.

Catch-up Option. Under the catch-up option, you agree in advance of the leave without pay period that:

- You will continue FEHB coverage while on leave without pay;
- Your employer will advance your share of FEHB premiums to OPM during your leave without pay period; and
- You will repay the advanced amounts when you return from leave without pay.

The repayment of the amount owed will be treated on a pre-tax basis, if it's deducted from pay and you participate in premium conversion at the time the deduction is made.

If you choose to repay the amount owed to your agency directly out-of-pocket your taxable income is not reduced.

Prepay Option. Your agency may (but is not required to) offer you the option to prepay your FEHB premiums from salary before you go on a period of leave without pay.

The amount of FEHB premiums you prepay in advance may either be deducted from your pay or paid directly "out-of-pocket" to your agency. Payments made "out-of-pocket" do not reduce your taxable income. The amount of FEHB premiums that you prepay will be treated on a pre-tax basis, if it is deducted from your pay and you participate in premium conversion.

IRS rules limit the amount you may prepay on a pre-tax basis. If your period of leave without pay will span two tax years, the amount that you may prepay on a pre-tax basis may not exceed the amount of FEHB premiums due for the remainder of the current tax year. If you wish to prepay the amounts due for the subsequent tax year as well, the deductions must be made after-tax. You may use the "pay-as-you-go" or "catch-up" options for amounts due in the subsequent tax year.

> Example. Max participates in premium conversion and has $100 per month in FEHB premiums deducted from his pay. He will go on leave without pay for three months beginning on October 31, 2000 and opts to continue his FEHB coverage. Max uses the pre-pay option to pay the $300 in FEHB premium payments that will be due while he is on leave without pay. He will receive pre-tax treatment on $200 of his FEHB premium prepayment (the amount he will owe for November and December 2000). The remaining $100 he prepaid (the amount due for January 2001) must be given after-tax treatment.

Employing Office Forwards both Government and Employee Shares each Pay Period. Public Law 104-208 requires your employing office to forward the full FEHB premium (both Government and employee contributions) to OPM on a current basis when you are in leave without pay status or when your pay is insufficient to make the withholdings. Your employing office must advance you salary to cover the employee share of your health benefits premiums when you are in leave without pay status and you do not make direct premium payments to your employing office, effective with the pay period beginning on or after September 30, 1996.

Recovering Salary Advances for Paying the Employee Share of Premiums. When your employing office advances your salary (the Catch-up Option) to cover the employee share of your health benefits premiums, you incur a debt to your employing office for the advance payments. It can recover that amount in the same manner as pay advanced to new appointees under 5 U.S.C. 5524a(c). It can offset against your accrued pay, amount of retirement credit, any other amounts due you from the U.S. or District of Columbia Governments, or in any other method provided by law.

The employing office that advanced your salary is permanently responsible for collecting the debt and must retain your written notice electing to continue FEHB coverage.

Since you must sign a statement agreeing that your debt may be withheld in full from future pay when you receive advance salary to cover your health benefits premiums, under 5 CFR 550.1102(b) your employing office is not required to offer you a hearing before it can begin its recovery of advance payments. However, your employing office must give you a notice that it intends to recover the advanced pay.

Coordination of Debt Repayments with Retirement or Workers' Compensation. When you apply for disability retirement or workers' compensation benefits, your annuity or compensation is generally payable from the day following your last day of pay. If you are eligible to continue health benefits coverage, the employee share is withheld from your annuity or compensation retroactive to the beginning date of the annuity or compensation payments.

If you have not made payments to your employing office for coverage during leave without pay status (either directly or through collection of the debt), your employing office recovers withholdings and contributions for the period in the same way as it adjusts errors in withholdings and contributions.

If you paid your employing office for coverage during leave without pay status and withholdings are being made from your annuity or compensation benefits for the same period, your employing office must refund these amounts to you to avoid double payments covering the same period. Your employing office makes the refund in the same way that it adjusts errors. In retirement cases, your employing office must refund the amount it received from you for periods after your last day in pay because these amounts are withheld from your annuity.

When your annuity doesn't begin on the day following your last day of pay, your employing office will not refund payments you made for time in leave without pay status until it receives OPM's notice that your disability retirement application was approved. This may happen when you don't meet the requirements for an annuity on the day after your last day of pay (e.g., you are receiving a disability annuity under CSRS and you don't complete 5 years of service until a later date). If your employing office isn't able to determine if withholdings from your annuity will cover all periods of leave without pay status after the last day of pay, it may request that OPM verify the correct period to be covered by the refund. Its request may be attached to your health benefits documents when they are sent to OPM with the final Individual Retirement Record (SF 2806 for CSRS or SF 3100 for FERS).

In workers' compensation cases, your employing office may request that the Office of Workers' Compensation Programs verify the dates that health benefits premiums have been withheld from your compensation benefits before it will refund any amounts you paid to it.

When you are a retiring employee and are indebted to your employing office for advanced pay to cover the employee share of your health benefits premium for a period that you weren't entitled to annuity or compensation benefits, the debt may be recovered by offset from your annuity.

Current Basis. Premium payments are due to your employing office after each pay period in which you are covered, according to the schedule it sets. If your employing office doesn't receive your payment by the due date, it will send you a notice stating that for your coverage to continue, you must make payment within 15 days (45 days if you live overseas) after you receive the notice. If you don't make any further payments, your enrollment will be terminated 60 days (90 days if you live overseas) after the date of the notice.

If you were unable to make timely premium payments for reasons beyond your control, you may ask your employing office to reinstate your coverage. Your request must be made in writing within 30 days from the termination date and must include documentation of the reasons. If your employing office grants your request, your enrollment will be restored retroactive to the termination date. If your request is denied, you may ask your employing office to reconsider its decision.

When You Allow Your Enrollment to Terminate

Your enrollment will terminate if you:

- do not sign and return the written notice within 31 days of receiving the notice (45 days if you live overseas), or
- return the signed notice, electing to terminate your enrollment.

In either event, your employing office must terminate your enrollment on the Notice of Change in Health Benefits Enrollment (SF 2810). It must note in the remarks section: "Employee (did not timely return written notice)(elected to terminate the enrollment) during a period of (leave without pay status)(insufficient pay)." The file copy of the notice (or if you elected to terminate your enrollment, your signed notice) should be attached to the SF 2810 and filed in the permanent side of the Official Personnel Folder. Your employing office will distribute copies of the SF 2810 to your payroll office and carrier.

The effective date of your enrollment termination is retroactive to the end of the last pay period that premiums were withheld from your pay.

Effect of Termination. If you decide not to continue your coverage, your enrollment is terminated, not canceled. This means that you are entitled to a 31-day extension of coverage and conversion privilege. You do not have to wait until the next open season to reenroll.

A termination is not considered a break in the continuous enrollment necessary for continuing coverage during retirement.

You are not eligible for temporary continuation of coverage (TCC) when your coverage terminates during leave without pay status or insufficient pay. TCC is only available when your coverage terminates because of separation from employment.

Retroactive Reinstatement of Terminated Coverage. If you couldn't return the notice within the required time frame for reasons beyond your control, you may ask your employing office to reinstate your coverage. You must file the request within 30 calendar days from the date you were given notification of the termination by your employing office. You must describe the circumstances that prevented you from returning the notice on a timely basis and include the signed written notice electing to continue coverage and agreeing to either pay the premium directly or incur a debt.

If your employing office decides to reinstate your enrollment, it completes parts A, D, and H of the Notice of Change in Health Benefits Enrollment (SF 2810); notes in the remarks section "Employee reinstated"; and distributes copies of the SF 2810 to your payroll office and carrier.

If your employing office rejects your reinstatement request, it must notify you of your reconsideration rights.

When You may Enroll after Termination. If you terminated your enrollment while you were in leave without pay status, you may reenroll within 60 days of returning to pay status in a position in which you are eligible for FEHB coverage.

If you terminated your enrollment while your pay was insufficient, you may reenroll within 60 days after the end of the first pay period your pay becomes sufficient to cover the premium. Your reenrollment takes effect the first day of the first pay period after your employing office receives your request to reenroll and that follows a pay period in which you were in pay status for any part of that pay period.

You can reenroll in any plan or option available to you. You are not restricted to enrolling into the same plan and option you had when your coverage terminated.

If you do not reenroll during the 60-day time period, you must wait for an open season to enroll, unless another qualifying event occurs before the next open season. This would be considered a break in the continuous coverage necessary for continuing coverage into retirement.

Special Circumstances

Student Trainees. If you are a student trainee with a career or career-conditional appointment, your enrollment continues during periods of leave without pay status as long as you are participating in the Student Career Experience Program (5 CFR 213.3202(b)). If you want to continue your enrollment during periods of leave without pay status, you must continue to pay the employee share of the premiums.

Active Duty Military Service. Under the Uniformed Service Employment and Reemployment Rights Act of 1994 (USERRA), if you enter active duty military service for more than 30 days, you may continue your health benefits enrollment for up to 18 months, unless you elect to have your enrollment terminated before you enter active duty. (You are considered to be on military furlough for health benefits purposes.) During the first 365 days in leave without pay status, you are required to pay only the employee share of the premium and you may postpone payment. After the first 365 days, you must pay both the employee and Government shares plus a 2 percent administrative charge directly to your employing office on a current basis. Your eligibility under USERRA ends 18 months after your absence for service in the uniformed service began or 90 days after your service ends, whichever is earlier.

While Receiving Compensation. Your enrollment may continue when you receive compensation under the Federal Employees' Compensation law for the first 365 days while in leave without pay status. After that period, you must meet the same participation requirements as for continuing an enrollment after retirement. OWCP, not your employing office, is responsible for determining your eligibility.

Part-time Employees. If you are a part-time career employee who receives a prorated Government contribution, during periods of leave without pay status you must pay the same health benefits premiums that are withheld from your pay while you are in pay status in your regularly scheduled tour of duty.

Temporary Appointments. If you are a temporary employee enrolled for FEHB coverage, during periods of leave without pay status you must continue to pay both the employee and Government shares of the premiums.

If you accept a temporary position while your enrollment is continuing during leave without pay status, your enrollment must be transferred to the employing office for your temporary position.

If you are still in leave without pay status when your temporary employment ends, your enrollment must be transferred back to your original employing office. The original employing office must determine the remaining length of time you are entitled to continued coverage while in leave without pay status. If you are no longer being carried as an employee in your original position when your temporary position expires, your enrollment must be terminated.

The two employing offices involved must coordinate these actions so that withholdings and contributions are made timely. The employing office that first becomes aware of the situation must contact the other employing office and arrange for transfer of the enrollment, if appropriate.

Family and Medical Leave. Under the Family and Medical Leave Act (FMLA) of 1993 (Public Law 103-3), you are entitled to up to 12 weeks of unpaid leave for certain medical and family needs.

FMLA leave usually runs concurrently with the 365 day period of coverage during leave without pay status allowed under the FEHB law. In these cases the regular rules for coverage during periods in leave without pay status apply. If

you are granted leave under FMLA that exceeds the 365 days of continued coverage allowed under the FEHB law, you must pay your share of premiums directly to your employing office on a current basis during the period that exceeds 365 days. (This may happen if you have already used an extensive amount of leave without pay before you invoke your rights under FMLA).

If your coverage is terminated for nonpayment during FMLA leave, you may reenroll when you return to pay and duty status.

Appointments to Employee Organizations. If you go into leave without pay status to serve as a full-time officer or employee of an employee organization, you may elect to continue health benefits coverage within 60 days from the start of the leave without pay status.

The health benefits coverage continues for the length of the appointment, even if the leave without pay status lasts longer than 365 days. You must pay to your employing office the full cost of your health plan premiums. There is no Government contribution. You must pay your premiums to your employing office before, during, or within three months after the end of each pay period. You will be eligible for premium conversion if the employee organization adopts the OPM premium conversion plan.

Your employing office must keep you informed of all developments that affect health benefits. It must also adjust your share of the premium and the agency contributions when appropriate.

Your coverage will terminate if you do not pay your premiums within this time frame, subject to the 31-day extension of coverage and conversion right. Your coverage cannot resume until you enter in pay and duty status in Federal service.

> Exception: your coverage will be restored retroactively if your employing office finds that you were unable to make the premium payments for reasons beyond your control and you make the payments at the first opportunity.

Appointment to State or Local Governments or Institutions of Higher Education, Indian Tribal Government, or other Organizations. If you go into leave without pay status while assigned to a State or local government, institution of higher education, Indian tribal government, or certain other organizations specified in 5 CFR Part 334 , you are entitled to continue health benefits coverage for the length of the assignment, even if the leave without pay status lasts longer than 365 days.

You must elect to continue your health benefits coverage and pay the employee share of your premiums to your employing office before, during, or within three months after the end of each pay period. Your employing office must continue to pay its contributions as long as you make your payments.

Your employing office must keep you informed of all developments that affect health benefits. It must also adjust your share of the premium and the agency contributions when appropriate. Your coverage will terminate if you do not pay your premiums, subject to the 31-day extension of coverage and conversion right. Your coverage cannot resume until you enter on pay and duty status in Federal service. Exception: your coverage will be restored retroactively if your employing office finds that you were unable to make the premium payments for reasons beyond your control and you made the payments at the first opportunity.

If you elect to be covered under a State or local government's health benefits program that OPM determines to be similar to the FEHB Program, you are not entitled to continue coverage under the FEHB Program. Send your request for OPM's determinations to Office of Personnel Management, Retirement and Insurance Service, Office of Insurance Programs, P.O. Box 436, Washington, D.C. 20044.

Transfers to International Organizations. You may continue health benefits coverage if you are transferred to an

international organization as provided in 5 U.S.C. 3582. You must elect to continue health benefits coverage and pay the employee share of your premiums to your employing office before, during, or within three months after the end of each pay period. Your employing office must continue to pay its contributions as long as you make your payments. You will be eligible for premium conversion if the organization agrees to adopt the OPM premium conversion plan.

Your employing office must keep you informed of all developments that affect health benefits. It must also adjust your share of the premium and the agency contributions when appropriate.

Your coverage will terminate if you do not pay your premiums, subject to the 31-day extension of coverage and conversion right. Your coverage cannot resume until you enter on pay and duty status in Federal service. Exception: your coverage will be restored retroactively if your employing office finds that you were unable to make the premium payments for reasons beyond your control and you made the payments at the first opportunity.

If you do not elect to continue your health benefits enrollment, you are not considered to be a Federal employee for health benefits purposes while employed by the international organization.
Regulations governing these transfers are in 5 CFR part 352.

If You Pay Your FEHB Premiums over less than 12 Months. If your annual salary is normally paid over a period of less than 12 months (such as a teacher on a 10-month contract), your employing office will prorate your annual health benefits contributions over the number of salary installments during the year, so that you don't pay any additional premiums during your expected nonpay period. If you enter a leave without pay status during your normal working period, you must pay premiums for that period the same as other employees in leave without pay status.

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Termination, Conversion & Temporary Continuation of Coverage

Cancellation

Electing to Cancel. If you participate in premium conversion, you may cancel your enrollment:

- During the annual Open Season; or
- Within 60 days after you have a qualifying life event. Your cancellation must be consistent with and correspond to your qualifying life event.

Example. LaTonya gets married, and since her husband's company provides health insurance for a spouse, she wants to cancel her FEHB enrollment. She can make this enrollment change outside of Open Season since it is consistent with and corresponds to her qualifying life event (marriage).

If you do not participate in premium conversion, you may cancel your enrollment at any time. Your cancellation becomes effective on the last day of the pay period in which your employing office receives your Health Benefits Election Form (SF 2809) or other enrollment request. When you cancel your enrollment, you are not eligible for the 31-day extension of coverage and you can't convert your coverage to an individual policy.

If your temporary continuation of coverage (TCC) or spouse equity enrollment ends because you didn't pay the premiums, it is considered to be a voluntary cancellation.

When you cancel your enrollment, your family members' coverage terminates at midnight of the day that your cancellation is effective, with no 31-day extension of coverage.

Your Responsibility. When you cancel your enrollment, your signature certifies that you are aware:

- of the effect the election not to enroll could have on your eligibility to continue health benefits coverage after retirement;
- that you may not enroll again until an event occurs (such as marriage or open season) that permits enrollment.

Your employing office will process your termination by following the applicable instructions in "Employing Office Review of SF 2809." It will use the old carrier copy to notify your carrier of your cancellation and discard the new carrier copy.

Annuitants. When you cancel your enrollment as an annuitant, you may never reenroll unless:

- you become reemployed in a position that conveys coverage, or
- you had canceled your FEHB enrollment to enroll in a Medicare managed care plan or Medicaid and that coverage ends.

Termination

Enrollees. Your enrollment will terminate, subject to a 31-day extension of coverage, on the earliest of the following dates:

- the last day of the pay period in which you separate from service (unless you transfer, retire, or begin receiving Workers' Compensation benefits);

- the last day of the pay period in which you separate after you meet the requirements for an immediate annuity under the FERS MRA+10 provision and you postpone receipt of your annuity (see chapter 42A of the CSRS/FERS Handbook for Personnel and Payroll Offices);

- the last day of the pay period in which you change to a position that is excluded from coverage;

- the last day of the pay period in which you die, unless you have a family member eligible to continue enrollment as a survivor annuitant;

- the last day of the pay period that includes the 365th day of continuous leave without pay status or the last day of leave under the Family and Medical Leave Act, whichever is later;

- the last day of the last pay period in pay status, if you haven't had 4 consecutive months of pay status after you exhausted the 365 days continuation of coverage in leave without pay status;

- the day you are separated, furloughed, or placed on leave of absence to serve in the uniformed services for duty over 30 days, if you elect in writing to have your enrollment terminated;

- the date that is 24 months after the date of your separation, furlough, or leave of absence to serve in the uniformed services for duty over 30 days, or the date your entitlement to continued coverage ends, whichever is earlier;

- the day on which your temporary continuation of coverage (TCC) expires;

- the last day of the pay period for which withholding was made when you are a temporary employee enrolled under 5 U.S.C. 8906a whose pay is insufficient to pay the withholdings and you didn't or couldn't choose a plan for which your pay would cover the premiums.

Your enrollment may also terminate when you enter leave without pay status.

Family Members. Your family member's coverage terminates, subject to a 31-day extension of coverage, at midnight on the earlier of the following dates:

- the day that you change your enrollment to self only or your enrollment terminates (unless you die and you have a survivor eligible to continue your enrollment);

- the day that he/she is no longer an eligible family member.

You cannot continue coverage for your spouse under your self and family enrollment upon your divorce. He/she may be eligible for his/her own enrollment under either the spouse equity or temporary continuation of coverage provisions.

When you cancel your enrollment, your family members' coverage terminates at midnight of the day that your cancellation is effective, with no 31-day extension of coverage.

Processing Terminations

Employing Office Responsibilities. When your enrollment terminates, your employing office must prepare a Notice of Change in Health Benefits Enrollment form (SF 2810), showing the reason for your termination in the remarks section. Your employing office must prepare, process and distribute the SF 2810 as quickly as possible so your carrier knows

that you are no longer covered under the health benefits plan.

By Termination of Membership in Employee Organization. When the employee organization plan you are enrolled in instructs your employing office to terminate your enrollment because you are no longer a member, your employing office will do so on the Notice of Change in Health Benefits Enrollment (SF 2810). It will note in the Remarks section: "Your enrollment was terminated by the plan because you are no longer a member of the sponsoring employee organization. You may enroll in another plan from 31 days before to 60 days after the date in Part A, item 8, above." (This date is the last day of the pay period in which your employing office received the plan's notice of termination.) Your new enrollment will be processed as an enrollment change.

For Other Reasons. When your enrollment terminates for any reason other than cancellation or termination of your membership in an employee organization, your employing office must:

- complete parts A, B, and H of the Notice of Change in Health Benefits Enrollment (SF 2810);
- state the reason for the termination in the Remarks section (e.g., "Employee resigned"); and
- send the carrier and payroll office copies to the payroll office for transmission to the carrier and for posting to the payroll records, respectively.

31-Day Extension of Coverage and Conversion

Extension of Coverage. You and your eligible family members' coverage continues at no cost for 31 days after your enrollment terminates for any reason except when you voluntarily cancel your enrollment or your plan is discontinued.

If you or a family member are an inpatient in a hospital on the 31st day of your extension of coverage, FEHB benefits for the hospitalized person will continue for the length of the hospitalization, up to a maximum of 60 more days, unless you convert to an individual contract.

Conversion Rights. When your enrollment terminates, you are entitled to convert to an individual policy offered by the carrier of your plan. You are not required to provide evidence of insurability.

> Exception: you are not entitled to convert to an individual policy if you voluntarily canceled your enrollment or your plan was discontinued.

Benefits under a Conversion Contract. Many conversion contracts provide fewer benefits at a higher cost than what is offered under the FEHB Program. Also, there is no Government contribution to the cost of the individual conversion contract. If you anticipate that a family member will lose coverage in the near future, the benefits and cost of a plan's conversion contract may be an important consideration in your choice of a health plan. If you or a family member are considering converting to an individual policy, you should contact the carrier of your plan for information about the benefits and cost of its conversion contract.

Conversion for Family Members. If a family member loses coverage under your enrollment (including as a result of your change to self only), he/she is also entitled to convert to an individual policy offered by the carrier of your plan. Your family member is not required to provide evidence of insurability.

Exception: your family member is not entitled to convert to an individual policy if you voluntarily canceled your enrollment or your plan was discontinued.

It is the responsibility of you or your family member to know when he/she is no longer eligible for coverage and to apply for a conversion contract in a timely manner. Your employing office is not obligated to inform you of your family member's conversion rights when he/she is no longer eligible for coverage. Your employing office

may, from time to time, publish reminders of family members' right to convert in internal publications.

To apply for conversion, you or your family member must make a written request to the carrier of your plan. You or your family member must apply for conversion within 31 days after his/her coverage as a family member terminated.

Conversion for Enrollees. When your enrollment terminates, your employing office must give you a notice of your right to convert to an individual policy on the Notice of Change in Health Benefits Enrollment form (SF 2810). Your employing office should provide you with this notice immediately upon your enrollment termination, but no later than 60 days from the termination date.

To apply for conversion, complete the back of your copy of the SF 2810 and take or mail it to the carrier of your plan within 31 days from the date of your employing office's notice to you (part H of SF 2810), but no later than 91 days from the date your enrollment terminates (Part A, item 8 of SF 2810).

Late Conversion. When your employing office doesn't give you the required conversion notice within 60 days, or you aren't able to request conversion on time for reasons beyond your control, you can request a late conversion by writing directly to the carrier of your plan.

You must send your request within six months after the date your enrollment terminated. Your request must:

- include some documentation that your enrollment has terminated (for example, an SF 50 showing separation from service);
- include proof that you were not notified of the enrollment termination and the right to convert (for example, a letter from your employing office confirming that it did not provide timely notice of the conversion option), and were not otherwise aware of it, or
- include proof that you weren't able to convert because of reasons beyond your control.

If six months or more have passed since the date you became eligible to convert, the carrier of your plan is not required to accept a request for conversion.

If the carrier accepts your request for a late conversion, you must enroll and pay your first premium within 31 days of the carrier's notice. If you don't convert within this time period, you are considered to have waived your conversion rights, unless the carrier determines that you did not convert for reasons beyond your control. If the carrier determines that your failure to convert was within your control, you may request that OPM review its decision. To request an OPM review, write to U.S. Office of Personnel Management, Retirement and Insurance Service, Office of Insurance Programs, P.O. Box 436, Washington, D.C. 20044.

Effective Date of Conversion Contract. Your or your family member's conversion contract becomes effective at the end of the 31-day extension of coverage, even when you or your family member are an inpatient in a hospital on the 31st day of extended coverage.

Reinstatement of Enrollment after Conversion. If you converted to an individual contract after your enrollment terminated, and your enrollment is later reinstated retroactive to the effective date of your termination (e.g., you were removed and later ordered restored to duty with full restitution of back pay; or you retire with an annuity starting date made prior to your enrollment termination because of 365 days in leave without pay status), you may get a refund of all the premiums you paid on the conversion contract. You must apply in writing to the carrier of your plan for the refund. If you received benefits when your conversion contract was in effect, you are entitled to an adjustment of the difference between the benefits paid by the carrier under the conversion contract and the benefits payable under your FEHB enrollment.

Termination of Erroneous Enrollment

If your position is excluded from FEHB coverage but you were erroneously allowed to enroll, your employing office must terminate or void your coverage as soon as the error is discovered. Your employing office must explain to you why you are not eligible for coverage and the effect of the termination.

If Withholdings were Made. If you were erroneously enrolled and premium withholdings and contributions were made, your employing office must terminate your coverage and discontinue withholdings and contributions at the end of that pay period. No adjustments are made for contributions and withholdings that already have been made. You and your covered family members are entitled to full plan benefits during the time you were erroneously enrolled. You are entitled to convert to an individual contract the same as any other employee whose enrollment is terminated.

If Withholdings were not Made. If no premium withholdings and contributions were made before your erroneous enrollment is discovered, your employing office must void your enrollment. In addition, your employing office will note in the Remarks section of the payroll office copy of the Health Benefits Election Form (SF 2809) (which is sent to the carrier): "Erroneous enrollment--enrollee responsible for any benefits provided." You will be responsible for any claims paid during your erroneous enrollment. Your carrier will contact you to recover any payment it made.

Temporary Continuation of Coverage

If you lose your FEHB coverage because you separate from Federal service, you may enroll under the Temporary Continuation of Coverage (TCC) provision of the FEHB law to continue your coverage for up to 18 months. Exception: you are not eligible for TCC if your separation is due to gross misconduct.

Your family members who lose coverage because they are no longer eligible family members may enroll under TCC to continue FEHB coverage for up to 36 months.

Law. Title II of Public Law 100-654, effective January 1, 1990, established the temporary continuation of coverage provision for the FEHB Program.

Eligibility. An employee, a child, and a former spouse are eligible for temporary continuation of coverage based on specific qualifying events.

Employee. You are eligible for temporary continuation of coverage when you:

- separate from service, voluntarily or involuntarily, unless your separation is due to gross misconduct; and
- you would not otherwise be eligible to continue FEHB coverage (not counting the 31-day extension of coverage).

You are eligible for temporary continuation of coverage when you separate for retirement and are not eligible to continue FEHB coverage as an annuitant.

Health Reform's Effect on Children. On March 23, 2010, President Obama signed into law the “Patient Protection and Affordable Care Act,” Public Law 111-148. While some aspects of this law will not take effect until 2014, there are several major provisions that become effective before that time.

Coverage for a dependent adult until age 26 is effective the first day of the plan year that is six months following enactment of the law. For the Federal Employees Health Benefits (FEHB) Program, that means January 1, 2011.

Children's Eligibility in the FEHB Program. It is your responsibility to know when a family member is no longer eligible for coverage – your agency will not notify you. Your child can be covered under your Self and Family

enrollment until he or she marries or turns age 22. It does not matter whether he or she attends college. Your stepchildren and foster children are included in your Self and Family enrollment if they live with you in a regular parent-child relationship. An unmarried dependent child age 22 or over who is incapable of self-support because of a mental or physical disability that existed before age 22 is also an eligible family member.

Options When Your Child Turns 22. When your child reaches age 22, he/she is no longer an eligible family member until January 1, 2011. Your child's coverage continues at no cost for 31 days after the enrollment terminates. Your child is also eligible to enroll in Temporary Continuation of Coverage (TCC) or to convert to an individual policy with your carrier.

If your child is interested in TCC, you must contact your Human Resources Office and inform them your child is turning age 22. After your notification, your Human Resources Office will give you information about enrolling your child for TCC. You have 60 days from the 22nd birthday to notify your Human Resources Office your child turned 22. Your child has 60 days from the later of (1) the 22nd birthday, or (2) the date of the TCC notice from the Human Resources Office to request enrollment for TCC. For more information about TCC, please review the TCC coverage pamphlet at www.opm.gov/insure/health/eligibility/tcc/.

When your child's TCC enrollment terminates, he/she is entitled to convert to an individual policy by your plan. Your child is not required to provide evidence of insurability. To apply for conversion, you or your child must make a written request to the carrier of your plan. You or your child must apply for conversion within 31 days after his/her coverage as a family member terminated.

Former Spouse. Your former spouse is eligible for temporary continuation of coverage when he/she has been covered as a family member at some time during the 18 months before your marriage ended, but does not meet the remaining requirements for coverage under the spouse equity provisions of the FEHB law because he/she:

- remarried before reaching age 55; or
- is not entitled to a portion of your annuity benefits or a survivor benefit based on your service.

Persons not Eligible. You are not eligible for temporary continuation of coverage (TCC) when:

- you transfer to a position that is excluded from FEHB coverage by law;
- you lose coverage after 12 months in a leave without pay status;
- you are a compensationer and you lose coverage because your compensation terminates;
- you are a family member who loses coverage when the enrollee changes to a self only enrollment, cancels coverage, or separates from service and does not elect TCC;
- you are a spouse who loses coverage because of the death of an employee or annuitant (most surviving spouses can continue regular coverage as survivor annuitants, and so don't need TCC);
- you are a surviving spouse whose annuity terminates;
- you are a child who enters military service (you are still considered an eligible dependent child).

In some cases, a child who would ordinarily be covered as a family member may want TCC coverage instead. This may happen when your unmarried child has a child and wants to provide health benefits coverage for this child. Usually, your grandchild is not eligible for coverage as a family member under your enrollment, unless he/she qualifies as a foster child. For your child to enroll through TCC and cover his/her child, you must prove that he/she is

no longer a dependent.

Employing Office Responsibilities. The employing office that is responsible for your TCC enrollment on the date of the qualifying event remains responsible for your enrollment for the length of your TCC enrollment. (Many employing offices contract with the National Finance Center to administer TCC enrollments and to act as the employing office.) Your employing office's responsibilities in administering temporary continuation of coverage (TCC) include:

Providing Information for Employees. The employing office is responsible for providing all employees who are enrolled or eligible to enroll in FEHB with information about their right to TCC.

However, your employing office is not obligated to notify you or your family member when he/she is no longer eligible for coverage under your enrollment or provide notification of his/her eligibility for TCC.

Administering the Enrollment Process. Each employing office must establish procedures for notifying former employees about their eligibility to enroll, including what documents are needed to determine eligibility, and accepting enrollment elections from former employees, children and former spouses.

Verifying Eligibility to Enroll. The employing office must verify the eligibility of a child or former spouse to enroll. If there is conflicting information on a child's date of birth or marriage or the date of your divorce, the employing office must determine the correct date.

Collecting Premiums. The employing office of the employee or annuitant at the time of the qualifying event is responsible for collecting premiums. The employing office sends the premiums it collects to OPM.

Maintaining the Health Benefits File. The employing office must maintain a health benefits file for each TCC enrollee separate from his or her personnel records as an employee or former employee.

Denying TCC Due to Involuntary Separation for Gross Misconduct. The employing office must make determinations of gross misconduct and follow the required administrative procedures.

Maintaining Enrollment. The employing office must provide services to TCC enrollees similar to those provided to enrolled employees. For example, it must provide open season information and process enrollment changes and cancellations.

Notification Requirements for Separating Employees. When you separate from service and are eligible for temporary continuation of coverage (TCC), your employing office must notify you no later than 61 days after your separation of your opportunity to elect TCC.

This notice should include your right to convert to an individual contract offered by your plan. This notice must explain your right to enroll in TCC and how you can get the registration form and additional information. Your employing office should attach the pamphlet, Temporary Continuation of Coverage under the Federal Employees Health Benefits Program (RI 79-27) to the notice. If you want to elect TCC, you must respond within the specified time limit.

Sample Notice for Separating Employees. Your employing office may use the following sample notice to notify you of your TCC rights upon your separation:

> *Dear (name):*
>
> *Your coverage in the Federal Employees Health Benefits (FEHB) Program ends on the last day of the pay period in which you separate from Federal service, subject to a 31-day extension of coverage (at no cost to you) with opportunity for conversion to an individual contract with your insurance carrier.*

You also have the right to temporarily continue your FEHB coverage for up to 18 months after your separation instead of converting to an individual contract at this time. You may select any plan in the FEHB Program in which to continue your coverage if you are eligible to enroll in the plan. To continue your coverage, you must pay the full amount of the premium (both the employee and Government shares) plus a 2 percent administrative charge. If you choose to continue your coverage, you have the free coverage described above for the first 31 days. Your Temporary Continuation of Coverage (TCC) enrollment and premium charges begin on the day after the 31-day period of free coverage ends. If you continue TCC to the end of the 18-month period, you will have another 31-day extension of coverage with opportunity for conversion to an individual contract.

If you are interested in continuing your FEHB coverage, you can get additional information and an election form by calling (Name of person to contact) at (telephone number) or you can pick up the material at the following address: (enter address).

If you want to continue your coverage, your election form must be received at the address shown below within 60 days after the date of separation or 65 days after the date of this notice, whichever is later. Bring or mail your election form to:(enter address)

Sincerely,

(Name of appropriate official)

If your employing office gives this notice directly to you, it should add the following note and make two copies of the notice:

I acknowledge receipt of this notice.
*Employee's signature Dat*e

Notification Requirements for Children

If your child becomes eligible for temporary continuation of coverage (TCC), it is your responsibility as the enrolled employee to notify your employing office of the change in your child's status. You must provide your child's name, address, and date of the event that caused his/her loss of FEHB coverage within 60 days from the loss of coverage. Your employing office then has 14 days to notify your child of his/her TCC rights.

Your child or another person may notify your employing office of the child's loss of coverage; but the time limit for electing TCC will be shorter than if you provided the notification.

The notice from your employing office to your child must include:

- an explanation of your child's right to TCC;
- FEHB Guide (RI 70-5);
- Health Benefits Election Form (SF 2809);
- Temporary Continuation of Coverage Under the Federal Employees Health Benefits Program (RI 79-27);
- how the child can get additional information; and

- if there is doubt about the date of the qualifying event, a request for the appropriate information or documentation.

Sample Notice for Child. Employing offices may use the following sample notice of TCC rights when you timely notified your employing office of your child's loss of coverage:

Dear (child's name):

Your coverage in the Federal Employees Health Benefits (FEHB) Program as a family member of (enrollee's name) ended when you (enter reason), subject to a 31-day extension of coverage (at no cost) with opportunity for conversion to an individual contract with your insurance carrier.

You also have the right to temporarily continue your FEHB coverage for up to 36 months after the date of (enter reason) instead of converting to an individual contract at this time. You may select any plan in the FEHB Program in which to continue your coverage if you are eligible to enroll in the plan. If you choose family coverage, your spouse and your children will also be covered. To continue your coverage under the temporary continuation of coverage (TCC) provision, you must pay the full amount of the premium (both the employee and Government shares) plus a 2 percent administrative charge. If you choose to continue your coverage, during the first 31 days you have the free coverage described above. Your TCC enrollment and premium charges begin on the day after the 31-day period of free coverage ends. If you continue the coverage to the end of the 36-month period, you will have another 31-day extension of coverage with opportunity for conversion to an individual contract.

An election form and detailed information about your opportunity to continue coverage is enclosed. You may get additional information by calling (name of contact) at (telephone number).

If you want to continue your coverage, your election form must be received at the address shown below within 60 days after the date of your (enter reason) or 65 days after the date of this notice, whichever is later. Bring or mail your election form to: (enter address).

Sincerely,

(Name of appropriate official)

If your employing office gives the notice directly to your child, it should add the following note and make two copies of the notice:

I acknowledge receipt of this notice.

Child's signature Date

If someone other than yourself (the enrollee) notified the employing office of your child's loss of coverage, the sample notice's last paragraph should be replaced by the following paragraph:

If you want to continue your coverage, your election form must be received at the address shown below within 60 days after the date of your (enter reason). Bring or mail your election form to: (enter address).

Notification Requirements for Former Spouses

If your former spouse is eligible for temporary continuation of coverage (TCC), either you or your former spouse must notify your employing office within 60 days after the date of your divorce or annulment. Your employing office then has 14 days to notify your former spouse of his/her rights. The notice to your former spouse must include the same

information as the notice to a child. In addition, the notice must request a certified copy of the divorce decree or other document showing the date of the divorce or annulment. If he/she wants to elect TCC, he/she must respond within the specified time limit.

Another person may notify your employing office of your former spouse's loss of coverage; but the time limit for electing TCC will be shorter than if you or your former spouse provided the notification.
Sample Notice for Former Spouse. Your employing office may use the following sample notice of TCC rights when you or your former spouse timely notified your employing office:

Dear (former spouse's name):

Your coverage as a family member in the Federal Employees Health Benefits (FEHB) Program ended when you were divorced or your marriage was annulled, subject to a 31-day extension of coverage (at no cost) with opportunity for conversion to an individual contract with your insurance carrier.

You also have the right to temporarily continue your FEHB coverage for up to 36 months after your divorce instead of converting to an individual contract at this time. You may select any plan in the FEHB Program in which to continue your coverage if you are eligible to enroll in the plan. If you choose a family enrollment, it will cover yourself and the children of both you and the Federal employee under whose enrollment you have been covered. If your former spouse still carries a family enrollment, you can enroll for self only. To continue your coverage under the Temporary Continuation of Coverage provision (TCC), you must pay the full amount of the premium (both the employee and Government shares) plus a 2 percent administrative charge. If you choose to continue your coverage, during the first 31 days you have the free coverage described above. The TCC enrollment and premium charges begin on the day after the 31-day period of free coverage ends. If you continue the coverage to the end of the 36-month period, you will have another 31-day extension of coverage with opportunity for conversion to an individual contract.

Enclosed is an election form and detailed information about your opportunity to continue your coverage. You can get additional information by calling (name of contact) at (telephone number).

If you want to continue your coverage, your election form must be received at the address shown below within 60 days after the date of your divorce or annulment or 65 days after the date of this notice, whichever is later. Bring or mail your election form and a certified copy of the divorce decree or another document showing your divorce date to: (enter address).

Sincerely,

(Name of appropriate official)

If your employing office gives the notice directly to your former spouse, it should add the following note and make two copies of the notice:

I acknowledge receipt of this notice

Former spouse's signature Date

If someone other than you or your former spouse notified the employing office of his/her loss of coverage, the sample notice's last paragraph should be replaced by the following paragraph:

If you want to continue your coverage, your election form must be received at the address shown below within 60 days after the date of your divorce or annulment. Bring or mail your election form to: (enter address).

Receipt of Notice. Your employing office must either give the notice directly to the person eligible for temporary continuation of coverage (TCC) or send it by first class mail. (A notice that is mailed is considered to be received 5 days after the date of the notice.) If you, your child, or former spouse are given the notice directly by your employing office, it will require that you acknowledge receipt by signing a copy of the notice. The signed copy must be placed on the right side of your Official Personnel Folder (OPF) or the equivalent. If the notice is sent by mail, a dated copy of the notice must be filed in your OPF.

Time Limits for Electing Temporary Continuation of Coverage

If you are a separating employee, you must submit your Temporary Continuation of Coverage (TCC) election to your employing office within 60 days after the date of your separation or 65 days after the date of your employing office's notice, whichever is later.

Your eligible child must submit his or her TCC election to your employing office within either:

- 60 days after the date of the qualifying event, if you (the enrollee) did not notify your employing office within the required 60-day notification period (even if someone else provided notification); or,

- 65 days after the date of your employing office's notice, if you notified your employing office within the required 60-day notification period.

Your former spouse must submit his or her TCC election to your employing office by the later of:

- 60 days after the date of your divorce or annulment, if you or your former spouse did not notify your employing office within the required 60-day notification period (even if someone else provided notification); or

- 65 days after the date of your employing office's notice, if you or your former spouse notified your employing office within the required 60-day notification period; or

- 60 days after the date he/she lost coverage under spouse equity provisions (because of remarriage before age 55 or loss of the qualifying court order), if the loss of coverage is within the 36-month period of TCC eligibility.

If you or your former spouse do not notify your employing office within the 60-day period, your former spouse's opportunity to elect TCC ends 60 days after the divorce or annulment.

Guardian may File. A court-appointed guardian may file a temporary continuation of coverage (TCC) election on behalf of an eligible person that is unable to file because of a mental or physical disability.

Late Election. Your employing office may allow a late temporary continuation of coverage (TCC) election if it determines that you or your family member were unable to elect it on a timely basis for reasons beyond your control. It must accept the TCC election within 31 days after it provides notification of its decision to allow a late enrollment. Coverage is made retroactive, and retroactive premiums are due, to the date it would have been effective if elected on a timely basis.

Your employing office cannot accept a late election when it did not receive the required notification of your family member's eligibility for TCC within the time limits set by law and regulation.

Election Options. When you elect Temporary Continuation of Coverage (TCC), you may choose self only or self and family coverage in any plan or option that you are eligible to join. You are not limited to the plan, option, or type of enrollment under which you had been covered.

Covered Family Members. If you are a former employee with a Temporary Continuation of Coverage (TCC) self and family enrollment, the eligibility requirements for your family members are the same as for active employees.

When your child enrolls for self and family, covered family members are his/her spouse and eligible children. When your former spouse enrolls for self and family, covered family members are limited to the children of both you (the employee) and your former spouse. If your former spouse remarries, the new husband or wife is not covered. Stepchildren that were covered under your enrollment because they lived with you are not covered under your former spouse's TCC enrollment. (Usually, a stepchild's coverage ends before the divorce because he/she stops living with you. The stepchild then becomes eligible to enroll under TCC because he/she is no longer a covered family member.)

After the initial enrollment, a TCC enrollee may change enrollment during an open season or when another event occurs that would allow a change in enrollment.

Election Procedures. To make a Temporary Continuation of Coverage (TCC) election, you should submit a Health Benefits Election Form (SF 2809) to the employing office that is servicing your account. If you submit a signed election request in a format other than the SF 2809, your employing office must complete a SF 2809 on your behalf based on your written request. Your name, date of birth, and social security number must be entered in part A of the form.

If you are a separated employee, your employing office must enter the following information under Remarks: "Eligibility expires: (enter date 18 months after separation date)."

If you are a child or former spouse, your servicing employing office must enter the following information under Remarks: name, date of birth, and social security number of the employee or annuitant; the expiration date of eligibility for enrollment; and your relationship to the employee.

Effective Date of Coverage. The effective date of your Temporary Continuation of Coverage (TCC) enrollment is the day after the 31-day extension of coverage ends. Your coverage is retroactive to that date if you elect TCC after the 31-day extension of coverage ends.

Exception: When your former spouse loses coverage in the 18 month period before your divorce or annulment because you change to a self only enrollment, the 31-day extension of coverage takes place after he/she loses coverage, not after the divorce or annulment. In this case, your former spouse's TCC enrollment is effective the day after the date of your divorce or annulment. Since there is a gap in FEHB coverage between the end of the 31-day extension of coverage and the beginning of the TCC enrollment, your former spouse may want to convert his/her coverage to an individual contract until the TCC enrollment can begin.

If you elect a different plan or option when you enroll under TCC, and you or a covered family member are an inpatient in a hospital on the 31st day of the extension of coverage, coverage under your old plan or option will continue for the hospitalized person for the length of the confinement, up to 60 days. The other family members' coverage will switch to the new plan or option after the 31-day extension of coverage ends.

Length of Temporary Continuation of Coverage

Former Employee. If you are a former employee, your Temporary Continuation of Coverage (TCC) eligibility time period continues up to 18 months from the date you separated from service.

Child. Your child's TCC eligibility time period continues for up to 36 months from the date of his/her change in status as a family member. If the change in status as a family member takes place while he/she is covered as a family member under your TCC enrollment as a former employee, he/she is eligible to enroll under TCC in his/her own right, but the TCC enrollment cannot continue beyond 36 months after the date of your separation from service.

Former Spouse. Your former spouse's TCC eligibililty time period continues for up to 36 months from the date of your divorce or annulment that takes place before your separation from service. If your divorce or annulment takes place while he/she is covered as a family member under your TCC enrollment as a former employee, he/she is eligible to enroll under TCC in his/her own right, but the TCC enrollment cannot continue beyond 36 months after the date of your separation from service.

Length of Coverage Based on Qualifying Event. Your Temporary Continuation of Coverage (TCC) eligibility time period is based on the qualifying event that made you eligible for TCC.

Separating Employee. If you are a separating employee, you lose regular FEHB coverage at the end of the pay period in which you separate. Then you have a 31-day extension of coverage, at no cost to you, before your TCC coverage begins. Your 18-month eligibility time period begins immediately after your separation, although the first 31 days fall under the 31-day extension of coverage provision. Your TCC coverage is effective on the day after the 31-day extension of coverage ends.

If you change plans or options upon election of TCC, your enrollment in your previous plan or option will continue through the 31-day extension of coverage. Your enrollment in the new plan or option will become effective the day after the 31-day extension of coverage and will continue for up to 17 months.

After your TCC coverage ends (except if you canceled your enrollment or your plan was discontinued), you are eligible for another 31-day extension of coverage at no cost to you, and you are eligible to convert to an individual contract offered by your health benefits plan.

Child or Former Spouse. If you are a child or former spouse of a Federal employee or annuitant, you also have a 31-day extension of regular FEHB coverage (at no cost to you) before your TCC coverage begins, beginning the day after the event that caused the loss of coverage. The 36-month TCC eligibility time period begins immediately after the event, although the first 31 days fall under the 31-day extension of coverage provision. TCC coverage is effective on the day after the 31-day extension of coverage ends, and continues for up to 35 more months.

If you change plans or options upon election of TCC, your enrollment in the previous plan or option will continue through the 31-day extension of coverage. Your enrollment in the new plan or option will become effective the day after the 31-day extension of coverage and will continue for up to 35 more months.

After your TCC coverage ends (except if you canceled your enrollment or your plan was discontinued), you are eligible for another 31-day extension of coverage at no cost to you, and you are eligible to convert to an individual contract offered by your health benefits plan.

Premium Payments. There is no Government contribution towards the premiums charged for a Temporary Continuation of Coverage (TCC) enrollment. If you are a TCC enrollee, you must pay the full premium charge (both employee and Government shares) plus a 2 percent administrative charge. Premium charges, and your TCC coverage, begin on the day after the free 31-day extension of coverage ends. If you elect TCC after the 31-day extension of coverage, you will be billed for premiums retroactive to the effective date of coverage.

Exception: certain Department of Defense employees who have TCC based on a separation due to reduction in force as described in 5 U.S.C.8905a(d)(4) continue to receive a Government contribution towards premiums.

Each payment is due after the pay period in which you are covered according to the schedule established by your servicing employing office. Your servicing employing office submits the premium payments it collects along with its regular health benefits payments to OPM.

Unlike most enrollments, the beginning and ending dates of TCC enrollments are not always the same as the beginning and ending date of a pay period. In this case, your servicing employing office must prorate the premium charge. It

must determine a daily premium rate by multiplying the monthly premium rate (including the administrative charge) by 12 and dividing the result by 365.

Nonpayment of Premiums. If your servicing employing office does not receive your premium payment by the due date, it must notify you in writing that you must make payment within 15 days (45 days if you live overseas) for your coverage to continue. If you don't make payment within this time frame, you are considered to have voluntarily canceled your enrollment effective with the last day that you paid your premiums. If you don't make any payments within 60 days (90 days if you live overseas) after the date of the notice, your enrollment ends, effective with the end of the last pay period that you paid your premiums.

If your coverage is canceled because you didn't pay your premiums, you aren't entitled to the 31-day extension of coverage and you can't convert to an individual contract. You may not reenroll or be reinstated unless you were unable to make payment within the specified time frames for reasons beyond your control.

Sample Notice for Delinquent Premiums. Your employing office may use the following sample notice for enrollees who do not make payments on time:

> *Dear (name):*
>
> *We have not received your payment for health benefits coverage in the amount of $ that was due on (date), and represents payment for coverage for the month of (month, year). If we do not receive the payment with 15 days after the date you receive this letter, your health benefits will be terminated, effective (last day of coverage for which premiums were paid).*
>
> *Termination of health insurance because of nonpayment of premiums is considered to be a voluntary cancellation by the enrollee. If your enrollment is canceled, you may not enroll again nor be reinstated (except as explained in the following paragraph). In addition, you will not be entitled to convert your coverage to an individual contract with your insurance carrier or to have the 31-day temporary extension of coverage.*
>
> *If your coverage is canceled, it may be reinstated only if you were prevented by circumstances beyond your control from making the payment within the time frame specified above. You may request reinstatement by writing to the following address: (enter employing office address).*
>
> *Sincerely,*
>
> *(Name of appropriate agency official)*

Effective Date of Enrollment Change. Generally, an enrollment change that you make while you are covered under Temporary Continuation of Coverage (TCC) is effective on the first day of the first pay period that begins after the date your servicing employing office receives your Health Benefits Election Form (SF 2809).

When your servicing employing office determines that you were unable, for reasons beyond your control, to change your enrollment within the specified time limits, you may do so within 60 days after your employing office tells you of its determination.

At your servicing employing office's discretion, a person with your authorization to take health benefits actions may enroll or change your enrollment on your behalf.

Opportunities to Change Your TCC Enrollment

When you make a change based on one of the following events, your servicing employing office will follow the same procedures as for employees enrolled under regular FEHB coverage.

Change to Self Only. You may change your enrollment from self and family to self only at any time. Generally, the change is effective on the first day of the first pay period that begins after the date your servicing employing office receives your request to change your enrollment. Your employing office may make a change to self only retroactive to the first day of the pay period after the one in which you no longer had any eligible family members. This type of retroactive change will be made only if you request it and your employing office is satisfied that the last family member lost eligibility for coverage.

Open Season. During Open Season, you may change your enrollment from self only to self and family, from one plan or option to another, or make any combination of these changes. Exception: if you are an enrolled former spouse, you may change from one plan or option to another, but you cannot change from self only to self and family unless you are covering a child of both you and the employee or annuitant on whose service your coverage was based.

Your Open Season enrollment change is effective on the first day of the pay period that begins in January of the next year. If your servicing employing office accepts a late Open Season change from you, the effective date is the same date it would have been if submitted timely, even if that means it is effective retroactively.

Change in Family Status. If you are an enrolled former employee or child, you may change your enrollment from self only to self and family, from one plan or option to another, or make any combination of these changes, when you have a change in family status. You must make the enrollment change during the period beginning 31 days before and ending 60 days after the date of the change in family status.

If you are an enrolled former spouse, you may change your enrollment from self only to self and family, from one plan or option to another, or make any combination of these changes within the period beginning 31 days before and ending 60 days after the birth or acquisition of a child of both you and the employee or annuitant on whose service your coverage was based.

A change that you make because of the birth or acquisition of a child is effective on the first day of the pay period in which your child is born or becomes an eligible family member.

Reenrollment Under TCC. If your TCC enrollment ended because you acquired regular FEHB coverage (as an employee or family member), you may reenroll if your regular FEHB coverage ends before your 18- to 36-month eligibility period ends (however, you may be eligible for a new TCC enrollment period). Your coverage does not extend beyond your original eligibility period. The effective date of your reenrollment is the day following the date that your regular FEHB coverage ended.

Loss of FEHB Coverage or Coverage under Another Group Insurance Plan

You may change your enrollment from self only to self and family, from one plan or option to another, or make any combination of these changes when you lose other FEHB coverage or your eligible family member loses FEHB coverage or coverage under another group health plan. Except as noted, you must change your enrollment within the period beginning 31 days before and ending 60 days after the loss of coverage. Some examples of loss of coverage are:

- loss of coverage under another FEHB enrollment because the covering enrollment was terminated, canceled, or changed to self only
- loss of coverage under another Federally-sponsored health benefits program
- loss of coverage under the Medicaid program or a similar State-sponsored program of medical assistance for the needy
- loss of coverage under a non-Federal health plan

- loss of coverage because of termination of membership in an employee organization sponsoring or underwriting an FEHB plan

- loss of coverage because the FEHB plan is discontinued.

Move from an HMO's Service Area. If you are enrolled in an HMO and you move or become employed outside the HMO's service area (or, if already living or working outside this area, move or become employed further away), you may change your enrollment. You must notify your employing office of the change.

You Become Eligible for Medicare. You may change your enrollment from one plan or option to another at any time beginning on the 30th day before you become eligible for Medicare. You may make an enrollment change under this event only once in a lifetime.

Termination of TCC Enrollment or Coverage. Your Temporary Continuation of Coverage (TCC) enrollment will end either because your eligibility period ends or you cancel your enrollment (this includes cancellation when you don't pay your premiums). If your enrollment ends because your TCC eligibility period ends, you are entitled to the 31-day extension of coverage for conversion to an individual contract.

Your family member's coverage ends when your enrollment ends or when he/she no longer is eligible for coverage as a family member. If your family member loses TCC coverage for any reason other than your cancellation (this includes cancellation when you don't pay your premiums), he/she is entitled to the 31-day extension of coverage for conversion to an individual contract. If you are a former employee, your family member that loses coverage is also eligible for TCC in his/her own right.

Your enrollment ends when your premiums remain unpaid 60 days (90 days if you live overseas) after the date of your employing office's notice of nonpayment.

If your enrollment ends because you didn't pay your premiums, it is considered to be a voluntary cancellation effective with the last day of the pay period for which you made payment. Your servicing employing office must complete a Health Benefits Election Form (SF 2809) for you. In part G, which normally would have your signature, your employing office will enter "Canceled due to nonpayment of premiums." In part H, it will enter "N/A" in item 2, and in item 3 it will enter the effective date of the cancellation. In cases where you never made payment, it enters the same effective date as on the original SF 2809 enrolling you. In the Remarks section it enters "This cancellation voids the prior SF 2809 enrolling this individual in your plan on the date in item 3." This voiding action has the same effect as a cancellation for nonpayment of premiums.

31-Day Extension of Coverage and Conversion to an Individual Contract. If you lose your Temporary Continuation of Coverage (TCC) other than by cancellation (including cancellation by nonpayment of premiums) or discontinuance of the plan, your coverage is automatically extended for 31 days, at no cost to you. You are also entitled to convert to an individual contract with your health benefits carrier, without providing evidence of insurability. You are eligible for the 31-day extension of coverage and have the right to convert even if you are eligible to elect TCC in your own right (e.g., you are a child of a former employee and you lose TCC coverage because you are no longer considered a covered family member).

Denial of TCC because of Involuntary Separation for Gross Misconduct. Under the law, you are not eligible for Temporary Continuation of Coverage (TCC) when you are involuntarily separated from Federal service because of gross misconduct.

Your employing office must determine whether the offense for which you are being removed constitutes gross misconduct. The determination must be made on a case-by-case basis by employing office staff (employee relations, Office of General Counsel, etc.) with a knowledge of case law involving gross misconduct.

General Guidelines for Gross Misconduct Determination. Generally, an offense punishable as a felony is considered gross misconduct. Lesser offenses may also be gross misconduct, depending on the circumstances. Other elements that must be considered are:

- There must be a connection between the offense and your job. Also, some individuals, such as judges, are held to a higher standard of conduct than others.
- You must have the ability to understand the gravity of your conduct.
- Your offense must be affirmative and willful, not simply negligent.

An adverse action procedure (5 CFR Part 752) does not result in a specific finding of gross misconduct. There are some offenses for which you can be removed under adverse action procedures that are not considered gross misconduct or are even considered disciplinary in nature (e.g., your refusal to transfer with your function).

Removal Must Result from Gross Misconduct. In order to be denied Temporary Continuation of Coverage (TCC) eligibility for gross misconduct, your removal (or resignation in lieu of removal) must be a direct result of your gross misconduct. If you resign before your employing office initiates adverse action procedures, your separation is considered voluntary and you are entitled to TCC. If you resign after receiving notice of your employing office's proposal to remove, but before you are removed, your separation is considered to be involuntary and you are not entitled to TCC. If you commit an offense that would be considered gross misconduct, but you are removed on another basis (e.g., unsatisfactory performance), your removal is not due to the gross misconduct and you are entitled to TCC.

> Example. Simon was found to have embezzled money from his employing office's imprest fund. His employing office notifies him that it will begin an adverse action procedure to have him removed from service. Simon resigns the next day. He is not entitled to TCC since this is considered an involuntary separation.

Notification Requirements. When your employing office determines that your offense constitutes gross misconduct, it must notify you in writing that it intends to deny you TCC eligibility. The notice must:

- give the reason for the denial;
- give you at least 7 days to respond;
- be given to you no later than the date of your separation.

This notification may be combined with other notifications required for adverse action procedures or other procedures for actions based on misconduct.

Response. Your response may be oral or in writing. You are entitled to be represented by an attorney or other representative. Your employing office must designate an official who has the authority to either make or recommend a final decision to hear your oral answer. If you respond to the notice of denial, your employing office must issue a final decision that fully describes its findings and conclusion.

The final decision is not subject to OPM reconsideration. If you want to challenge the decision, you may file suit against your employing office in a district court.

Coordination with the Office of Workers' Compensation Programs (OWCP)

Your employing office is responsible for providing notification to eligible family members who lose family member status, for accepting their enrollments, and for collecting their premiums.

When you are a covered compensationer and you aren't entitled to continue your FEHB coverage as a compensationer upon your separation from service, your employing office must provide you with notification of your right to elect Temporary Continuation of Coverage (TCC), accept your enrollment, and collect your TCC premiums in the same way as for any other separating employee.

If your enrollment has been transferred to OWCP, your employing office must contact OWCP to determine whether you are enrolled and, if the person seeking continued coverage is a family member, whether the enrollment is for self and family. If your child is seeking continued coverage and his/her date of birth is not available, OWCP can supply that information.

If you are a compensationer who is no longer an employee, OWCP is responsible for providing notification to eligible family members who lose family member status, for accepting their enrollments, and for collecting their premiums.

Coordination with Spouse Equity Provisions. If you are a former spouse of a Federal employee or annuitant and you don't qualify for FEHB coverage under spouse equity provisions, you may be eligible for Temporary Continuation of Coverage (TCC).

Coverage under the spouse equity provisions is often delayed because the retirement system must determine whether you have a qualifying court order. Coverage does not begin until the pay period after the employing office receives the determination that the court order is qualifying (although you may request retroactive enrollment). You may be eligible for TCC while you are waiting for coverage under the spouse equity provisions to begin (but not beyond 36 months after your divorce or annulment).

Your coverage under the spouse equity provisions will end if you remarry before you reach age 55. If you remarry during the 36 months following your divorce or annulment, you are eligible for TCC. Your TCC will expire 36 months after the date of your divorce or annulment from the Federal employee.

Health Benefits File. When you become enrolled under Temporary Continuation of Coverage (TCC), your servicing employing office will establish a health benefits file in your name. If you are a former employee, this file must be separate from your personnel records. If you are a former spouse or child, the name of the employee on whose service your TCC coverage is based must be noted on the front cover of your file.

Your servicing employing office must keep the following documents in your health benefits file:

- The Official Personnel Folder (OPF) copy of the Health Benefits Election forms (SF 2809) documenting your enrollment and any changes in enrollment;
- The OPF copy of the Notice of Change in Health Benefits Enrollment (SF 2810) terminating your enrollment; and
- Copies of any correspondence or other documents related to your enrollment (e.g., employing office notice of the premium amount and payment schedule; any notice of overdue premiums; documentation of a child's mental or physical disability before age 22; a cancellation request).

The contents of your file are subject to the provisions of the Privacy Act [5 U.S.C. 552a(b)]. Your health benefits file may be destroyed 2 years after the end of the calendar year in which your TCC eligibility period expires.

If you are a former spouse who elects TCC after you lose coverage under the spouse equity provisions, your servicing employing office must forward your spouse equity health benefits file to the employee's (on whose service your TCC coverage is based) retirement system. It must prepare a new health benefits file for your TCC enrollment.

When You have TCC Coverage and you become Employed by the Federal Government. When you have Temporary

Continuation of Coverage (TCC) and you become employed by the Federal government, your TCC coverage stops when you enroll for regular FEHB coverage. Either you or your new employing office must send a copy of the Health Benefits Election Form (SF 2809) documenting your new enrollment to the employing office that maintains your TCC enrollment, with a cover letter instructing it to stop your TCC enrollment.

If your regular FEHB coverage ends before the expiration of your TCC eligibility, you may resume your previous TCC enrollment. You will likely be eligible for a new TCC enrollment period based on your separation from service. In some cases, it may be more beneficial to continue your previous TCC enrollment. This would happen when your previous TCC enrollment was for 36 months and it extends beyond the 18-month eligibility period after your separation from service.

9

Annuitants and Compensationers

Eligibility for Health Benefits After Retirement

Requirements. When you retire, you are eligible to continue health benefits coverage if you meet all of the following requirements:

- you are entitled to retire on an immediate annuity under a retirement system for civilian employees (including FERS MRA + 10 retirements); and
- you have been continuously enrolled (or covered as a family member) in any FEHB plan(s) for the 5 years of service immediately before the date your annuity starts, or for the full period(s) of service since your first opportunity to enroll (if less than 5 years).

When you elect not to enroll or cancel your enrollment, you certify by your signature on the Health Benefits Election form (SF 2809) that you understand the effect this has on your eligibility to carry coverage into retirement.

MRA + 10. If you are a separating employee covered under FERS and you qualify for an immediate annuity under the Minimum Retirement Age (MRA) + 10 provision, you can continue your enrollment when your annuity starts, as long as you meet the requirements for continuing coverage.

If you postpone receipt of your annuity, your enrollment will terminate when you separate from your employment. You will be eligible for temporary continuation of coverage (TCC) or to convert to an individual contract. You may choose to resume FEHB coverage on the date you select for your annuity to begin.

Service. For purposes of continuing FEHB coverage into retirement, "service" means time in a position in which you were eligible to be enrolled. You are not required to have been an enrollee continuously, but you must have been continuously covered by an FEHB enrollment. This includes:

- time you are covered as a family member under another person's FEHB enrollment;
- time you are covered under the Uniformed Services Health Benefits Program (also known as TRICARE or CHAMPUS) as long as you were covered under an FEHB enrollment at the time of your retirement. (You must enroll in FEHB within 60 days after you lose coverage under the Uniformed Services Health Benefits Program for that time to be considered as part of continuous FEHB coverage.)

Coverage under Medicare does not count in determining continuous coverage.

Service as a Non-appropriated Fund employee does not count in determining continuous coverage since it is not Federal service and not subject to FEHB coverage.

Break in Service. Breaks in service are not counted as interruptions when the 5 years of service requirement is determined, as long as you reenroll within 60 days after your return to Federal service.

Late Election. You are considered to have been continuously enrolled when you are allowed to make a late election because your employing office determined that you weren't able to timely enroll for reasons beyond your control.

Service with an International Organization. If you transfer to an International Organization and elect to continue FEHB

coverage, the service with the International Organization is included in determining whether the 5 years of service requirement is met. If you don't elect to continue your FEHB coverage or drop your enrollment before you return to Federal service, the time with the International Organization without FEHB coverage is not included in determining whether the 5-year requirement was met.

Eligibility as a Temporary Employee. Your decision not to enroll as a temporary employee eligible for coverage under 5 U.S.C. 8906a doesn't affect your future eligibility to continue coverage as a retiree. Only service for which the Government contributes toward the cost of your health benefits counts in determining whether you meet the 5 years of service (or first opportunity) requirements to continue coverage as a retiree. Since the Government doesn't share in the cost of a temporary employee's enrollment, eligibility to enroll under 5 U.S.C. 8906a is not considered your first opportunity for purposes of continuing health benefits coverage into retirement.

Eligibility under Temporary Continuation of Coverage. Your enrollment or eligibility for enrollment as a former employee under the temporary continuation of coverage (TCC) provisions is not considered in determining whether you meet the 5 years of service requirement for continued coverage as a retiree, since you are not a Federal employee at that time. However, time that you were an employee eligible to enroll but were covered as a family member under the TCC enrollment of another person does count toward the 5 years of service requirement.

Who Makes the Determination? At retirement, your employing office will tentatively determine if you are eligible to continue your enrollment. OPM's Office of Retirement Programs (or your retirement system) will review your retirement and health benefits documents and make a final determination of your eligibility to continue your FEHB enrollment into retirement.

Waiver of 5-Year Enrollment Requirement. Public Law 99-251 gave OPM the authority to waive the 5 years of service requirement when, in its sole discretion, it determines that it would be against equity and good conscience not to allow a person to be enrolled in the FEHB Program as an annuitant.

Your failure to satisfy the 5-year requirement must be due to exceptional circumstances. If you request a waiver, you must provide OPM with evidence that:

- you had intended to have FEHB coverage as a retiree;
- the circumstances that prevented you from meeting the 5-year requirement were essentially outside your control; and
- you acted reasonably to protect your right to continue FEHB coverage into retirement. (This includes reading and acting on information provided and requesting information if none is given automatically.)

How OPM Applies Its Waiver Authority. OPM's approval of your waiver request depends on the extent to which you could have controlled the events leading to the loss of coverage at retirement. When OPM reviews a waiver request, it considers:

- whether you had a compelling reason to believe you were covered as a family member of another person enrolled in FEHB during the time in question;
- evidence that your employing office would not allow you to enroll;
- the extent to which you could have controlled the events that led up to the loss of the right to continued FEHB coverage;
- whether you had acted to gain FEHB coverage at the earliest opportunity after learning of the loss of benefits or possible loss of future rights;

- whether you had substantial FEHB coverage during your career even though there was a break in continuity during the last 5 years of service.

When OPM Does Not Grant a Waiver. OPM generally doesn't grant a waiver if it is within your control to complete the eligibility requirements for continued coverage. In the case of a voluntary early retirement, you can choose instead to remain in Federal service to complete the eligibility requirements. In this case, you generally can't qualify for a waiver unless some circumstance other than an early retirement makes it impossible to complete the participation requirement.

Where to Send a Waiver Request. If you are a retiring employee and want to ask OPM to waive the participation requirement in your case, you should send your waiver request to: Office of Personnel Management, Retirement Benefits Branch, 1900 E Street, NW, Washington, D.C. 20415-3532.

Current Waiver Policy. While Public Laws 103-226 and 104-208 authorized Government-wide voluntary separation incentive payments (VSIPs), more recently, Congress has been authorizing buyouts for individual agencies. Each agency's VSIP legislation specifies different beginning and ending dates.

OPM's current waiver policy provides pre-approved waivers for any employee who has been covered under the FEHB Program continuously since October 1, 1996, or the beginning date of an agency's latest statutory buyout authority, whichever is later.

To be eligible for a pre-approved waiver, you must:

- retire during your agency's statutory buyout period; and
- receive a buyout under the agency's statutory buyout authority; or
- take early optional retirement as a result of early-out authority in your agency; or
- take a discontinued service retirement based on an involuntary separation due to reduction in force, directed reassignment, reclassification to a lower grade, or abolishment of position.

If you meet these requirements, you do not need to write a letter requesting a waiver. Instead, your agency must attach a memorandum to your retirement application stating that you meet the requirements for a pre-approved waiver by OPM as set forth in Benefits Administration Letter (BAL) 00-220. The memorandum should provide the number of the Public Law granting your agency VSIP authority and the beginning and the ending dates of your agency's statutory buyout period.

If You Do Not Qualify for a Pre-approved Waiver. Some employees who retire during a buyout period will not be eligible for a pre-approved waiver. This includes employees who retire on a regular optional retirement but do not qualify for a VSIP.

If you do not qualify for a pre-approved waiver, you may ask OPM to waive the participation requirements in your case. OPM will consider each case on its own merits, based on the criteria that are applied to all other retiring employees. You should explain why you believe OPM should consider you for a waiver (e.g. why you are unable to meet the 5-year requirement or why meeting it would be harmful to you) and send your waiver request to the following address:

Office of Personnel Management, Office of Retirement Programs
Retirement Services Branch – Waiver Request
Washington, DC 20415-3532

When an Agency has Separate Buyout Authority. Some agencies, such as the Departments of Defense and Agriculture, have separate buyout authority. If you retired before October 1, 1996 from an agency that has separate buyout authority, your employing office should follow the waiver policy for retirements on or after March 30, 1994. If you separated for retirement on or after October 1, 1996, your employing office should follow the waiver policy for retirements on and after October 1, 1996.

Qualifying Retirement Systems

Type of System. For FEHB purposes, you must retire under a civilian retirement system for Federal or District of Columbia Government employees.

Qualifying Systems. Civilian systems include, but are not limited to, the following:

- Civil Service Retirement System (CSRS)
- Federal Employees Retirement System (FERS)
- Board of Governors of the Federal Reserve System
- CIA Retirement System
- District of Columbia Courts Judges Retirement System
- Federal Judiciary Retirement System [28 U.S.C. 371(a)]
- Financial Institutions Retirement Fund System
- Foreign Service Pension System
- Foreign Service Retirement System
- Judiciary of the Territories Retirement System (28 U.S.C. 373)
- Lighthouse Retirement System
- Military Court of Appeals Judges Retirement System
- National Oceanic and Atmospheric Administration System
- Nonappropriated Fund Retirement System
- Officers of the Public Health Service System
- Policemen and Firemen of the District of Columbia Retirement System
- Public School Teachers of the District of Columbia System
- Teachers Insurance Annuity Association and Collegiate Retirement Equities Fund Retirement System
- U.S. Court of Veterans Appeals Judges Retirement System
- U.S. Tax Courts Judges Retirement System

For health benefits purposes, the Social Security system is not a retirement system for Federal civilian personnel.

Benefits and Cost. As an annuitant, you are entitled to the same benefits and Government contribution as non-Postal active employees enrolled in the same plan. Your share of the enrollment cost also continues to be the same as for a non-Postal employee and is deducted from your annuity payments.

If your annuity is not large enough to cover your share of the premiums for your plan, you may either change to a lower-cost plan or option (one in which your share of the premium is low enough to be withheld from your annuity) or choose to pay your premiums directly to your retirement system. Even if your employing office thinks that your annuity will not cover your share of the premiums, it will transfer your existing enrollment to your retirement system. Your retirement system will notify you of your options and take whatever actions you request.

Benefits and Cost

Direct Premium Payments. If you decide to pay your share of premiums directly to your retirement system, your retirement system will establish a payment schedule for you. You must continue to make premium payments directly for the length of your enrollment even if your annuity increases enough to cover your premiums.

Nonpayment of Premiums. If you are making direct payments and your retirement system doesn't receive your premium payment by the due date, it must notify you in writing that you must make payment within 15 days (45 days if you live overseas) for your coverage to continue. If you don't make payment, your retirement system will terminate your enrollment 60 days (90 days if you live overseas) after the date of the notice. Your coverage will be terminated retroactive to the end of the last pay period in which you made the payment. You may not reenroll, unless nonpayment was for reasons beyond your control.

If you weren't able to make timely payment for reasons beyond your control, you may write to your retirement system to ask that your coverage be reinstated. You must file the request within 30 days from the date your enrollment was terminated and provide proof that the nonpayment was beyond your control. Your retirement system will determine if you are eligible for reinstatement of coverage. If it decides to allow reinstatement, it will be restored retroactive to the termination date. If your request is denied, you may request that your retirement system reconsider its initial decision.

Procedures for Retiring Employees

If You Want to Continue Your Health Benefits Coverage. If you meet all the requirements, you don't need to do anything to have your same health benefits enrollment continue after your retirement.

If You Want to Cancel or Change Your Health Benefits Coverage. If you don't want to continue your health benefits enrollment upon your retirement, you must cancel it on the Health Benefits Election form (SF 2809) or other appropriate request. This must be your action; your employing office must not initiate the termination of your enrollment unless you aren't eligible to continue it after your retirement.

When you cancel your FEHB enrollment as an annuitant, you will never be able to reenroll unless you had canceled it to enroll in a Medicare managed care plan or you had furnished proof of eligibility for Medicaid.

If you are a retiring employee and you submit a request to cancel or change your enrollment, but the cancellation or change can't become effective until after the starting date of your annuity, your employing office will note on part H of your request the date it received the form, and will send all copies of your request to your retirement system with your other health benefits and retirement records.

Your retirement system will make the cancellation effective on the last day of the pay period in which your employing office received your request. If you requested an enrollment change, it will be made effective as indicated in

"Opportunities to Enroll or Change Enrollment." Even though you have requested a cancellation or change, your retirement system needs information on the enrollment in effect on the day of your retirement, since this enrollment may remain in effect during a part of your retirement.

Employing Office Procedures

General. At your retirement, your employing office will tentatively determine whether you are eligible to continue your health benefits enrollment. Your retirement system will make the final determination after it reviews all of your retirement and health benefits documents. Your employing office must take the appropriate action described below.

If You Appear Eligible to Continue Your Enrollment

Nondisability Retirement. Your employing office will document your health benefits status on your retirement application (Section A, item 6 of the Agency Checklist). It will attach a separate memorandum to note any circumstances that would be helpful for the retirement system to know when it determines your eligibility for continued coverage (such as information that you were covered as a family member before your own enrollment).

It will note your plan's enrollment code in the Remarks space on the Individual Retirement Record (SF 2806 for the Civil Service Retirement System and SF 3100 for the Federal Employees Retirement System). For other retirement systems, it should follow the same procedures.

It will send the following to the retirement system along with the Individual Retirement Record, the retirement application and any other retirement papers:

- all Notice of Change in Health Benefits Enrollment forms (SF 2810), and
- all Health Benefits Election forms (SF 2809) or other enrollment requests, with any attached medical certificates or other documentation, filed in your Official Personnel Folder (including any on which you elected not to enroll or to cancel, or that are marked VOID).

Disability Retirement. Your employing office will note your current plan's enrollment code in the Remarks section of the preliminary Individual Retirement Record. It will not send any health benefits forms from your Official Personnel Folder to the retirement system with the preliminary Individual Retirement Record, even if you are enrolled and eligible to continue the enrollment.

If your disability retirement application is denied, your employing office doesn't need to take any further action unless you are separated.

If your disability retirement application is approved, your employing office will then follow the same procedures as for a nondisability retirement.

If You Appear Ineligible to Continue Your Enrollment. If you don't meet all the requirements for continuing your enrollment into retirement, your employing office will document your retirement application (Section A, item 6 of the Agency Checklist) and note in the Remarks column of the Individual Retirement Record (both the preliminary and final Record in disability retirement cases): "Not eligible to continue health benefits" and state the reason (e.g., "not enrolled since first opportunity" or "not enrolled 5 years"). Your employing office will terminate your enrollment on the Notice of Change in Health Benefits Enrollment (SF 2810) and transmit all of your health benefits documents to the retirement system, where a final decision on your eligibility to continue your FEHB enrollment will be made. If you are unable to continue your regular FEHB enrollment into retirement, you may be eligible to temporarily continue your health benefits coverage through the Temporary Continuation of Coverage (TCC) provision of the FEHB law. Contact your employing office for information on TCC.

If You Aren't Enrolled. If you aren't enrolled in the FEHB Program, your employing office will document your retirement application (Section A, item 6 of the Agency Checklist) and note in the Remarks column of the Individual Retirement Record (both the preliminary and final Record in disability retirement cases): "Not enrolled for health benefits." It will retain your health benefits forms in your Official Personnel Folder. It doesn't need to take any other action on your health benefits, unless your enrollment terminated after 365 days in leave without pay status.

If Your Enrollment Terminates after 365 Days in Leave Without Pay Status. If your enrollment terminates because of 365 days in leave without pay status, it will be reinstated if your retirement application is approved with an annuity starting date before the end of the 365 days of leave without pay status. Your employing office should follow the procedures described in "If You Appear Eligible to Continue Your Enrollment" if you otherwise would be eligible to continue your enrollment. It will send the Notice of Change in Health Benefits Enrollment (SF 2810) that terminated your enrollment to the retirement system along with your other documents.

If your enrollment terminates after 365 days in leave without pay status and you have a pending disability retirement application, you should convert to an individual contract. If your disability retirement application is approved later, the retirement system will reinstate your enrollment, retroactive to the starting date of your annuity (as long as you meet the requirements to continue your enrollment).

If You Separate and Later Retire. When you are eligible for an immediate annuity, but don't apply for retirement, your employing office will terminate your enrollment on the Notice of Change in Health Benefits Enrollment (SF 2810) upon your separation. Also, your enrollment will terminate when you are separated while your application for retirement (such as for disability) is pending in a retirement system.

You should enroll under the temporary continuation of coverage (TCC) provisions even though you plan to apply for retirement later or have a disability retirement pending in a retirement system. If your retirement application is approved later, your retirement system will reinstate the enrollment, retroactive to the starting date of your annuity (as long as you meet the requirements to continue your enrollment). Your employing office will refund the premiums you paid for the TCC coverage when you provide documentation showing the retroactive coverage as a retiree.

FERS MRA + 10 Benefits. If you are a separating FERS employee eligible for an immediate annuity under the minimum retirement age and 10 years of service (MRA + 10) provision, you may receive the benefits immediately or you may postpone receiving your annuity to lessen the age reduction applicable to persons under age 62.

If you are eligible for an MRA+10 annuity and are not applying for retirement at the time of separation, your employing office will terminate your enrollment on the Notice of Change in Health Benefits Enrollment form (SF 2810). It will notify you of your right to enroll under temporary continuation of coverage (TCC) or convert to an individual contract. If you meet the requirements for continuing health benefits as a retiree, you may reenroll when you decide to allow your annuity to begin.

If you are applying for retirement and appear eligible to continue your enrollment, your employing office will follow the procedures in "Nondisability Retirement."

If you apply for an immediate annuity under the MRA + 10 provisions and later decide to postpone your annuity starting date, OPM will notify your employing office that it must offer you the opportunity to elect TCC coverage.

When You Apply for MRA + 10 Annuity. If you are requesting that your annuity begin under the MRA + 10 provision, you may enroll in any plan for which you are eligible within 60 days after OPM notifies you of your eligibility. If you die before the end of this 60 day period, your survivors entitled to an annuity may enroll within 60 days after OPM's notification to your survivor of his/her eligibility.

Your enrollment is effective the first day of the month after the month that OPM receives your request, or on the starting date of your annuity, whichever is later. Your survivor's enrollment is effective on the first day of the

month after the month that OPM receives his/her request for enrollment.

Opportunities for Annuitants to Enroll or Change Enrollment

Effective Date. Unless otherwise specified, enrollment changes take effect on the first day of the month that follows your retirement system's receipt of your enrollment change request.

Late Elections. If you were unable, for reasons beyond your control, to make an enrollment election or change within the required time limits, your retirement system may allow you to make a late election. You must make your election within 60 days after you were notified of the retirement system's determination.

Election by Proxy. Your retirement system may permit your representative to make an enrollment election or change for you with your written authorization.

Change to Self Only. You may change your enrollment from self and family to self only at any time under the same conditions as an active employee.

Open Season. If you are an enrolled annuitant, you may change plans, options, or type of enrollment during Open Season.

If you are a nonenrolled annuitant, you are not permitted to enroll during an Open Season unless you had canceled your FEHB enrollment:

- to join, and have subsequently voluntarily disenrolled from, a Medicare managed care plan; or
- because you furnished proof of eligibility for Medicaid (or a similar State-sponsored program of medical assistance for the needy) and you wish to reenroll in FEHB for reasons other than involuntary loss of that other coverage.

Your enrollment change or reenrollment (including a belated enrollment change) is effective on the first day of the first pay period that begins in January of the next year (January 1 for most annuitants).

Change in Family Status. You may change plans, options, or type of enrollment when you have a change in family status under the same conditions as an active employee (but you can't enroll if you aren't already enrolled). There are different rules for an enrolled survivor annuitant.

When Coverage under Medicare Managed Care Plan or Medicaid Ends. If you were enrolled (or eligible to enroll) in the FEHB Program as an annuitant and:

- you suspended your FEHB enrollment to enroll in a Medicare managed care plan or because you furnished proof of eligibility for Medicaid (or a similar State-sponsored program of medical assistance for the needy); and
- your enrollment in the Medicare managed care plan or Medicaid ends involuntarily,

you can immediately reenroll in any available plan at any time from 31 days before to 60 days after your coverage in the Medicare managed care plan or Medicaid ends. The reenrollment is effective on the date following the involuntary loss of coverage as shown in documentation from the Medicare managed care plan or Medicaid. An involuntary loss of coverage includes when the Medicare managed care plan ceases to be offered, you move from the area served by the Medicare managed care plan, or you lose eligibility for Medicaid.

If you voluntarily disenroll from the Medicare managed care plan or Medicaid, you may reenroll in the FEHB Program

during the following Open Season.

Upon Restoration of Disability Annuity. If you were receiving a disability annuity and:

- your disability annuity was terminated because you were found restored to earnings capacity or recovered from your disability;
- you were enrolled in an FEHB plan immediately before your disability annuity was terminated; and
- your disability annuity is later restored,

you may reenroll in a health benefits plan within 60 days from OPM's notice of your eligibility to reenroll. Your reenrollment is effective on the first day of the month after OPM receives your enrollment request.

Loss of Coverage under FEHB or Another Group Insurance Plan. If you are an annuitant eligible to enroll, but you are covered as a family member under another FEHB enrollment, you may enroll in your own name if you lose coverage under the other enrollment.

If you are an enrolled annuitant, you may change plans, options, or from Self Only to Self and Family when you lose coverage under another group health benefits plan or when an eligible family member loses coverage under FEHB or another group health benefits plan.

Some examples of loss of coverage are:

- You or your family member lose FEHB coverage because the covering enrollment was terminated, canceled, or changed to Self Only;
- You or your family member lose coverage under another federally-sponsored program;
- Your membership ends in the employee organization that sponsors your health benefits plan;
- You are enrolled in a plan that is discontinued;
- You or your family member lose coverage under Medicaid or a similar program;
- You or your family member lose coverage under a non-Federal health plan.

When Your Plan is Discontinued. You may change to another plan when you are enrolled in a plan that is discontinued in whole or in part. You may enroll in the new plan for either Self Only or Self and Family coverage. If your plan is discontinued at the end of a contract year, you must change your enrollment during Open Season unless OPM establishes a different time.

Normally, a plan that terminates its participation in the FEHB Program will terminate as of December 31 of a given year. The plan will continue to provide benefits until the new coverage takes effect. When a plan is discontinued at any time other than at the end of a contract year, OPM will issue special instructions about the proration of premiums and the effective date of subsequent enrollment changes.

If you don't change to another plan when:

- The plan that is discontinued has only one option, you are considered to have enrolled in the standard option of the Blue Cross and Blue Shield Service Benefit Plan.

- One option of a two-option plan is discontinued, you are considered to have enrolled in the remaining option of the plan.

- Both options of a two-option plan are discontinued, you are considered to have enrolled in the same option of the Blue Cross and Blue Shield Service Benefit Plan. Exception: when your annuity is insufficient to pay the premiums of the high option of the Blue Cross and Blue Shield Service Benefit Plan, you are considered to have enrolled in the Blue Cross and Blue Shield Service Benefit Plan standard option.

Move from an HMO's Service Area. If you are enrolled in an HMO, and you or an enrolled family member move or become employed outside the HMO's service area, or, if already outside of this area, move or become employed further from this area, you may change your enrollment under the same conditions as an active employee.

Retirement from Overseas Duty Post. You may change plans, options, and type of enrollment within 60 days of your retirement from a post of duty outside the United States. Your eligible survivors may also make these changes if you were stationed outside the United States at the time of your death.

Return from Military Service. You may change plans, options, and type of enrollment within 60 days after separation from at least 31 days of duty in a uniformed service.

You become Eligible for Medicare. You may change your enrollment to any option of any available plan at any time beginning on the 30th day before you become eligible for Medicare. You may make an enrollment change under this event only once.

Annuity Insufficient to Pay Withholdings. If your annuity is not sufficient to pay your plan's premiums, your retirement system must notify you of the plans available at a cost that doesn't exceed your annuity. You may either pay your premiums directly to your retirement system or you may enroll in another plan where the cost is no greater than your annuity. Coverage under your new plan is effective immediately upon termination of your old plan's coverage.

If you don't take either of these actions and you are enrolled in the high option of a plan, you are considered to have enrolled in the standard option of the same plan (unless your annuity is insufficient to pay the standard option premiums).

If you don't take either of these actions and your enrollment is terminated, you may apply to your retirement system for reinstatement of your enrollment in any available plan or option.

Reemployed Annuitants

If You Aren't Enrolled. If you are an annuitant not enrolled under the FEHB Program and you become reemployed in a position that doesn't exclude you from coverage, you must make an election the same as any other new employee. You can continue your enrollment after separation from reemployment if you meet all the requirements that any other retiring employee must meet. (The immediate annuity requirement is met if you receive a supplemental annuity when you separate from the reemployment.)

> Exception: If you are reemployed under the authority of section 108 of the Federal Employees Pay Comparability Act (FEPCA) of 1990 to meet emergency hiring needs or because of severe recruiting difficulties, you aren't considered an employee for retirement purposes. Although you may enroll in FEHB with your employing office if you don't have coverage as an annuitant, you don't earn eligibility toward continuing coverage as an annuitant during your reemployment under FEPCA.

Annuity Terminated by Reemployment. If you are enrolled under the FEHB Program as an annuitant and are reemployed under conditions that terminate your annuity, your employing office must notify your retirement system that you are reemployed and transfer in your enrollment. Your employing office must then determine whether you are

eligible to continue your enrollment during reemployment using the same criteria as for other employees that transfer from one payroll office to another, and must either allow your enrollment to continue or terminate it, as appropriate.

When you separate from service, your employing office will follow the procedures that apply to other employees being separated or retired. It will either terminate your enrollment or transfer the enrollment back to your retirement system.

Annuity Continued during Reemployment. If you are enrolled under the FEHB Program as an annuitant and are reemployed under conditions that do not terminate your annuity, your employing office needs to transfer your enrollment from your retirement system to your employing agency. Your FEHB premiums will be deducted from your pay as an employee, not from your annuity. (This applies only if you want to participate in premium conversion; see below.)

Can Reemployed Annuitants Participate in Premium Conversion?

Yes, effective with the first pay period beginning on or after October 1, 2000, you will be covered automatically by premium conversion, provided you are employed:

- In a position that conveys FEHB eligibility; and
- By an agency covered by premium conversion.

Your employing office will contribute the employer share of the FEHB premium in the same manner as that for other employees.

You may waive participation in premium conversion within 60 calendar days from the date you become eligible for premium conversion. The waiver will be effective on the first day of the first pay period after the date your employing office receives it. In this case, you will keep your FEHB coverage as an annuitant and your premiums will be deducted on an after-tax basis.

Your participation in premium conversion ends on the last day of the last pay period as an employee. When you separate from active service, your FEHB enrollment must be transferred back from your employing agency to your retirement system.

Your right to continue FEHB as an annuitant following your period of reemployment is unaffected.

Annuity Suspended during Reemployment. If you are a disability annuitant under age 60 who:

- has been found to be recovered or restored to earning capacity; and
- become reemployed in a position not subject to the retirement system before being dropped from the annuity roll,

your employing office must notify your retirement system that you are reemployed (so your annuity can be suspended). Your employing office must then transfer in your enrollment. When you separate from service, your retirement system must then transfer in your enrollment.

Open Season Opportunities for Reemployed Annuitants. If you are a reemployed annuitant not enrolled for health benefits, you may enroll during an open season the same as any eligible employee. If you are enrolled, during an open season you may change enrollment regardless of the type of your appointment. You will submit your open season change to your employing office, if that office is administering your enrollment. If your retirement system administers your enrollment, follow the directions provided by the retirement system.

Survivor Annuitants

Continued Enrollment for Your Family Members. If you die while enrolled for Self and Family, and all the requirements are met, your enrollment will continue for your eligible family members who become survivor annuitants under a qualifying retirement system.

Benefits and Cost. If the enrollment continues, your eligible survivors are entitled to the same benefits and Government contribution as active and retired employees enrolled in the same plan. The survivor annuitant's share of the premiums normally is deducted from his/her annuity payments.

Action by Survivor. Your survivors don't need to take any action to continue your enrollment if they meet all the requirements.

If they don't want to continue your enrollment, they must send to the retirement system a letter or a Health Benefits Election form (SF 2809) canceling the enrollment. Your survivors must take this action; your employing office will not terminate your enrollment when you die unless it appears that you have no survivors eligible to continue it.

Requirements for Continuing Enrollment. For your surviving family members to continue your health benefits enrollment after your death, all of the following requirements must be met:

- You must have been enrolled for Self and Family at the time of your death; and
- At least one family member must be entitled to an annuity as your survivor.

All of your survivors who meet the definition of "family member" can continue their health benefits coverage under your enrollment as long as any one of them is entitled to a survivor annuity. If the survivor annuitant is the only eligible family member, the retirement system will automatically change the enrollment to Self Only.

Under FERS, your surviving spouse who is entitled to a basic employee death benefit, or your surviving children whose benefits are offset by Social Security, may continue your health benefits enrollment by paying premiums directly to OPM.

If the survivor annuity is not large enough to cover the enrollee share of the premiums for your plan, your survivors may either change to a lower-cost plan or option (one in which the enrollee share of the premium is low enough to be withheld from the annuity) or choose to pay the premiums directly to the retirement system. Even if your employing office thinks that the survivor annuity will not cover the enrollee share of the premiums, your retirement system will transfer in the enrollment. The retirement system will notify your survivors of their options and take whatever actions they request.

When your surviving spouse will not receive any survivor benefits because your former spouse has a court-ordered entitlement to a survivor annuity, your surviving spouse can continue FEHB coverage if you had a Self and Family enrollment. The retirement system will notify your surviving spouse of his/her options and take whatever actions are requested.

Employing Office Procedures. At your death, your employing office will tentatively determine your survivors' eligibility for continued health benefits enrollment. The retirement system will make the final determination of their eligibility after it reviews all of your retirement and health benefits records. Your employing office will take one of the following actions, as appropriate:

If Your Survivors Appear Eligible to Continue the Enrollment. If your survivors appear eligible to continue your enrollment, your employing office will note your plan's enrollment code in the Remarks section of the Individual Retirement Record.

It will send the following to the retirement system along with the Individual Retirement Record, the retirement death claim (if any) and any other retirement papers:

- all Notice of Change in Health Benefits Enrollment forms (SF 2810),
- all Health Benefits Election forms (SF 2809) or other appropriate requests, with any attached medical certificates or other documentation, filed in your Official Personnel Folder (including any on which you elected not to enroll or to cancel, or that are marked VOID), and
- a memorandum giving any information regarding your health benefits that is not evident from the other documents.

If No Survivors are Eligible to Continue the Enrollment. If you have no survivors eligible to continue your enrollment (e.g., you had a Self Only enrollment), your employing office will note in the Remarks section of the Individual Retirement Record: "No survivor eligible to continue health benefits." It will terminate your enrollment on the Notice of Change in Health Benefits Enrollment (SF 2810), note in the Remarks section: "Enrollee died (date)," and leave all health benefits documents in your Official Personnel Folder.

Your employing office will send the enrollee copy of the SF 2810 to your nearest living relative or to the representative of your estate. However, if it appears that a survivor who has been covered as a family member may be eligible for conversion, it will send the SF 2810 to him/her.

If No Surviving Spouse Annuity is Payable because of a Former Spouse Benefit. When your surviving spouse will not receive any survivor benefits because your former spouse has a court-ordered entitlement to a survivor annuity, your surviving spouse can continue FEHB coverage if you had a Self and Family enrollment. Your employing office should follow the procedures in "If Your Survivors Appear Eligible to Continue the Enrollment."

If You Were Not Enrolled. If you weren't enrolled for health benefits at your death, your employing office will note in the Remarks section of the Individual Retirement Record: "Not enrolled for health benefits." It will leave all health benefits documents in your Official Personnel Folder and take no further action on your health benefits.

When You are Eligible Both as an Employee and a Survivor Annuitant. If you are an employee eligible for health benefits who is covered as a family member under your spouse's Self and Family enrollment, and:

- your spouse dies, and
- you are eligible to continue the enrollment as a survivor annuitant,

you may cancel your enrollment as an annuitant and enroll as an employee because you had a change in family status (death of spouse). Or, you may continue the enrollment as a survivor annuitant. However, if you want to participate in premium conversion, you must be enrolled as an employee.

If you enroll as an employee on this basis, and you later separate under conditions not entitling you to continued enrollment, your employing office must terminate your enrollment. If you are still a survivor annuitant, you may apply to the retirement system for reinstatement of your enrollment as a survivor annuitant, and for health benefits deductions to be made from your annuity.

If the retirement system receives your application within 60 days after your separation from employment, it will reinstate your enrollment retroactive to the day after it was terminated by your employing office. If it receives your application more than 60 days after your separation, it will reinstate your enrollment effective on the first day of the month after the month that it received the application.

If you are enrolled as an employee with a Self and Family enrollment and you become a survivor annuitant upon your spouse's death (or, if both you and your spouse were enrolled in Self Only enrollments) and you later separate but cannot continue your enrollment as a retiree, you can enroll as a survivor annuitant. You must make the change from coverage as an employee to coverage as a survivor annuitant within 30 days of separation from service.

If you decided to continue the survivor annuitant enrollment and later lose entitlement to a survivor annuity, you may enroll as an employee.

Deferred Annuity. Since you generally are not eligible for FEHB coverage when you are receiving a deferred annuity, your surviving spouse is not eligible for FEHB coverage as a survivor annuitant even if he/she had FEHB coverage as an employee. If he/she loses coverage as an employee, it can't be transferred to the survivor annuity.

If you are receiving a deferred annuity, your former spouse may be eligible for FEHB coverage under the spouse equity provisions.

If You Die Before Receipt of MRA+10 Annuity. If you die before your postponed MRA+10 annuity begins, your surviving spouse is considered to be the surviving spouse of an annuitant. Your surviving spouse is eligible for FEHB coverage under the same conditions as any other survivor annuitant and may enroll under FEHB when his/her survivor annuity begins.

Opportunities for Survivor Annuitants to Change Enrollment

Enrolled survivor annuitants have the same opportunities to change enrollment as other annuitants, except when there is a change in family status because of the acquisition of a child.

Change in Family Status Due to Acquisition of an Eligible Child. A survivor annuitant's enrollment change based on the acquisition of a child can only be made when the child is an eligible family member of the deceased employee or annuitant. The enrollment can be changed from Self Only to Self and Family, from one plan or option to another, or any combination of these changes from 31 days before to 60 days after the acquisition of the child, and will be effective on the first day of the pay period in which the child is born or becomes an eligible family member.

Restoration of Survivor Annuity

Spouse. If your surviving spouse's:

- survivor annuity or basic employee death benefit was terminated because he/she remarried;
- he/she was covered under an FEHB enrollment immediately before his/her annuity or death benefit terminated; and
- his/her survivor annuity or death benefit is later restored,

he/she may enroll in a health benefits plan within 60 days from OPM's notice of eligibility to enroll.
The restored survivor annuity enrollment is effective on the later of:

- the first day of the month after OPM receives his/her enrollment request; or
- the date the survivor annuity is restored.

The basic employee death benefit enrollment can only be restored when your surviving spouse's remarriage ends and he/she provides OPM with a certified copy of the death notice or the court order terminating the remarriage. The

restored enrollment is effective on the first day of the month after OPM receives his/her enrollment request and documentation of the end of the marriage.

Child. If your surviving child's:

- survivor annuity was terminated because he/she married or ceased being a student;
- he/she was covered under an FEHB enrollment immediately before his/her annuity terminated; and
- his/her survivor annuity is later restored,

he/she may enroll in a health benefits plan within 60 days from OPM's notice of eligibility to enroll. The enrollment is effective on the later of:

- the first day of the month after OPM receives his/her enrollment request; or
- the date the survivor annuity is restored.

Compensationers

Requirements for Continued Coverage. Your health benefits enrollment will continue when you enter on the compensation rolls of the Office of Workers' Compensation Programs (OWCP) and the Secretary of Labor determines that you are unable to return to duty. If your compensation lasts fewer than 29 days, OWCP won't transfer your enrollment. Instead, your enrollment will remain with your employing office.

If you are receiving compensation, your enrollment may continue during the first 365 days in leave without pay status. After that period, you must meet the same participation requirements as for continuing an enrollment after retirement. You must meet the requirements as of the date you started receiving compensation. OWCP, not your employing office, is responsible for determining your eligibility.

Transferring Your Enrollment to OWCP. Your enrollment will be transferred to the Office of Workers' Compensation Programs (OWCP) when:

- OWCP requests the transfer;
- ten months of leave without pay status have elapsed and OWCP has not requested transfer; or
- you separate from service before OWCP requests the transfer.

OWCP normally does not request an enrollment transfer unless it expects your compensation to continue for 6 months or longer.

OWCP will make withholdings when your compensation lasts more than 28 days, whether or not your enrollment has been transferred to OWCP.

Withholdings and Contributions. The Office of Workers' Compensation Programs (OWCP) makes health benefits withholdings regardless of whether your enrollment is transferred to OWCP. Withholdings begin on the later of:

- the date your compensation begins, or
- the date following the day your employing office stops making withholdings and contributions.

OWCP does not make withholdings when you receive compensation for fewer than 29 days. In this case, you must pay your share of the premiums and your employing office must pay its share.

(While OWCP is making the withholdings from compensation, its contributions are made from the Congressional appropriation authorized for the payment of Government contributions for retirees and compensationers.)

Reporting Your Enrollment to OWCP. When your employing office reports your compensable injury or illness on OWCP Form CA 7, it will show whether you were enrolled for health benefits on the date your pay stopped, your plan's enrollment code, and the ending date of the last pay period that insurance withholdings were made.

If OWCP determines that your compensation will continue for at least 6 months, it will normally request that your employing office transfer your enrollment to OWCP.

If you are separated before your employing office receives OWCP's request to transfer your enrollment, your employing office must check with OWCP to determine the status of your compensation claim. If your compensation is to continue beyond the date of separation, it will transfer your enrollment to OWCP.

If you make any permissible change in enrollment before your employing office receives OWCP's request for transfer, your employing office must promptly notify OWCP by letter of the change and its effective date.

If you are separated after your enrollment is transferred to OWCP, your employing office must notify OWCP by letter so it will know how to handle your enrollment if compensation payments end.

Transferring Your Enrollment at OWCP's Request. Your employing office will transfer your enrollment by attaching to the request form all Health Benefits Election Forms (SF 2809), Notice of Change in Health Benefits Enrollment forms (SF 2810), and any other related health benefits documentation and returning it to OWCP. Your employing office must keep a copy of the request form (and back-up copies of all other health benefits documentation) in your Official Personnel Folder to show that OWCP has the health benefits documentation. When OWCP receives the health benefits documentation, it must complete an SF 2810 transferring your enrollment to OWCP.

Transferring Your Enrollment When OWCP Hasn't Requested It. If you are being separated or you have been in leave without pay status for 10 months and OWCP hasn't requested that your enrollment be transferred, your employing office must check with OWCP on the status of your OWCP claim. If compensation will continue beyond your separation date or beyond the 365th day of continuous leave without pay status, your employing office must transfer your enrollment to OWCP by sending all Health Benefits Election forms (SF 2809), Notice of Change in Health Benefits Enrollment forms (SF 2810), and any other related health benefits documentation to OWCP by letter, explaining the reason for the action. When OWCP receives the documentation, it must complete an SF 2810 transferring your enrollment to OWCP.

When Compensation Ends and You Return to Duty. If your compensation ends and you return to duty, OWCP will transfer your enrollment back to your employing office by letter, transmitting the health benefits documentation and giving the date compensation ended. If you are eligible for continued coverage, your employing office will transfer your enrollment in to the agency by completing a Notice of Change in Health Benefits Enrollment (SF 2810). The effective date of the transfer is the day after your compensation terminated.
If you aren't eligible for continued coverage, your employing office will complete an SF 2810 terminating your enrollment effective with the date your compensation ended. A copy of OWCP's letter transferring the enrollment back to your employing office must be attached to the carrier copy of the SF 2810.

When you return to duty on a part-time basis and compensation payments continue, OWCP will keep your enrollment and continue to make withholdings and contributions for you.

When Compensation Ends but You Don't Return to Duty. If your compensation ends, but you don't return to pay

status, your enrollment terminates at midnight on the last day of the pay period in which your compensation terminates.

When You Return to Duty before Compensation Ends. If you return to duty on a full-time basis before OWCP terminates your compensation payments, your employing office must notify OWCP using OWCP Form CA 3. In the Remarks section, it will show the beginning and ending dates of the pay period in which you returned to work. Since OWCP will discontinue withholdings as of the beginning date of the pay period in which you return to full-time pay and duty status, your employing office will resume withholdings and contributions effective with the first pay period in which you return to pay status. If your enrollment had been transferred to OWCP, it will be transferred back to your employing office.

When You Elect Retirement. If you elect to retire and receive an annuity instead of compensation and your enrollment had been transferred to OWCP, the retirement system will ask OWCP to transfer your enrollment to the retirement system. If you are still in leave without pay status, your employing office will note under Remarks on the Individual Retirement Record: "Health benefits enrollment transferred to OWCP," and send it to the retirement system.

Restoration of Compensation Payments. If you were receiving compensation and:

- your compensation was terminated because OWCP determined that you had recovered from your injury or disease;
- you were enrolled in an FEHB plan immediately before your compensation was terminated; and
- your compensation is later restored because your disability recurred,

you may reenroll in a health benefits plan within 60 days from OWCP's notice of your eligibility to reenroll. Your reenrollment is effective on the first day of the pay period after OWCP receives your enrollment request.

Survivors of Compensationers

Requirements for Continued Coverage. If you die while a compensationer, your family members can continue your enrollment if you were enrolled for Self and Family at the time of your death and at least one of your covered family members receives compensation as a surviving beneficiary under the Federal Employees' Compensation law.

If Your Enrollment Wasn't Transferred to OWCP. If your enrollment had not been transferred to the Office of Workers' Compensation Programs (OWCP) before your death, your employing office must determine whether any surviving family members appear eligible to continue your enrollment. Your employing office will terminate your enrollment if it appears that you have no eligible survivors.

If it appears that your survivors are eligible to continue your enrollment, your employing office will send your health benefits documentation to the retirement system as if you had died in service. If your survivors elect to receive compensation rather than survivor benefits, the retirement system will transfer the enrollment to OWCP.
If Your Enrollment Was Transferred to OWCP. If your enrollment was transferred to OWCP before your death, your employing office must note in the Remarks section of your Individual Retirement Record, "Health benefits transferred to OWCP," and send it to the retirement system as usual. OWCP will determine whether you have any eligible survivors who want to continue your enrollment. If your survivors elect to continue to receive compensation, OWCP will continue or terminate your enrollment, as appropriate. If your survivors elect to receive survivor benefits instead of compensation, OWCP will transfer the enrollment to the retirement system.

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Family Coverage

Employing Office Responsibilities

Your employing office is responsible for making decisions about whether a family member is eligible for coverage. If the carrier of your health benefits plan has any questions about whether someone is an eligible family member, it may ask you or your employing office for more information. The carrier must accept your employing office's decision on your family member's eligibility.

General Eligibility for Coverage

Family members eligible for coverage under your Self and Family enrollment are your spouse (including a valid common law marriage) and children under age 26, including legally adopted children, recognized natural (born out of wedlock) children and stepchildren (including children of same-sex domestic partners). A child is eligible for coverage under your Self and Family enrollment, if a state-issued birth certificate lists you as a parent of that child.

Foster children are included if they meet the requirements listed here:

- the child must be under age 26 (if the child is age 26 or over, he/she must be incapable of self-support);
- the child must currently live with you;
- the parent-child relationship must be with you, not the child's biological parent;
- you must currently be the primary source of financial support for the child; and
- you must expect to raise the child to adulthood.

A child age 26 or over who is incapable of self-support because of a mental or physical disability that existed before age 26 is also an eligible family member. In determining whether the child is a covered family member, your employing office will look at the child's relationship to you as the enrollee. A grandchild is not an eligible family member, unless the child qualifies as your foster child. Special rules apply to family members if you are enrolled as a survivor annuitant or under the Spouse Equity or temporary continuation of coverage (TCC) provisions.

Defense of Marriage Act

On June 26, 2013, the Supreme Court ruled that Section 3 of the Defense of Marriage Act (DOMA) is unconstitutional. As a result of the Supreme Court's June 26, 2013 ruling that Section 3 of DOMA is unconstitutional, legally married same-sex spouses will be eligible family members under a Self and Family enrollment. Coverage is available to any legally married same-sex spouse of any Federal employee or annuitant, regardless of the employee's or annuitant's state of residency.

In addition, the children of same-sex marriages will be treated in the same manner as those of opposite-sex marriages and will be eligible family members according to the same eligibility guidelines. This includes coverage for children of same-sex spouses as stepchildren.

Eligible Family Members Automatically Covered

When you enroll for Self and Family, you automatically include all eligible members of your family. If you don't list an eligible family member on your Health Benefits Election Form (SF 2809) or other enrollment request, that person is still entitled to coverage. If you list a person who is not an eligible family member, your employing office will explain why the person is not eligible for coverage and will remove the name from the list. The listing of an ineligible person on the SF 2809 doesn't entitle him/her to benefits.

Adopted Children

Applicable State law governs whether a child has been adopted. The child is adopted if the adoption decree is final. The child also is considered adopted if the adoption decree is interlocutory and State law provides that the rights of the child generally are the same as those of an adopted child.
Stepchildren

In general, your spouse's child born within or outside marriage or adopted child is considered to be your stepchild. In addition, the child of your same-sex domestic partner (as described below & certified to your agency) is eligible for coverage under a Self and Family enrollment if you would marry your partner but live in a state that does not recognize same-sex marriage. However, your spouse or same-sex domestic partner's stepchild (by a previous marriage) is not your stepchild.

Children of Same-Sex Domestic Partners

Declaration of Domestic Partnership A domestic partnership is defined as a committed relationship between two adults, of the same sex, in which the partners:

- Are each other's sole domestic partners and intend to remain so indefinitely;
- Maintain a common residence and intend to continue the arrangement indefinitely;
- Are at least 18 years of age and mentally competent to consent to contract;
- Share responsibility for a significant measure of each other's financial obligations;
- Are not married or joined in a civil union to anyone else;
- Are not a domestic partner of anyone else;
- Are not related in a way that, if they were of opposite sex, would prohibit legal marriage in the U.S. jurisdiction in which the domestic partnership was formed.

To cover a child of a same-sex domestic partner, you must provide a Declaration of Domestic Partnership (your employing office or retirement system can give you a copy) establishing fulfillment of the above requirements and in which you certify:

- that you understand that falsification of the documentation may lead to disciplinary action; and
- that you would marry your partner but for the failure of your state of residence to permit same-sex marriage.

You do not need to meet any further requirements (e.g. state law requirements for registered domestic partners) for a domestic partnership besides those listed above. For employees and annuitants living in states that do not permit same-sex marriage, the completed Declaration of Domestic Partnership establishes employee or annuitant eligibility for this benefit and is considered a Qualifying Life Event.

Tax Treatment

If your stepchild is considered your tax dependent, providing coverage to your stepchild will have no effect on your taxable income.

If your stepchild is not considered your tax dependent, you will be taxed on the fair market value of the coverage provided to your stepchild. Please consult your tax advisor for further information.

To alert your agency or retirement system of the tax status of your stepchild, you must submit a Tax Certification. Contact your employing office or retirement system for a copy of the Tax Certification. A Tax Certification is not a requirement for covering your child; but, failure to submit a Tax Certification will result in taxation of the coverage

provided to your stepchild. You need to submit a new Tax Certification to your employing office or retirement system if your stepchild's tax dependent status changes.

Applicable State Law

Because state law concerning same-sex marriage may change during the year, for mid-year enrollments, the determination of the status of the law of the state where you live will be made as of the date you notify your employing agency/retirement system of your desire to cover your stepchild.

For Open Season enrollments, the status of the law of the state where you live as of the day before the beginning of Open Season will determine whether your stepchild is eligible to be covered.

If your state's law changes to allow same-sex marriage or if you move to a state that allows same-sex marriage in the middle of the year, your child's continuing eligibility for coverage as a stepchild for the remainder of a particular plan year will not be affected. However, if you marry your same-sex domestic partner mid-year, you should notify your employing office or retirement system; and your child will automatically be considered your tax dependent and there will no longer be any potential tax consequences associated with coverage of the child.

If the law in your state changes to allow same-sex marriage, your stepchild will only be permitted to continue to be covered under your enrollment as a stepchild in following plan years if, on the day before the beginning of Open Season for the following plan year, you live in a state that does not permit same-sex marriage. It is your responsibility to notify your employing office or retirement system if your stepchild is not eligible to be covered in the following year because you 1) move to a new state mid-year or 2) because the law changes in your state.

Please note that if your state law changes to allow same-sex marriage, you can continue to cover your child under a Self and Family enrollment in the following plan year if you and same-sex domestic partner are married.

A list of states that allow same-sex marriage is available on the OPM website.

Coverage of Stepchildren after Divorce

Under the FEHB Program, your stepchild remains a stepchild and an eligible family member after your divorce from, or the death of, the natural parent, provided that the stepchild continues to live with you in a regular parent-child relationship.

If your stepchild stops living with you in a regular parent-child relationship, the child is eligible for coverage under temporary continuation of coverage (TCC) provisions because he/she no longer meets the definition of an eligible child.

If you divorce and your former spouse is eligible to enroll under either the Spouse Equity or TCC provisions, only the natural or adopted children of both you and your former spouse are covered under your former spouse's Self and Family enrollment. Your stepchildren are not covered even though they may have been covered previously by your Self and Family enrollment. However, they may qualify for a TCC enrollment of their own.

Foster Children

Requirements. To be considered a foster child for health benefits purposes:

- the child must be under age 26 (if the child is over age 26 or over, he/she must be incapable of self-support);
- the child must currently live with you;
- the parent-child relationship must be with you, not the child's biological parent;
- you must currently be the primary source of financial support for the child; and

- you must expect to raise the child to adulthood.
- You don't need to be related to the child nor do you need to legally adopt him/her. As long as the above requirements are met, you may have a foster parent-child relationship even when:
- the child's natural parents are alive;
- the child's natural parent lives with you; or
- the child receives some support from sources other than you (for example, social security payments or support payments from a parent).
- Common examples of a foster parent-child relationship are:
- A child whose parents have died is living with, and being supported by, a close relative who is an enrollee.
- A child who is living with and financially dependent on a grandparent who is an enrollee. (The natural parent of the child may also be a dependent.)
- A child living with an enrollee under a preadoption agreement.
- A child who is in the legal custody of an enrollee.

How to Get a Foster Child Covered

For your foster child to be covered under your FEHB enrollment, you must provide documentation of your regular and substantial support of the child; sign a certification stating that your foster child meets all the requirements

Certification for Foster Children

You may use the following link to the foster child certification to establish your foster child's eligibility for coverage as a family member to your employing office. Your employing office must file the original statement in your Official Personal Folder.

STATEMENT OF FOSTER CHILD STATUS

This is to certify that my foster child meets the following requirements for coverage in the Federal Employees Health Benefits (FEHB) Program:

- The child is unmarried
- The child lives with me in a regular parent-child relationship.
- I contribute regular and substantial support for the child.
- I intend to raise the child into adulthood.

Child's Name:_____
Child's birth date:_____
Child's Social Security Number:_____
Child's relationship to annuitant:_____

I have enclosed proof of my regular and substantial support for name of child/foster child. I have also included a copy of his/her birth certificate. I will immediately notify OPM and my health benefits carrier if the child marries, moves out of my home, or ceases to be financially dependent on me. If this child moves out to live with a biological parent, he/she loses coverage and cannot ever again be covered as a foster child unless the biological parent dies, is imprisoned or becomes incapable of caring for the child due to a disability.

Annuitant Signature:_____
Date:_____
Phone Number:_____
Email:_____
FAX: 202-606-1640

Effective Date

The effective date of your foster child's coverage as a family member is the first day of the pay period in which your employing office receives all of the properly completed documents that establish the eligibility of the child as a foster child. When your foster child's mother is an eligible family member under your enrollment, you may request that the effective date be the first day of the pay period in which the child is born.

When Coverage Ends

Your foster child's coverage continues until he/she reaches age 26, becomes capable of self-support if age 26 or over, or is no longer living with you. If your foster child moves out of your home to live with a biological parent, the child cannot again be covered as your foster child unless:

the biological parent dies;
the biological parent is imprisoned;
the biological parent becomes unable to care for the child due to a disability; or
you obtain a court order for custody that takes parental responsibility from the biological parent and gives it to you.

Grandchildren

Grandchildren are not eligible family members. However, your grandchild can qualify as a foster child if all the requirements are met.

When a Child is Not Considered a Foster Child

A child who has been placed in your home by a welfare or social service agency under an agreement where the agency retains control of the child or pays for maintenance does not qualify as a foster child because there is no regular parent-child relationship. A child living temporarily with you as a matter of convenience does not qualify as a foster child. For example, a child who lives with you only while attending school normally does not qualify as a foster child because this is considered an arrangement of convenience.

Since it is impossible to cover every family situation, it may be necessary for the agency headquarters Benefits Officer to contact OPM for assistance in making difficult determinations.

A Child's Temporary Absences

If your foster child temporarily lives elsewhere while attending school or for other reasons, the child is still considered to be an eligible family member if he/she is otherwise living with you in a regular Parent-Child Relationship. Your foster child who lives with you at least 6 months of a year under a court order directing shared custody may be considered living with you in a regular Parent-Child Relationship.

Parent-Child Relationship

A "regular Parent Child Relationship" means that you are exercising parental authority, responsibility, and control over the child by caring for, supporting, disciplining, and guiding the child, including making decisions about the child's education and health care.

A Spouse Equity Self and Family enrollment is limited to natural and adopted children of both you and your former spouse. In this case, a foster child or stepchild is not a covered family member.

Relatives Who are Not Family Members

Your parents and other relatives are not eligible family members, even if they live with and are dependent upon you.

Child Incapable of Self-Support

Coverage

Your Self and Family enrollment covers your child age 26 or over who is incapable of self-support because of a physical or mental disability that existed before the child reached age 26.

Requirements

Your child age 26 or over may be considered incapable of self-support only if his/her physical or mental disability is expected to continue for at least one year and, because of the disability, he/she isn't capable of working at a self-supporting job.

A disability such as blindness or deafness isn't qualifying in itself because it doesn't necessarily make someone incapable of self-support. The onset of a disease before age 26 that doesn't result in incapability for self-support until age 26 or after doesn't qualify a child for continued coverage as a family member.
Determination of Incapacity for Self-Support

When Employing Office Must Make Determination

Your employing office is responsible for determining whether your dependent child age 26 or over is incapable of self-support because of a mental or physical disability that began before age 26 and for notifying the carrier of your plan of its determination. If your child's medical condition is listed below, the carrier may also approve coverage.

Your dependent child is incapable of self-support when:

- he/she is certified by a state or federal rehabilitation agency as unemployable;
- he/she is receiving: (a) benefits from Social Security as a disabled child; (b) survivor benefits from CSRS or FERS as a disabled child; or (c) benefits from OWCP as a disabled child;
- a medical certificate documents that: (a) your child is confined to an institution because of impairment due to a medical condition; (b) your child requires total supervisory, physical assistance, or custodial care; or (c) treatment, rehabilitation, educational training or occupational accommodation has not and will not result in a self-supporting individual;
- a medical certificate describes a disability that appears on the list of medical conditions; or
- you submit acceptable documentation that the medical condition is not compatible with employment, that there is a medical reason to restrict your child from working, or that he/she may suffer injury or harm by working.

If your child earns some income (generally no more than the equivalent of the GS 5, step 1), it doesn't necessarily mean that he/she is capable of self-support. Your employing office will take both your child's earnings and condition or prognosis into consideration when determining whether he/she is incapable of self-support.

When Carrier May Approve Coverage

If your child has a medical condition listed, and he/she had the condition before reaching age 26, you don't need to ask your employing office for approval of continued coverage after your child reaches age 26. The carrier of your health benefits plan may approve continued coverage to your child without referring you to your employing office.

When the carrier determines your child's incapacity for self-support, it sends the approval notice to you and advises you to give a copy of the notice to your employing office. Your employing office must file it with your other health benefits enrollment documentation in your Official Personnel Folder.

List of Medical Conditions that would Cause a Child to be Incapable of Self-Support During Adulthood

If your child has one of the following disabilities noted in the medical certificate, and the disability began before age 26, your employing office or health benefits carrier can automatically extend continued coverage.

- AIDS - CDC classes A3, B3, C1, C2, and C3 (not seropositivity alone)
- Advanced Muscular Dystrophy
- Any malignancy with metastases or which is untreatable
- Chronic Hepatic Failure
- Chronic neurological disease, whatever the reason, with severe mental retardation or neurologic impairment, for example:
    - Cerebral Palsy
    - Ectodermal Dysplasia
    - Encephalopathies
    - Uncontrollable Seizure Disorder
    - Chronic Renal Failure
    - Inborn errors of Metabolism with complications such as the following:
    - Adrenoleukodystrophy
    - Gaucher disease
    - Glycogen storage diseases
    - Homocysteinuria
    - Lesch-Nyhan disease
    - Mucopolysacharide disease
    - Nieman-Pick disease
    - Phenylketonuria
    - Primary hyperoxaluria
    - Tay-Sachs disease
    - Mental Retardation with IQ of 70 or less
    - Osteogenesis Imperfecta
    - Severe acquired or congenital Heart Disease with decompensation which is not correctable
    - Severe Autism
    - Severe Juvenile Rheumatoid Arthritis
    - Severe Mental Illness requiring prolonged or repeated hospitalization
    - Severe Organic Mental Disorder
    - Xeroderma Pigmentosa

This list doesn't include all the disabilities that would cause a child to be incapable of self-support.

Medical Certificate

Your child's doctor must complete a medical certificate for the employing office to make its determination of incapacity of self-support. The certificate must state that your child is incapable of self-support because of a physical or mental disability that existed before he/she became age 26 and that can be expected to continue for more than one year:

- your child's name and birth date;
- the type of disability;
- the period of time the disability has existed and the date the impairment began;

- diagnosis and history of the specific medical condition(s), references to findings from previous examinations, treatment and responses to treatment;
- clinical findings from the most recent physical examination, including objective findings of physical examination, results of laboratory tests, x-rays, EKG's and other special evaluations or diagnostic procedures, and, in the case of psychiatric disease, the findings of mental status examinations and the results of psychological tests;
- assessment of the current clinical status and plans for future treatment;
- assessment of degree to which the medical condition has become static or stabilized and an explanation of the medical basis for the conclusion;
- the probable future course and duration of the disability, including an estimate of the expected date of full or partial recovery;
- the special supervisory, physical assistance, or custodial care requirements of your child;
- any treatments, rehabilitation programs, educational training or occupational accommodation that would result in your child becoming self-supporting; and
- the doctor's name, signature, office address and telephone number.

When to Submit Certificate

You may submit the medical certificate to your employing office when you first enroll to cover your child under your Self and Family enrollment. To maintain continued coverage for your child after he or she turns age 26, submit the medical certificate within 60 days of your child reaching age 26.

If your employing office determines that your child is incapable of self-support, your employing office must notify the carrier of your plan by letter. The letter must identify you by name and social security number, and state the name and date of birth of your disabled child as well as the duration of the approval. It will send the letter to the carrier with a regular transmittal report. It will not send the medical evidence used in its determination to the carrier, but will attach it to your most recent Health Benefit Election form (SF 2809) or other enrollment request in your Official Personnel Folder.

If you have a new enrollment, your employing office will note its determination of incapacity of self-support in the Remarks section of your SF 2809.

Use of Physicians

In making its medical determinations, your employing office must use a physician's services if available, unless your child's condition is one for which it can automatically extend continued coverage. In doubtful cases, or if no physician is available, your employing office may request assistance from: Office of Personnel Management, Healthcare and Insurance, P.O. Box 436, Washington, D.C. 20044.

Duration and Approval of Incapacity for Self-Support

Depending on your child's medical certificate, your employing office may approve coverage due to disability for a limited period of time (1 year, for example), or without time limitation (permanent).

Renewal of Medical Certificate

If your employing office approves your child's medical certificate for a limited period of time, it must remind you, at least 60 days before the date the certificate expires, to submit either a new certificate or a statement that the certificate will not be renewed. If it is renewed, your employing office must notify the carrier of your plan of the new expiration date by letter.

Failure to Renew Certificate

If you don't renew a medical certificate for a disabled child age 26 or over, your child's status as a family member automatically ends and he/she is no longer covered. Your employing office must notify you and the carrier of your plan that your child is no longer covered.

Late Certificates

If you submit a medical certificate for a child after a previous certificate has expired, or after your child reaches age 26, your employing office must determine whether the disability existed before age 26. If your employing office determines that it did, and you continuously had a Self and Family enrollment, your child is considered to have been a covered family member continuously since age 26.

Change in Family Status

Election Opportunities

When you have a change in family status, including a change in marital status, you may enroll, change from Self Only to Self and Family, or change from one plan or option to another. You must submit your enrollment change from 31 days before to 60 days after the change in family status.

Certain restrictions apply if you are enrolled as a survivor annuitant or as a former spouse under the Spouse Equity or temporary continuation of coverage (TCC) provisions.

Events Considered to be Changes in Family Status

Generally, a change in family status is an event that adds to or decreases the number of your family members. Certain other events are also considered changes in family status. The following events are considered a change in family status for health benefits purposes:

- your marriage, including a valid common law marriage (in accordance with applicable State law);
- birth of your child (but not a stillborn child);
- your legal adoption of a child under age 26 or the acquisition of a foster child under age 26;
- your submission of a Declaration of Domestic Partnership to your employing office or retirement system;
- your child under age 26 or spouse enters into or is discharged from military service;
- issuance or termination of a court order granting to you or your spouse a final divorce, interlocutory divorce, limited divorce, legal separation, or separate maintenance;
- issuance of a court decree of annulment, or in the case of a marriage void from its beginning (ab initio) also a declaratory judgment, or conviction of the spouse of bigamy;
- issuance of a court order specifically requiring you to enroll for your children or provide health benefits protection for them;
- the death of your spouse, including a declaration by a court that your missing spouse is presumed dead.

When a Court Order Requires You to Provide Coverage for Your Children (Children's Equity)

Public Law 106-394 requires mandatory Self and Family coverage if you are eligible for FEHB coverage and you do not comply with a court or administrative order to provide health benefits for your children. If you are subject to such an order, you must enroll in Self and Family coverage in a plan that provides full benefits to your children in the area where they live or provide documentation that you have other health coverage for the children.

If you do not enroll in an appropriate health plan or provide documentation of other coverage for the children, your agency must enroll you for Self and Family coverage in the lower option of the Blue Cross and Blue Shield Service Benefit Plan (enrollment code 112).

Court/Administrative Orders

The court or administrative order can be submitted by anyone, including the custodial parent, an attorney for the custodial parent, and the State administrative agency that issues the order.

If the court order deals only with health benefits, it does not have to be certified. If the court order also deals with life insurance or retirement benefits, then it does have to be certified. Administrative orders come from State child support agencies, and will not be certified.

For it to be considered valid under Pub. L. 106-394, your agency must receive the court/administrative order on or after October 30, 2000.

Anyone who submitted a court/administrative order relating to health benefits for your children before October 30, 2000, would have to resubmit it. The court/administrative order can be issued before October 30, 2000, but it doesn't have any validity for FEHB purposes unless your agency receives it on or after October 30, 2000.
Employing Office Review

Your employing office must review your records to determine whether you are eligible for FEHB and, if so, whether you are enrolled in a Self and Family plan that provides full benefits in the location where your children live. If you have such coverage, your employing office will notify whoever sent in the court/administrative order. It will send a copy of your SF 2809 to your health benefits carrier, along with a copy of the court/administrative order to notify the carrier of the additional family members being covered under the Self and Family enrollment.

Your employing office will file the order in your Official Personnel Folder (OPF), and flag the OPF or other file in some manner that it will know the file contains a court/administrative order relating to health benefits.

If You Don't Have Self and Family Coverage or Coverage that Provides Full Benefits in the Area Where the Children Live

If you are eligible for FEHB but don't have the appropriate coverage, you employing office will notify you that it has received a court order requiring you to provide health benefits for your children. Your employing office will give you until the end of the pay period following the one in which you get the notice to enroll in an appropriate health plan or provide documentation that you have other health benefits for the children.

Your employing office may use the following sample notification.

Sample Notice

Dear [Employee's name]:
We have received a [court/administrative] order stating that you must provide health benefits for your child[ren]. You are not currently enrolled in Self and Family coverage under the Federal Employees Health Benefits (FEHB) Program in a health plan that provides full benefits in the area where your child[ren] live[s].

Pub. L. 106-394 requires Federal agencies to ensure that employees comply with the terms of such court and administrative orders. You must enroll in Self and Family coverage in a plan that provides full benefits where your child[ren] live[s] or provide documentation that you have other health benefits for your child[ren] by [insert date that is the last day of the pay period following the one in which this notice is issued].

If you do not enroll or provide documentation of other coverage for your child[ren] by [repeat date from paragraph above], we will enroll you for Self and Family coverage under the lower option of the Blue Cross and Blue Shield Service Benefit Plan program. As long as the [court/administrative] order remains in effect and your child[ren] [is/are] eligible under the FEHB Program, you must continue Self and Family coverage in a plan that provides full benefits where your child[ren] live[s], unless you provide documentation that you have obtained other coverage.

Sincerely,
[Signature, name, and title of appropriate official]
[In addition to sending a copy to the employee, keep a copy in the employee's OPF or other record.]

What Happens If YouDon't Enroll or Provide Documentation of Other Coverage by the Due Date?

If you don't enroll in an appropriate plan or provide documentation of other coverage for the children, your employing office will enroll you as follows:

- If You Are Not Enrolled at All
- If you are not enrolled for any FEHB coverage, your employing office will enroll you for Self and Family coverage in the lower option of the Blue Cross and Blue Shield Service Benefit Plan (enrollment code 112).
- If You Have Self Only Coverage
- If you have a Self Only enrollment in a fee-for-service plan, your employing office will change your enrollment to Self and Family in the same option of the same plan.
- If you have a Self Only enrollment in an HMO, and the HMO serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan.
- If you have a Self Only enrollment in an HMO, and the HMO does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the lower option of Blue Cross and Blue Shield Service Benefit Plan.
- If You Have Self and Family Coverage in an HMO That Doesn't Serve the Area Where Your Children Live
- If you already have a Self and Family enrollment, but it's in an HMO that doesn't serve the area where your children live, your employing office will change your enrollment to Self and Family in the lower option of Blue Cross and Blue Shield Service Benefit Plan.
- How an Agency Enrolls You Involuntarily
- If your employing office needs to enroll you involuntarily, it will complete a Health Benefits Election form (SF 2809) with your identifying information. It will use event code 1C (Change in family status). In the signature block in Part G, it will write "See Remarks." In the remarks block in Part I, it will write "Being enrolled for Self and Family coverage involuntarily under Pub. L. 106-394."

When your employing office sends the SF 2809 to your health plan, it will attach a copy of the court/administrative order. It will send your copy of the SF 2809 to the custodial parent, along with a plan brochure, and make a copy for you.

What is the Effective Date If You are Enrolled Involuntarily?

In most cases, the effective date will be the first day of the pay period following the one in which your employing office completes the SF 2809.

Example

Chester's employing office receives an administrative order on November 14, 2010, saying that he must provide health benefits for his two children. Chester doesn't have any FEHB coverage. His employing office notifies him that he has until December 2, 2010 (the end of the following pay period) to enroll or provide documentation that he has other coverage for them. He doesn't respond. On December 4, 2010, Chester's employing office completes an SF 2809 enrolling him for Self and Family coverage in the lower option of Blue Cross and Blue Shield Service Benefit Plan. The effective date would be December 17, 2010 (the first day of the next pay period).

Exception: There is one instance in which the enrollment would be retroactive, and that's if the court/administrative order specifies an effective date. In this case, your employing office must make the enrollment retroactive to the beginning of the pay period that includes that effective date, but no further back than 2 years.
How Does My Employing Office Identify My Eligible Family Members?

Usually the court/administrative order will have the names and birthdates of the children. If the order does not have this information, your employing office will leave item 12 on the SF 2809 blank. The health plan will obtain the information from the custodial parent.

What Happens If You Go into a Nonpay Status or Your Pay is Insufficient to Make the Withholdings?

The provisions of 5 CFR 890.502(b) apply (see "Leave Without Pay Status and Insufficient Pay"). However, in this case, you do not have the option of terminating coverage. You must continue the coverage and either make direct premium payments or incur a debt to the Government.

If Your Employing Office Enrolls You, Can You Later Make Enrollment Changes?

If you are involuntarily enrolled and your employing office finds that circumstances beyond your control prevented you from making your own enrollment election, you may change the enrollment prospectively within 60 days after your employing office advises you of its finding. Otherwise, it depends on the enrollment change you want to make. During Open Season or when you have an event that allows an enrollment change, you can change to a different fee-for-service plan or to an HMO that provides full benefits where your children covered under the court/administrative order live.

However, you cannot (even during Open Season):

- Cancel your enrollment,
- change to Self Only, or
- change to an HMO that doesn't provide coverage in the area where your children live,
- as long as the court/administrative order is still in effect and the children are eligible under the FEHB Program (unless you provide documentation that you have other coverage for the children). This applies whether you are enrolled voluntarily or involuntarily. If you submit an SF 2809 making such an enrollment change, your employing office will not process it. If it gets processed by mistake, your employing office will void it. Your employing office will notify you that you cannot make the change and that your existing Self and Family enrollment will remain in effect.

What Happens If You Make a "Not-Allowed" Enrollment Change by Employee Express?

Your payroll office should flag the records for all employees subject to a court/administrative order for health benefits. You will then not be able to make an enrollment change through Employee Express.

If your agency has its own electronic system for FEHB enrollments, it will take similar action.

How Long Must You Keep the Self and Family Enrollment?

If the court/administrative order doesn't specify a time limit on the coverage, you must keep the Self and Family enrollment until the last child marries or reaches age 26.

If the court/administrative order states that coverage must continue until a specific age--and that age is over age 26--the coverage must continue until the last child reaches age 26. Unless they meet the requirements for being incapable of self-support, children cannot continue FEHB coverage beyond age 26, regardless of what the court/administrative order says.

If the court/administrative order states that the coverage must continue until a specific age--and that age is below age 26, you may cancel the coverage or change to Self Only as follows:

If You Participate in Premium Conversion

You may cancel or change to Self Only the Open Season following when the child reaches the age stated in the court/administrative order.

If You Waived Premium Conversion

You may cancel or change to Self Only at any time after the last child reaches the age stated in the court/administrative order.

What Happens When You Retire?

If you are eligible to carry FEHB coverage into retirement, you must continue the Self and Family coverage after retirement to provide coverage for the children covered under the court/administrative order. As long as the court/administrative order remains in effect, you cannot:

- cancel or suspend coverage,
- change to Self Only, or
- change to an HMO that doesn't provide full benefits where the children live.

If your retirement becomes insufficient to make the premium withholdings, you may not choose to terminate the enrollment. Instead, you must continue the coverage and make direct premium payments for as long as the order remains in effect and the child or children continues to be eligible.

What If Your Employing Office Gets More Than One Court/Administrative Order for You?

A Self and Family enrollment automatically covers all eligible family members. If you are subject to a court/administrative order, and another court/administrative order is filed relating to a different child (or children), that child is automatically covered under your existing Self and Family enrollment.

Your employing office will send your health plan a copy of the subsequent court/administrative order, along with a copy of the SF 2809 marked "Duplicate."

If you are enrolled in an HMO, and the children mentioned in the subsequent court/administrative order live in an area that the HMO doesn't serve, your employing office will notify you and give you a chance to choose a different health plan. . If you don't change plans, your employing office will change your enrollment to the lower option of Blue Cross and Blue Shield Service Benefit Plan. It will attach copies of all court/administrative orders to the SF 2809.

Changes that Do Not Affect Enrollment

Family Members

You don't need to report to your employing office any change in the number of family members that doesn't affect your health benefits enrollment. However, the carrier of your plan may request this information, including evidence of family relationship.

Your enrollment is not affected when:

- your child is born when you already have a Self and Family enrollment;
- your spouse dies or you divorce and you have children still covered under your Self and Family enrollment;

- your child reaches age 26, and you have other children or a spouse still covered under your Self and Family enrollment. (If you want temporary continuation of coverage (TCC) or a conversion contract for your child, you must inform your employing office of your child's loss of FEHB eligibility within 60 days.)

Name Changes

If you change your name for any reason, your employing office must report the change to the carrier of your plan. If no other changes are involved (e.g., you legally change your name, or you change your name upon your marriage but keep your Self Only enrollment), your employing office reports the name change on the Notice of Change in Health Benefits Enrollment (SF 2810).

You are also eligible to change your enrollment upon your marriage. (Note: If your spouse is a Federal employee with a Self and Family enrollment, you are automatically covered as a family member under that enrollment, and you generally must cancel your enrollment to avoid dual enrollment.) If you change your enrollment, you must submit a new Health Benefits Election Form (SF 2809) under your new name, showing your former name in the Remarks section of the form.

Loss of Family Member Status

When a family member loses coverage because he/she is no longer an eligible family member, he/she will be entitled either to temporary continuation of coverage or to convert to an individual policy with your carrier. If you are divorcing, your former spouse may be eligible for coverage under the spouse equity provisions.

When a Family Member is no Longer Eligible

- Your family member immediately loses eligibility for coverage under your Self and Family enrollment when:
- Your divorce decree is final (according to State law);
- Your child reaches age 26, unless he/she is incapable of self-support;
- Your foster child marries or stops living with you in a regular Parent-Child Relationship.
- Your stepchild no longer meets requirements for coverage.

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Former Spouses

Spouse Equity Law

Law. The Civil Service Retirement Spouse Equity Act of 1984 (Public Law 98-615) was enacted on November 8, 1984. Under this act, as amended, certain former spouses of Federal employees, former employees, and annuitants may qualify to enroll in a health benefits plan under the FEHB Program.

Eligibility. Your former spouse is eligible to enroll under Spouse Equity provisions if:

- you were divorced during your employment or receipt of annuity;
- he/she was covered as a family member under an FEHB enrollment at least one day during the 18 months before your marriage ended (Note: This requirement is also met when both you and your former spouse have FEHB enrollments);
- he/she is entitled to a portion of your annuity or to a former spouse survivor annuity; and
- he/she has not remarried before age 55.

Your employing office will determine whether your former spouse is eligible to enroll.

Loss of Coverage as a Family Member. Your former spouse loses coverage as a family member upon your divorce, subject to a 31-day extension of coverage. However, his/her enrollment under the spouse equity provisions may not begin for several months after the divorce, depending on how long it takes to establish eligibility. To avoid a gap in coverage for this period, your former spouse may:

- convert to an individual contract during the 31-day extension of coverage; or
- continue FEHB coverage under the Temporary Continuation of Coverage (TCC) provisions of the FEHB law.

If your former spouse will seek coverage under spouse equity provisions, it is advisable to stay with the same plan.

If your former spouse acts promptly, he/she may request retroactive enrollment once the application for enrollment under the spouse equity provisions has been approved. For enrollment to be retroactive, the employing office must receive an appropriate request and satisfactory proof of eligibility within 60 days after the date of divorce.

Enrollment

Enrolling under the Spouse Equity provisions is a three-step process. First, your former spouse must apply to enroll within the required time limit. Second, he/she must establish eligibility to enroll. Third, actual enrollment can take place only after the first two steps have been completed.

Type of Enrollment. Your former spouse may elect a self only or self and family enrollment. A self and family enrollment covers only your former spouse and any unmarried dependent natural or adopted children of you and your former spouse.

Where Former Spouses Apply. If your marriage ends before your retirement, your former spouse must apply and pay premiums to the employing office of the agency for which you worked when your marriage ended. If the application is

approved, this will be your former spouse's employing office until he/she begins receiving annuity payments, even if you transfer to another employing office.

Your former spouse must apply and pay premiums to the retirement system responsible for your annuity payment if:

- he/she is receiving a portion of your retirement benefit or a former spouse survivor annuity; or
- the divorce occurred after your retirement; or
- the divorce occurred before May 7, 1985, and you worked for the Central Intelligence Agency (CIA) or the Foreign Service.

OPM is your former spouse's employing office if you are receiving compensation from the Office of Workers' Compensation Programs (OWCP), and your health benefits enrollment had been transferred to OWCP before your marriage ended.

Application to Enroll. Your former spouse's application to enroll can either be a completed Health Benefits Election Form (SF 2809) or a written notice of intent to apply for health benefits. His/her own name, date of birth, and Social Security number is entered on Part A of the SF 2809. Your name and date of birth must be entered in the Remarks section.

If there is a mental or physical disability that prevents your former spouse from applying for benefits, a court appointed guardian may file the application.

Time Limit. Your former spouse must apply to his/her employing office in writing by the latest of:

- 60 days after your marriage ends;
- 60 days after the date of OPM's notice of his/her eligibility to enroll based on a qualifying court order awarding entitlement to a portion of your future annuity (see section 5A5.1-2 of the CSRS/FERS Handbook for Personnel and Payroll Offices), or to a former spouse survivor annuity; or
- 60 days after the date of the notice of his/her eligibility to enroll based on entitlement to a former spouse annuity under another retirement system for Government employees.

If your former spouse doesn't apply to the employing office in person, the employing office will use the postmark date on the application to determine if he/she meets the time limit.

Deferred Enrollment. Once your former spouse has applied to enroll within the required time limit, he/she may postpone actual enrollment indefinitely.

Determination of Entitlement to Future Annuity. When your former spouse applies to the employing office for benefits, it will advise him/her that he/she must send a written request to the retirement system for a determination of entitlement to either:

- a portion of your future retirement annuity, or
- a former spouse survivor annuity.

The request must include:

- a certified copy (not a photocopy of a certified copy) of the divorce decree, property settlement, and/or court

order (if applicable);

- your name, date of birth, Social Security number, and last employing agency.

Unless you are subject to the CIA or Foreign Service retirement systems, OPM, not the agency, will make the annuity benefit determination based on the court order supplied. Your former spouse can not enroll until OPM makes its determination. OPM will send your former spouse a written decision. If eligibility is determined, he/she will submit the decision to your employing office.

Retirement System Addresses

Your Retirement System:	Request for Review Sent to:
CSRS or FERS	Office of Personnel Management, Retirement and Insurance Service, Office of Retirement Programs, P.O. Box 17, Washington, D.C. 20044.
CIA	CIA Retirement and Disability System, Central Intelligence Agency, P.O. Box 1925, Washington, D.C. 20505.
Foreign Service	Foreign Service Retirement and Disability System, Department of State, Retirement Division, Room 1251, Washington, D.C. 20520.
Any Other Retirement System	Your former spouse must obtain that retirement system's certification of his/her eligibility to a portion of your future annuity or a former spouse survivor annuity, and must submit the certificate to OPM when applying for eligibility to enroll.

Determining a Former Spouse's Eligibility. When your former spouse applies for eligibility to enroll under the spouse equity provisions, his/her employing office must first verify that you were employed by the agency at the time of your divorce. If you separate from Federal service before becoming eligible for an immediate annuity, your former spouse is eligible to enroll only if your marriage ended before you left Federal service.

The employing office must then determine if your former spouse is eligible to enroll. To be eligible, he/she must meet all of the following requirements:

- He/she must not have remarried before age 55;
- He/she must have been covered as a family member in an FEHB plan at least one day during the 18 months before your marriage ended;
- He/she must provide documentation from OPM (or the CIA or Foreign Service retirement system, if applicable) of entitlement to a portion of your future annuity, or a former spouse survivor annuity.

If you worked for the CIA, your former spouse could qualify to enroll based on your CIA employment, if you were married for at least 10 years during your CIA service, at least 5 years of which both of you spent outside the United States, and your marriage ended before May 7, 1985.

If you worked for the Foreign Service, your former spouse could also qualify to enroll based on your Foreign Service employment if you were married for at least 10 years during your Government service, and your marriage ended before May 7, 1985.

Effective Date. The effective date of your former spouse's enrollment is the first day of the first pay period after the employing office receives the Health Benefits Election Form (SF 2809) and has approved eligibility.

If your former spouse requests immediate coverage, and the employing office receives the Health Benefits Election Form (SF 2809) and satisfactory proof of eligibility within 60 days after the date of the divorce, the enrollment may be made effective on the same day that temporary continuation of coverage would otherwise take effect.

When both You and Your Former Spouse have FEHB Enrollments. If both you and your spouse have your own FEHB enrollments and divorce, it is important for each of you to establish your eligibility for FEHB coverage under spouse equity provisions within the required time frame. In this way you can protect your future entitlement to FEHB coverage under spouse equity provisions if you lose your own FEHB coverage. You must apply to your former spouse's employing office for the determination, not your own employing office.

If you are enrolled as a Federal employee when your former spouse's employing office determines that you are eligible for coverage under spouse equity provisions, you must provide a copy of this determination to your current employing office. Your current employing office must note on your Individual Retirement Record that you are eligible for FEHB coverage under spouse equity provisions. Your former spouse's employing office must maintain a health benefits file for you and note that you are deferring your enrollment under spouse equity provisions until you lose enrollment as an employee.

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Military Service

For 30 days or Less. If you enter one of the uniformed services for 30 days or less, your FEHB enrollment will continue without change. Withholdings and Government contributions will also continue, as long as you are in pay status or until your military orders are changed so that your period of duty is more than 30 days.

For More than 30 Days. If you enter on active duty or active duty for training in one of the uniformed services for more than 30 days, you may continue your FEHB enrollment for up to 24 months. Or, you may elect to terminate your enrollment as of the day before entering active duty.

If you terminate your enrollment, your employing office must promptly process a Notice of Change in Health Benefits Enrollment (SF 2810) to notify your health benefits carrier of the termination.

If you continue your enrollment during military service, you are responsible for the employee share of the premiums for the first 12 months, just like any other employee in leave without pay status. During the last 12 months of the 24-month period, you must pay both the employee and the Government shares of the premium, plus an additional 2 percent of the total premium, on a current basis.

Your employing office may waive the requirement that you pay your share of FEHB premiums during all or any part of the 24-month period.

If You are Separated. If you are separated to enter on active military service, you are considered to be on military furlough (in leave without pay status) for the 24-month period if you continue to be eligible for reemployment rights under 5 CFR Part 353 or similar authority. You are entitled to continued coverage for up to 12 months in leave without pay status whether or not your eligibility for reemployment rights continues. To be entitled to the additional 12 months of coverage, you must continue to be eligible for reemployment rights.

Notice Required. If you enter military service for more than 30 days, your employing office must give you a notice explaining that your enrollment may continue for up to 24 months and that you are responsible for the employee share of the premiums for the first 12 months and for 102 percent of the premium afterwards. It must also explain that you must notify your employing office in writing if you decide to terminate your enrollment for the period of your military service.

Termination. If you elect to terminate your enrollment, it must be terminated effective on the day you are separated, furloughed, or placed on leave of absence for entering military service. This applies even if part of your military service is covered by paid leave immediately followed by furlough or other leave without pay. You and your covered family members are entitled to a 31-day extension of coverage and to convert to an individual contract.

Return from Military Service After Enrollment Termination

Not in Exercise of Reemployment Rights. If you return from military duty after your enrollment terminated, but not in the exercise of reemployment rights, you must (if eligible for coverage) elect to enroll within 60 days after returning to civilian duty, the same as a new employee. You may elect to enroll for self only or for self and family in either option of any plan available.

In Exercise of Reemployment Rights. If you exercise reemployment rights on your return from military duty, your terminated enrollment will be reinstated on the Notice of Change in Health Benefits Enrollment (SF 2810), effective on the day you return to civilian duty. Your employing office will show in the Remarks section of the reinstating SF 2810 that a previously terminated enrollment is being reinstated because of return from military service.

The reinstatement of your enrollment is effective on the day you return to civilian duty (the same date of the restoration action shown on SF 50, Notification of Personnel Action) and is not retroactive to the date you separated from military service. If there is a gap between your separation from military service and return to active civilian duty, there will also be a gap in health benefits coverage because coverage under the Uniformed Services Health Benefits Program generally ends on the day of discharge without any extension of coverage.

If you return to civilian duty in the exercise of reemployment rights, you may change your reinstated enrollment from self only to self and family, and to either option of any plan available, within 60 days after you return to civilian service. If you weren't enrolled when you entered military duty, you may enroll within 60 days after your return to civilian service. Your election becomes effective on the first day of the pay period that begins after your employing office receives your completed enrollment request and that follows a pay period during any part of which you were in pay status.

If You Die. If you die after your self and family enrollment was terminated or suspended upon your entry into military service, and your family members are entitled to an annuity or to a basic employee death benefit under the Federal Employees Retirement System, your family members may have the enrollment reinstated effective on the day after your death. Your family members also may change the enrollment just as if you were returning to civilian duty in the exercise of reemployment rights.

If You Retire

If your enrollment was terminated and you:

- retire on an immediate annuity without having returned to duty; and
- meet the participation requirements for continuing coverage as a retiree

you may request reinstatement of your enrollment within 60 days after your retirement, regardless of whether you are still on active military duty. If you don't request reinstatement, the retirement system will automatically reinstate your enrollment when your military service ends.

Continuous Enrollment. For purposes of eligibility to continue enrollment after retirement, you are considered to have had continuous enrollment if your enrollment terminated for military service and:

- it is reinstated when you return to civilian duty;
- you reenroll within 60 days after returning to civilian duty; or
- you retire on an immediate annuity without returning to civilian duty.

Military Service During Persian Gulf War

If you were ordered to active military duty in support of the Persian Gulf war before September 1, 1995, you weren't required to pay the employee share of premiums if you continued your enrollment while on military furlough (leave without pay). You were eligible if you were called into active military service for at least 31 days and remained on your employing office's rolls in a military furlough status in accordance with the provisions of 5 CFR 353 or similar authority, and your military orders were issued under the authority of section 688 or sections 12301, 12302, 12304, 12306, or 12307 (formerly sections 672, 673, 673b, 674, and 675) of title 10, United States Code.

After 365 days in leave without pay status, these enrollments terminated, subject to the 31-day extension of coverage and conversion rights. Like other terminations of enrollment after 365 days in leave without pay status, there was no entitlement to temporary continuation of coverage.

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Health Care Flexible Spending Accounts

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) is a tax-favored program offered by employers that allows their employees to pay for eligible out-of-pocket health care and dependent care expenses with pre-tax dollars. By using pre-tax dollars to pay for eligible health care and dependent care expenses, an FSA gives you an immediate discount on these expenses that equals the taxes you would otherwise pay on that money.

In other words, with an FSA, you can both reduce your taxes and get more for your money by saving from 20% to more than 40% you would normally pay for out-of-pocket health care and dependent care expenses with after-tax (as opposed to taxed) dollars.

FSAFEDS offers three types of FSAs:

- The Health Care Flexible Spending Account (HCFSA), which can be used to pay for qualified medical costs and health care expenses that are not paid by your Federal Employees Health Benefits (FEHB) plan or any other insurance. PLEASE NOTE: A HCFSA cannot be used to pay for any type of insurance premiums, including long-term care insurance premiums.

- The Limited Expense Health Care Flexible Spending Account (LEX HCFSA), only available to employees who enroll in a Federal Employees Health Benefits (FEHB) Program or under a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) . Eligible expenses are limited to dental and vision care services/products that meet the IRS definition of medical care. By using a LEX HCFSA, you can preserve the funds in your Health Savings Account to use/save for other purposes.

- The Dependent Care Flexible Spending Account (DCFSA), used to pay for eligible dependent care expenses such as child care for children under age 13 or children who are physically or mentally incapable of self-care and, in some cases, elder care, so that you (and your spouse, if you are married) can work, look for work, or attend school full-time.

Your participation in any FSA is completely voluntary, and it's important to remember that unlike other Federal benefits, your FSA election is only effective for one Benefit Period. In other words, you must enroll each year that you choose to participate. If you do not enroll during Open Season, you will not participate in the next Benefit Period, unless you experience a Qualifying Life Event (QLE) that allows you to make an election outside of Open Season . Open Season for FSAFEDS runs concurrently with the FEHB Open Season in November and December each year for enrollment in the following year. The FSAFEDS Benefit Period will always run from January 1 of the current Benefit Period through March 15 of the following year. This includes a 2 ½ month grace period from January 1 through March 15 of the following year. During the grace period, eligible expenses incurred from January 1 through March 15 of the following year can be applied towards your prior year's balance. The intent is to help account holders avoid forfeiting any of the funds they deposited in FSA accounts. It is important to carefully consider the amount you choose to elect.

OPM has adopted the grace period on behalf of all agencies and employees that are part of FSAFEDS and has also extended the filing deadline for claims against the prior year account (including claims incurred during the "grace period") to April 30.

FSAFEDS follows Internal Revenue Service (IRS) guidelines to determine eligible expenses and other requirements for participation in an FSA issued under Sections 105, 125, and 129 of the Internal Revenue Code.

Differences Between Health Care Flexible Spending Account, Limited Expense Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account

A Health Care Flexible Spending Account pays for the qualified medical expenses not covered or reimbursed by your FEHB plan or any other type of insurance. It is NOT limited to only dental and vision care services/products.

Though the LEX HCFSA is similar to the HCFSA, it differs by the type of expenses it covers. The expenses are limited to dental and vision care services/products that meet the IRS definition of medical care. Also, only those employees who have a HDHP/HSA are eligible to enroll in a LEX HCFSA.

The Dependent Care Flexible Spending Account pays for child care or adult dependent care expenses that are necessary to allow you or your spouse to work or attend school full-time. It also pays while you or your spouse look for work, However, it does not pay if you (or your spouse) did not find a job and have no earned income for the year. The Dependent Care Flexible Spending Account does NOT pay for medical care for your dependents.

Despite the differences between the accounts, each allows you to pay for qualified expenses with pre-tax dollars, money that is deducted from your paycheck before taxes are taken out by your employer - saving you 20% to 40% or more.

FSA Tax Savings

An FSA offers tax savings by allowing you to pay for out-of-pocket expenses with pre-tax money. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after federal (and often state and local) taxes are deducted.

The example below illustrates tax savings based on 25% Federal and 7.65% FICA taxes, resulting in a 32.65% discount on eligible expenses paid through an FSA. State and local taxes are not included. Actual savings will vary based on your individual tax situation, and on whether you are covered under Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS). You may wish to consult a tax professional for more information on the tax implications of an FSA.

	CSRS		FERS	
Annual Tax Savings Example*	FSA	No FSA	FSA	No FSA
If your taxable income is:	$50,000	$50,000	$50,000	$50,000
Pre-tax FSA contribution:	(2,000)	0	(2,000)	0
Taxable income:	48,000	50,000	48,000	50,000
Federal income and Social Security taxes:	(8,866)	(9,395)	(11,842)	(12,495)
After-tax dollars spent on eligible expenses:	0	(2,000)	0	(2,000)
Available after tax income:	39,134	38,605	36,158	35,505
Discount with an FSA:	$529* or 26%		$653* or 33%	

How Does an FSA Work?

First, you calculate your annual election(s).

When you decide to enroll in FSAFEDS each year during Open Season, you first need to determine how much money you want to elect for your account(s) for the upcoming Benefit Period. The maximum you can elect for a Benefit Period is $5,000 per account (HCFSA or LEX HCFSA and/or DCFSA). However, your election for a DCFSA can only

be $2,500 if you are married, but filing separately. The minimum annual amount you can elect is $250 per account. Most people review their current year expenses, think about expenses they may incur in the 2-1/2 month grace period, and take into account changes that will occur in the coming year when making their annual elections. You have 14-1/2 months to use up your annual election, so you may wish to contribute more than you expect you'd spend in one year. However, you will also forfeit any monies you don't use within those 14-1/2 months, so plan carefully.

Second, you actually enroll in the program.

Once you have decided on your annual election, you formally enroll in a HCFSA, a LEX HCFSA, a DCFSA, or a combination of accounts (you cannot have a HCFSA and a LEX HCFSA), and you specify your annual election(s) — that is, how much money you want to have deducted from your pay and deposited into your account(s) during the upcoming year, for you to use during the upcoming Benefit Period. SHPS is the Third Party Administrator that oversees the day-to-day administration of FSAFEDS. You can enroll online during Open Season at www.FSAFEDS.com or if you have questions you may contact an FSAFEDS Benefits Counselor, toll-free, at 1-877-FSAFEDS (372-3337), TTY: 1-800-952-0450, Monday through Friday, from 9:00 A.M. until 9:00 P.M., Eastern Time.

Next, your annual election(s) is deducted from your pay in allotments.

After you make your election for the Benefit Period, FSAFEDS directs BENEFEDS to deduct your annual election(s) in installments, called allotments. The allotments are spread evenly over the number of pay dates remaining in the Benefit Period. In certain circumstances, you may be approved to have your allotments accelerated so your annual election is taken over a lesser number of pay periods. You can accelerate your allotments during enrollment for reasons such as the two listed below:

- If you know you are going on a period of Leave Without Pay (LWOP), you may prefer to meet your annual election amount prior to beginning your LWOP.

- If you are a teacher, you may prefer to have your allotments match the months in the Benefit Period you are actively teaching.

Even though your enrollment may be effective, FSAFEDS will not be able to pay your claims until your employment is confirmed with your employing agency or its payroll provider. On occasion, reimbursements are delayed because of problems in setting up payroll deductions. These delays may be caused by incorrect data that was provided during enrollment, such as the wrong Social Security Number or employing agency.

Does participating in FSAFEDS cost you anything? No. On November 24, 2003, President Bush signed the National Defense Authorization Act into law. Section 1127 of this law (Public Law 108-136) requires agencies participating in FSAFEDS to cover the administrative fee(s) on behalf of their enrolled employees.

How do you know if you are eligible to enroll in FSAFEDS? If you are an active employee of an Executive Branch agency, or an agency, commission, or other Federal entity that has adopted The Federal Flexible Spending Account Program, you are most likely eligible to enroll for at least one of the flexible spending accounts. Refer to the Eligibility and Status section to determine if you are eligible to enroll.

Some Federal agencies do not participate in FSAFEDS, but may offer their own FSA program to their employees. These agencies include:

- Administrative Office of the U.S. Courts (The Federal Judiciary)

- District of Columbia Government

- Farm Credit Administration

- Farm Credit System Insurance Corporation
- Federal Deposit Insurance Corporation
- Federal Reserve System
- Office of the Controller of the Currency
- Office of Thrift Supervision
- Overseas Private Investment Corporation
- Presidio Trust
- U.S. Postal Service

Eligible Expenses for Reimbursement

Many of your typical out-of-pocket health care expenses may be reimbursed by a HCFSA. Some common reimbursable expenses not covered by most FEHB or FEDVIP plans are listed below. All of these items meet IRS criteria for a covered medical expense. For more complete listings of eligible medical expenses, please contact an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), TTY line: 1-800-952-0450 Monday through Friday, from 9:00 a.m. until 9:00 p.m., Eastern Time.

- Chiropractic services
- Co-insurance, co-pay amounts and deductibles
- Contact lenses and cleaning solutions
- Dental care and procedures not covered under a FEDVIP plan (including crowns, endodontic services, implants, oral surgery, periodontal services and sealants)
- Eye surgery not covered under a FEDVIP plan(cataract, LASIK, corneal rings, radial keratotomy, etc.)
- Eyeglasses not covered under a FEDVIP plan(including prescription sunglasses and over-the-counter reading glasses)
- Hearing aids and batteries
- Infertility treatments
- Orthodontia not covered under a FEDVIP plan
- Over-the-counter medicines and products (including antacids, allergy medicines, cold medicines and pain relievers)

Note: Insurance premiums, including health insurance, life insurance, long-term care insurance and Temporary Continuation of Coverage, are not eligible for reimbursement.
Expenses eligible for reimbursement only if medically necessary. Some expenses are eligible for reimbursement only when a doctor or other licensed health care practitioner certifies that they are medically necessary. Your doctor's certification (note or letter) must indicate your specific medical disorder, the specific treatment needed, how this

treatment will alleviate your medical condition, and the length of treatment required. Examples include:

- Air conditioners, central air, heaters, and humidifiers installed in your home for allergy relief
- Cosmetic surgery following an accident, disease or other surgery
- Home Medical Equipment (e.g., reclining chairs, bed boards, special mattress)
- Hydrotherapy
- Massage therapy
- Water fluoridation units
- Weight loss program for treatment of a specific disease (e.g., heart disease), not including cost of food
- Wigs for hair loss due to chemotherapy or radiation treatment

FSAFEDS has a sample Letter of Medical Necessity (LMN) that you and your health care provider can use. A personal letter from your provider will also suffice as long as it includes all the information necessary to determine medical necessity. Please note, if the treatment extends beyond the time period listed, you need to submit a new certification/physician letter covering the new time period.

Your letter may be denied if it does not contain all of the information listed below:

- Date
- Employee Name and SSN/UserID
- Patient Name
- Diagnosis (specific medical condition or disorder)
- CPT Code assigned to your diagnosis
- Specific treatment prescribed by the provider
- How the treatment will alleviate the condition
- Duration of the treatment
- Provider signature, license number, state and telephone number

Expenses NOT Eligible for Reimbursement

The following is a list of common medical expenses not eligible for reimbursement. For more complete listings of eligible medical expenses, please contact an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), TTY: 1800-952-0450, Monday through Friday, 9:00 A.M. until 9:00 P.M., Eastern Time:

- Insurance premiums, including those for health insurance, dental and/or vision insurance, life insurance, long-term care insurance, and Temporary Continuation of Coverage

- Cosmetic surgery or procedures
- Exercise and fitness programs for general health, including health club membership dues*
- Expenses that have been reimbursed elsewhere
- Expenses not incurred during your period of coverage
- Fees paid to a health care provider in advance of services being rendered (this includes health maintenance fees but excludes braces.
- Personal use items (items ordinarily used for personal, living or family purposes such as household disinfectants)
- Physician charges for services that are not direct medical care, such as monthly fees for guaranteed access and quicker appointments (so-called "boutique practice fees")

*Fees paid for a fitness program may be an eligible expense if prescribed by a physician and substantiated by his or her statement or letter of medical necessity that treatment is necessary to alleviate a medical problem.

Eligible over-the-counter (OTC) medicines or products for reimbursement through HCFSA

Under IRS guidance non-prescription antacids, allergy medicines, pain relievers, cold medicines and other medicines or products purchased to alleviate or treat the personal injuries or sickness of you and/or your dependents are eligible items for reimbursement through a HCFSA. Vitamins and other dietary supplements that are merely beneficial to you and/or your dependent remain ineligible for reimbursement. If you have questions about the eligibility of a certain item(s), contact an FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), TTY: 1-800-952-0450, Monday through Friday, 9:00 A.M. until 9:00 P.M., Eastern Time. Keep in mind that when submitting a claim for OTC medicines and products, a detailed receipt naming the product will be required. If your receipt does not contain the name of the product provided, you will need to submit copies of the label or the front of the box/container for over-the-counter (OTC) products.

Requirements for an OTC drug to be eligible for reimbursement through HCFSA

- The item must be a medicine or drug used "primarily for the treatment or alleviation of a physical defect or illness" and would not be used but for a particular medical condition.
- The item must not be used for general health or cosmetic purposes.
- You, your spouse or dependent must use the item.
- The expense must be for medical care during the current Benefit Period.

What OTC items are not eligible for reimbursement? OTC items are not eligible for reimbursement if they are normally used for general health or are used even when there is not a medical condition being treated (ex. toothpaste, mouthwash, shampoo, lotion or moisturizer that also contains sunscreen) or are cosmetic in nature (teeth whitening products, wrinkle reducers).

What is the "Use or Lose" Rule?

Under IRS tax rules, you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Benefit Period. This is known as the "use or lose" rule. When you contribute to an FSA, you agree to reduce

your salary by a specified amount and your employing agency contributes that amount to an FSA for you. Since you never received that money, you can't be taxed on it. If you were to receive the unused amount at the end of the Benefit Period, the IRS would consider this "deferred compensation". Section 125 of the IRS Code prohibits deferred compensation, thus the "use or lose" rule. Agencies cannot provide waivers for any employee regarding funds that might be forfeited. The "use or lose" rule is why you should plan carefully, and conservatively, when making your annual FSA election. Also remember that reimbursement for expenses is generally based on when an expense is incurred, not when it is paid.

Important Note: You will FORFEIT any money that you do not use in your account(s) by the end of the Benefit Period. This is known as the "use or lose" rule. The Grace Period provides you with an additional 2 ½ months (January 1 to March 15) to incur expenses against your prior year's account. You have until April 30 following the end of the Benefit Period to file claims for reimbursement for eligible expenses incurred during the previous Benefit Period. We encourage you to carefully plan how much money to contribute to your account(s). *Neither OPM, nor your employing agency, has the authority to make any exception to this IRS rule.*

What is a Qualifying Life Event?

A Qualifying Life Event is an event defined by the Internal Revenue Service in Section 125 that allows you to change your FSA election. FSAFEDS permits all QLE's defined by the IRS. These QLEs include:

- Change in your legal marital status (i.e., marriage, legal separation, divorce, or death of your spouse)
- Change in employment status (for you, your spouse, or dependent) that affects eligibility for health insurance benefits
- Change in your number of tax dependents
- Birth or date you adopt a child, or placement for adoption
- Death of your spouse or dependent
- Change in your dependent's eligibility (for example, your child reaches age 13 where he/she is no longer eligible under a DCFSA)
- Change in your child care/elder care provider or cost or coverage, such as a significant cost increase charged by your current daycare provider, or a change in your daycare provider. This applies to a DCFSA only. It does NOT apply to a HCFSA or LEX HCFSA.

Note: A dependent is anyone you claim on your federal income tax return or someone with whom you jointly file a federal income tax return.

If you or your dependents experience a QLE, you may enroll or change your current election(s) in the FSAFEDS Program; however, your requested change must be consistent with the event that prompted the election change. For example, if you adopt a baby, you may want to increase your HCFSA and/or DCFSA elections to accommodate the added medical expenses and/or daycare costs you may incur for this adopted child. However, in general, you could not decrease your DCFSA elections for that QLE. You may wish to decrease your DCFSA, for example, if your spouse decided to stay home with your child and you no longer had eligible daycare costs.

If your requested change is due to the birth or adoption of a child, the change will be retroactive to the child's date of birth, date of adoption, or placement for adoption, consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you are a Federal employee and experience a QLE, such as the death of your spouse, you may enroll in the FSAFEDS Program.

Additionally, you cannot reduce your HCFSA, LEX HCFSA or DCFSA election(s) below the amount already reimbursed or already in your account.

After September 30 of any Benefit Period, only those QLEs resulting in a decrease in the annual election will be considered. QLEs resulting in an increase in the annual election will not be accepted due to the limited number of pay periods remaining in the calendar year.

HCFSA or LEX HCFSA Eligibility

If you are eligible for the Federal Employees Health Benefits (FEHB) Program and are an active employee of the Executive Branch or of another agency that participates in FSAFEDS, you are eligible to participate in a health care FSA with FSAFEDS. You need only be eligible to participate in FEHB — you do not need to be currently enrolled. There is no household limit on the amount of money that you can set aside for a HCFSA or LEX HCFSA, although the FSAFEDS limit per Federal employee is $5,000 ($10,000 for a "Federal couple"). If your spouse is not a "Fed", and has access to an FSA, he or she may enroll up to the maximum of his or her own company's health care account.

A LEX HCFSA is for employees enrolled in a Federal Employees Health Benefits (FEHB) Program High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), or whose spouse is enrolled in a non-FEHB HDHP with an HSA. The LEX HCFSA is limited to eligible dental and vision expenses only. Under IRS rules, you are not eligible to contribute to an HSA and be enrolled in a FSAFEDS general purpose HCFSA at the same time.

Under the IRS Code, annuitants (other than re-employed annuitants) cannot participate in an FSA. An FSA is a way to set aside part of your salary – before taxes – for payment of eligible expenses. An annuity is not considered salary.

DCFSA Eligibility

If you are an active employee of the Executive Branch or of another agency that participates in FSAFEDS, you are eligible to participate in a DCFSA with FSAFEDS. The only exception(s) are intermittent or "when actually employed" (WAE) employees who are expected to work less than six months in a calendar year. Also, there is a $5,000 household limit ($2,500 if single) on the amount that can be set aside in a DCFSA. It's very important to discuss your elections with your spouse to ensure the household limit is not exceeded. If you and your spouse elect more than the $5,000 household limit, FSAFEDS will not be able to cancel your election per IRS guidelines. You will need to resolve the over-deduction through your federal income tax return.

Under the IRS Code, annuitants (other than re-employed annuitants) cannot participate in a DCFSA. An FSA is a way to set aside pre-tax salary for payment of eligible expenses. An annuity is not considered salary.

To be reimbursed through your DCFSA for child and dependent care expenses, you must meet the following conditions:

- You must have incurred the expenses in order for you and your spouse, if married, to work, look for work*, unless your spouse was either a full-time student, was physically or mentally incapable of self-care or each of you have earned income during the year. However, if you did not find a job and have no earned income for the year, your dependent care costs are not eligible.

- You cannot have made the payments to someone you can claim as your dependent on your Federal Income Tax return or to your child who is under age 19.

- Your filing status must be single, qualifying widow(er) with a dependent child, married filing jointly, or

married filing separately.

- The care must have been provided for one or more qualifying dependents identified on the form you use to claim the credit.

- You and your spouse must maintain a home that you live in for more than half the year with the qualifying child or dependent.

Maximum/minimum allotments for a flexible spending account

The maximum annual election is $5,000 for the HCFSA and $5,000 for the LEX HCFSA. The DCFSA maximum annual election is $5,000.00 per household or $2,500.00 if married, filing separately. The minimum annual election for Health Care FSA, Limited Expense FSA and Dependent Care FSA is $250.00.

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Same Sex Domestic Partner Benefits

Supreme Court Ruling

On June 26, 2013, the Supreme Court ruled that Section 3 of the Defense of Marriage Act (DOMA) is unconstitutional. As a result of the Supreme Court's decision, legally married same-sex spouses are eligible family members. The same benefits that are currently available to opposite-sex spouses of Federal employees and annuitants are available to same-sex spouses. Coverage is available to a legally married same-sex spouse of a Federal employee or annuitant, regardless of his or her state of residency.

In addition, the children of same-sex marriages will be treated in the same manner as those of opposite-sex marriages and will be eligible family members according to the same eligibility guidelines. This includes coverage for children of same-sex spouses as stepchildren. Check http://www.opm.gov/FAQs/topic/domesticpartner/ for program updates.

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Appendix – Glossary of Terms

Agency. A department or independent establishment (e.g., the U.S. Postal Service) of the executive branch of the United States Government, including Government-owned or controlled corporations, the legislative and the judicial branches of the United States Government and entities under their supervision, the District of Columbia Government (for certain eligible employees), and Gallaudet College. The term agency refers to the whole organization, as distinguished from its subdivisions and field establishments.

In the executive branch, the Department of Defense, Department of the Army, Department of the Navy, and Department of the Air Force are considered to be separate agencies.

Annuitant. A former employee entitled to an annuity under a retirement system established for employees. This includes the retirement system of a nonappropriated fund instrumentality of the Department of Defense or the Coast Guard. Compensationers are considered annuitants for health benefits purposes.

Cancel. Your election on an enrollment request that you no longer want to be enrolled in the Federal Employees Health Benefits Program.

Carrier. A legal entity that offers a health benefits plan approved by the Office of Personnel Management.

Compensation. Compensation under subchapter I of chapter 81 of title 5, United States Code (Workers' Compensation), which is payable because of an on-the-job injury or disease.

Compensationer. An employee or former employee who is entitled to workers' compensation and whom the Department of Labor determines is unable to return to duty. Compensationers are considered annuitants for health benefits purposes.

Contributions. Amounts which each agency is required to pay from its salary appropriations or other available funds as the Government's share of the cost of the health benefits coverage of its enrolled employees. The Government contribution toward the cost of health benefits for most annuitants is paid from annual appropriations by Congress for this purpose.

Conversion Contract. An individual, nongroup policy offered by a carrier to enrollees whose FEHB coverage terminates.

Coordination of Benefits. When you are covered by more than one type of insurance that covers the same health care expenses, one pays its benefits in full as the primary payer and others pays a reduced benefit as a secondary or third payer. When the primary payer doesn't cover a particular service but the secondary payer does, the secondary payer will pay up to its benefit limit as if it were the primary payer.

Court Order. Any judgment or property settlement issued by, or approved by, any court of any State, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, or the Virgin Islands, and any Indian tribal court in connection with, or incident to, the divorce, annulment of marriage, or legal separation of a Federal employee or retiree.

CSRS. The Civil Service Retirement System.

Current Continuous Employment. For purposes of health benefits coverage for temporary employees, "current" means beginning with the present and counting back 1 full year (365 calendar days). "Continuous" means employment with

no break in service of more than 5 days. A break in service occurs when you are off the employment rolls. A break in service of 1 to 4 days does not interrupt the 1 year of current continuous employment and is counted toward the service requirement. Days on which a part-time employee is not scheduled to work are not breaks in service. "Employment" means full-time or part-time service that is not excluded by law or regulations applicable to the FEHB Program.

Days. Whenever, in this Guide, a period of time is stated as a number of days, or as a number of days from an event, the period is computed in calendar days, excluding the day of the event.

Dual Enrollment. Coverage under more than one FEHB enrollment at the same time; dual enrollment is prohibited under FEHB law.

Elect not to Enroll. Upon your first eligibility, your request not to be enrolled in the Federal Employees Health Benefits Program.

Eligible. Not excluded from coverage under the Federal Employees Health Benefits Program by the law or the regulations.

Employee. An individual appointed or elected to a position in or under the executive, legislative, or judicial branch of the United States Government, as defined at 5 U.S.C. 8901. This includes Government-owned or controlled corporations, the District of Columbia government (for certain eligible employees), and Gallaudet College.

Employee Organization. An association or other organization of Federal or postal employees that sponsors a health benefits plan approved by the Office of Personnel Management.

Employing Office. The agency office (or retirement system office) that has responsibility for health benefits actions.

Enroll. Election to join a health benefits plan under the Federal Employees Health Benefits Program. Your election must be submitted to your employing office on a Health Benefits Election Form (SF 2809) or other enrollment request.

Enrollee. The individual in whose name the health plan enrollment is carried. The term includes employees, annuitants, survivor annuitants, former employees, former spouses, or children who are enrolled after completing a valid election form or other enrollment request or who have continued an enrollment as an annuitant or survivor annuitant.

Enrollment Change. Your election of a different plan or option, or a different type of coverage (self only or self and family), submitted to your employing office on a Health Benefits Election Form (SF 2809) or other enrollment request.

Enrollment Code. A three-digit code assigned to a health plan and option. The first two digits identify the health plan; the third digit identifies the option (high or standard) and type of enrollment (self only or Self and family).

Enrollment Request. A properly completed health benefits enrollment form (SF 2809) or an alternative method acceptable to both your employing office and OPM. Alternative methods must be capable of transmitting to the health benefits plans the information they need to accept an enrollment, change of enrollment, or cancellation. Electronic signatures, including the use of Personal Identification Numbers (PIN), have the same validity as a written signature.

Extension of Coverage. Automatic continuation of your health benefits coverage for 31 days after FEHB eligibility terminates, except by your cancellation of coverage.

Family Members. Your spouse and unmarried dependent children under age 22. Such child includes:

- A legitimate child

- An adopted child
- A stepchild, foster child, or recognized natural child who lives with you in a regular parent-child relationship
- A recognized natural child for whom a judicial determination of support has been obtained, or to whose support the enrollee makes regular and substantial contributions.

A child age 22 or over is covered if he/she is incapable of self-support because of mental or physical disability that existed before the child reached age 22.

Certain restrictions apply to coverage of family members under former spouses' enrollments, under temporary continuation of coverage (TCC) and spouse equity provisions.

No other person is considered a family member for health benefits purposes.

Fee-for-Service Plan. A traditional type of insurance that lets you use any doctor or hospital, but you usually must pay a deductible and coinsurance. These plans are called fee-for-service because doctors and other providers are paid for each service, such as an office visit, or test. They help control costs by managing some aspects of patient care. Most FEHB fee-for-service plans also provide access to preferred provider organizations (PPOs).

FEHB. The Federal Employees Health Benefits law or program.

FERS. The Federal Employees Retirement System.

First Opportunity to Enroll. The first time that you were employed in a position in which you were eligible to enroll in the FEHB Program and were entitled to a Government contribution towards premiums. You are considered to have enrolled at the first opportunity if you were covered at that time by the FEHB enrollment of another employee or annuitant.

Former Spouse. A person whose marriage to a Federal employee or annuitant ended in divorce or annulment of the marriage. This term does not refer to widows or widowers.

Foster Child. A child who lives with the enrollee in a regular parent-child relationship and is expected to be raised to adulthood by the enrollee.

Fund. The Employees Health Benefits Fund.

Gross Misconduct. For purposes of qualifying for temporary continuation of coverage (TCC), a flagrant and extreme transgression of law or established rule of action for which you are separated from service and for which a judicial or administrative finding of gross misconduct has been made.

Health Benefits Plan. A group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for, health services.

Health Maintenance Organization (HMO). A type of health benefits plan that provides care through a network of doctors and hospitals in particular geographic or service areas. HMOs coordinate the health care services you receive. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work. Some FEHB HMOs have agreements with providers in other service areas for non-emergency care if you travel or are away from home for extended periods.

Immediate Annuity. An annuity that begins no later than one month after the end of the pay period during which you are separated from service; or An annuity under 5 CFR 842.204(a)(1) for which the starting date has been postponed.

Impaired Relationship. An irrepairable rift between an HMO's medical providers and the enrollee and/or family members, which jeopardizes the furnishing of adequate medical care.

Incapable of Self Support. Dependent on the enrollee because of a physical or mental disability which occurred before the child reached age 22.

Interim Appointment. The employment status of a person whose appeal of a personnel action to the Merit Systems Protection Board results in an initial decision granting relief, pending final action on a petition for review by a party to the appeal or OPM.

Interlocutory Divorce. An intermediate divorce; one that has not become finalized. The spouse is still considered to be an eligible family member under an FEHB enrollment. An interlocutory divorce is considered to be a change in family status that allows the enrollee to change his/her enrollment.

Intermittent Employee. A non-full time employee without a regularly scheduled tour of duty.

Law. Chapter 89 of title 5, United States Code.

Medically Underserved Area. Any of the 50 States of the United States where OPM determines that 25 percent or more of the residents are located in primary medical care manpower shortage areas designated under section 332 of the Public Health Service Act (42 U.S.C. 254e).

Medicare Managed Care Plan. A managed care plan such as an HMO or PPO that contracts with Medicare to enroll Medicare beneficiaries. Services must be obtained from the managed care plan's network of doctors and hospitals to receive full plan benefits. The managed care plan may charge a monthly premium and require copayments.

Official Personnel Folder. Your personnel records that are maintained by your employing office.

Open Season. The annual time period set by OPM in which all eligible persons may elect or change their health benefits coverage.

OPM. The Office of Personnel Management.

Option. A level of benefits provided by a health benefits plan. Some plans provide a high and a standard option; others provide only one option.

Overseas. Outside a State of the United States and the District of Columbia.

OWCP. The Office of Workers Compensation Programs, U.S. Department of Labor, which administers compensation benefits for Federal employees under subchapter I of chapter 81 of title 5, United States Code.

Pay Period. For former employees, former spouses, children enrolled under TCC provisions, and annuitants not actively receiving an annuity, pay period means any regular pay period for employees of the agency that is responsible for the health benefits actions for the enrollee.

Plan. See Health Benefits Plan.

Preferred Provider Organization (PPO). A fee-for-service option where you can choose plan-selected providers who

have agreements with the plan. When you use a PPO provider, you pay less money out-of-pocket for medical services than when you use a non-PPO provider.

Primary Payer. When coordinating benefits, the health plan that pays benefits first and to the full extent of its coverage.

Program. The Federal Employees Health Benefits Program.

Qualifying Court Order. A court order that awards a portion of your future annuity or a survivor annuity to your former spouse and is determined by OPM, CIA, or the Foreign Service, as appropriate, to meet the requirement of a qualifying court order.

Recognized Natural Child. For whom the father:

- Has acknowledged paternity in writing;
- Was ordered by a court to provide support;
- Before his death, was pronounced by a court to be the father;
- Was established as the father by a certified copy of the public record of birth or church record of baptism, if he was the informant and named himself as the father of the child; or
- Established paternity on public records, such as records of schools or social welfare agencies, which show that with his knowledge he was named as the father of the child.

If paternity is not established by one of the above means, other evidence such as the child's eligibility as a recognized natural child under other State or Federal programs or proof that the father included the child as a dependent child on his income tax returns may be considered.

Reconsideration. The final level of administrative review of an employing office's initial decision about an enrollment or enrollment change to determine if the employing office followed the law and regulations correctly.

Reemployed Annuitant. A Federal employee annuitant who has returned to active Federal service under conditions which do not result in termination of annuity.

Regular Tour of Duty. Your work schedule that is determined in advance and expected to continue indefinitely. It consists of a certain number of hours or other time units in a day, week, biweekly pay period, month, or year.

Regulations. Part 890 of title 5 and part 16 of title 48, Code of Federal Regulations.

Retired Federal Employees Health Benefits Program. A program that provides health benefits coverage for Federal employees who retired before July 1, 1960 or their survivors.

Secondary Payer. When coordinating benefits, the health plan that pays benefits only after the primary payer has paid its full benefits. When an FEHB fee-for-service plan is the secondary payer, it will pay the lesser of:

- its benefits in full, or
- an amount that when added to the benefits payable by the primary payer, equals 100% of covered charges.

Self and Family. The type of FEHB enrollment that covers the enrollee and all eligible family members.

Self Only. The type of FEHB enrollment that covers only the enrollee.

Service. Civilian service which is creditable under subchapter III of chapter 83 or subchapter II of chapter 84 of title 5, United States Code. This includes service under a nonappropriated fund instrumentality of the Department of Defense or the Coast Guard for an individual who elected to remain under a retirement system established for employees described in Section 2105 (c) of title 5.

Service Area. The geographical area in which an HMO's medical providers are located.

Spouse Equity. A provision of the FEHB law that allows eligible former spouses of Federal employees and annuitants to enroll in the FEHB Program in their own name.

Survivor Annuitant. A surviving family member of a deceased Federal employee or annuitant who is entitled to an annuity under a retirement system established for employees.

Suspension of FEHB Enrollment. When you notify your retirement system that you are giving up your FEHB coverage to enroll in a Medicare managed care plan, but still retain the right to reenroll in FEHB if your enrollment in the Medicare managed care plan ends. Otherwise, if you cancel your FEHB coverage as an annuitant, you probably may never reenroll.

Temporary Continuation of Coverage (TCC). A provision of the FEHB law that allows Federal employees who separate from service and family members who lose eligibility to temporarily continue FEHB coverage.

Withhholdings. Amounts deducted from your pay, annuity, or compensation for your share of the cost of health benefits.