Federal Employees Health Benefits Program

(FEHB)

A Handbook For Employees, Annuitants, Compensationers, and Employing Offices

Handbook Contents

Introduction

GENERAL OVERVIEW

The Federal Employees Health Benefits (FEHB) Program became effective in 1960. It 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.

Law and Regulations

Public Law 86-382, enacted September 28, 1959, created of the FEHB Program; the current law governing the Program is chapter 89 of title 5, United States Code. The 1959 Act became effective generally on the first day of the first pay period that began on or after July 1, 1960. It authorized the Civil Service Commission (now the Office of Personnel Management) to write any regulations necessary to carry out the Act. These regulations are in part 890 of title 5 and chapter 16 of title 48, Code of Federal Regulations.

FEHB Handbook

This Handbook provides the policies and procedures of the FEHB Program and provides additional guidance to those enrolled in the FEHB Program and their employing offices. These policies and procedures reflect operations under title 5, United States Code. This guidance does not cover any authority that individual agencies, such as the U.S. Postal Service, may have under different laws.

Enrollment

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 two types of enrollment: Self Only and Self and Family. A Self and Family enrollment covers you, your spouse, and your unmarried dependent children under age 22.

Premiums

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.

Who Provides the Coverage?

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.

Opportunities to Change Coverage

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 your enrollment, or change your enrollment outside of an Open Season.

CONTRACTUAL BENEFITS

Each carrier contracts with the Office of Personnel Management to provide certain health benefits to all persons who enroll in its participating plan. Contract negotiation is a bilateral process, and both OPM and the carrier must approve the final contract. Contract periods are usually one year. Individual policies or contracts are not issued to FEHB Program enrollees.

Once benefits have been agreed upon, OPM and each carrier jointly prepare a brochure describing each plan approved under the FEHB Program. This brochure is intended to be

a complete statement of benefits available to the enrollee, including the plan's benefits, limitations, and exclusions.

LEGAL ACTIONS

The District Courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, in any civil action or claim against the United States founded upon the law. Actions to recover on claims for health benefits must be brought against OPM. Actions to review the legality of OPM's regulations or a decision made by OPM must be brought against OPM. Actions to compel enrollment must be brought against the employing office that made the enrollment decision.

GARNISHMENT

Your plan's carrier may garnish your pay to collect debts you owe to it. Garnishment could occur, among other reasons, if you fail to pay deductibles and copayments or if the carrier overpaid claims in error. Federal employee retirement benefits may not be garnished for this purpose.

Your employing office must follow the provisions of 5 CFR part 582 to process a garnishment. These regulations protect some pay from garnishment, such as amounts to cover health benefits premiums and Basic life insurance withholdings. However, amounts to cover Optional life insurance withholdings are not protected. See the FEGLI Handbook for additional information about the effect of garnishment on life insurance coverage.

OPM RESPONSIBILITIES

OPM has the overall responsibility for the administration of the FEHB Program. This includes:

- 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.

AGENCY RESPONSIBILITIES

Headquarters Benefits Officer

The head of each agency must designate a person to serve as the headquarters benefits officer (Benefits Officer) for the agency. The agency head must notify OPM in writing of the designee's name or any change in the designation. The Benefits Officer is OPM's contact for agencywide insurance matters.

Agency heads can send their notification to Office of Personnel Management, Retirement and Insurance Service, Agency Services Division, P.O. Box 57, Washington DC 20044 or fax the notification to 202-606-1108.

Field Installation Responsibilities

The head of each agency must arrange for the designation of employees at the employing office level. This person will be responsible for explaining the FEHB Program to employees and other eligible persons. He/she will determine individual eligibility for enrollment, effective dates of health benefits actions, and other related matters.

An agency may also delegate responsibility for counseling and advising employees and maintaining records to decentralized local operating offices or field installations or provide the services in some other way.

Information and Counseling

Each agency has a responsibility to provide health insurance information and counseling to its employees. Agencies must become especially familiar with the participation requirements for continuing FEHB coverage into retirement and make this information available to employees, especially those considering retirement. OPM encourages agencies to develop counseling programs that meet the needs of their own employees. While these services must be provided, agencies are using many different approaches.

Specific information on resources within your agency should be available to you at your work site.

Contacts between Employees and Carriers

Authorized agency insurance officials should develop contacts with carrier representatives to assist their employees. These contacts must be limited to agency personnel who have FEHB Program responsibilities and to those employees enrolled in the carrier's plan, except during an Open Season. An agency may allow carrier representatives on agency premises to help enrollees with claim or service problems.

A carrier representative may give information only about the plan's benefit provisions and claim procedures. Carrier representatives must be qualified to explain and assist with problems involving the plan's benefit structure and claims procedures and they must confine themselves to these matters. If you have any other questions, such as questions on the law, the regulations, or the FEHB Program in general, you should ask authorized agency insurance officials.

Carrier representatives may address groups of employees during Open Seasons about their plan's benefits structure, methods of obtaining services, and similar matters. An agency may allow the use of its facilities or services for the distribution of OPM-authorized, carrier-supplied information on health benefits plans. An agency must treat employee organization carriers in accordance with current policies on labor-management relations in the Federal service, found in chapter 71 of title 5, United States Code.

Distribution of materials is limited to official brochures and other carrier-supplied information on a health insurance plan that the carrier certifies are in compliance with OPM's supplemental literature guidelines.

Employing Office Questions

Employing office questions concerning the FEHB Program must be directed to the headquarters Benefits Officer. This person may refer questions to OPM's Insurance Policy and Information Division. Questions about the benefits or claims procedure of a specific plan should be directed to a local office of that plan.

Other Agency Responsibilities

Agencies also are responsible for:

- providing eligible persons with information on their rights and responsibilities under the FEHB Program and ensuring that they have free choice among all plans in which they are eligible to enroll;
- determining the eligibility or ineligibility of, and enrolling employees, former employees, former spouses, and children (including decisions on belated enrollment and change of enrollment requests);

- reviewing enrollment reconsideration requests;
- ensuring that election forms are properly completed, including the enrollee's social security number;
- processing health benefits actions and determining proper effective dates;
- determining capability of self-support of children over age 22;
- stocking and distributing health benefits forms and literature;
- maintaining a controlled system of transmitting health benefits enrollment information to carriers;
- remitting and accounting for withholdings and contributions;
- maintaining and certifying necessary records;
- working with carriers to reconcile enrollment records.

CARRIER RESPONSIBILITIES

Each carrier is responsible for:

- adjudicating claims of, and providing health benefits to, enrollees and covered family members in accordance with its contract with OPM;
- typesetting, printing, and distributing brochures;
- furnishing each person enrolled in its health plan an identification card or other evidence of enrollment;
- contacting and working with agency payroll offices to reconcile enrollment records;
- acting on enrollee requests for reconsideration of disputed claims;
- maintaining financial and statistical records and reporting on the operation of its plan;
- developing and maintaining effective communication and control techniques to ensure that its subcontractors and local offices comply with regulations and OPM instructions.

Identification Cards

Your plan carrier will mail your identification cards directly to you. You will receive a new identification card if you change the type of enrollment within your plan or if your name changes. You will not receive a new identification card if you retire or change payroll or employing offices without changing your enrollment.

If you want a duplicate identification card, you must request the card from your carrier. Include in the request your date of birth, social security number, and any additional identifying number the plan may use. This number can usually be found on your current identification card.

Claim Kits

Some carriers provide claim kits as a convenient way for you to maintain claims expense records. Generally, carriers issue the kits to their enrollees at the same time they issue identification cards. Employing offices wanting information copies of these kits may obtain them from the nearest office of the plan.

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.

Health Insurance Questions

If you are a current employee, a former employee or family member covered under temporary continuation of coverage (TCC), a compensationer, or a former spouse of a current employee, you must direct questions about the FEHB Program to your servicing employing office. If you are an annuitant or a former spouse whose divorce occurred after the enrollee left Federal service, you can direct your questions to OPM's Retirement Information Office at 1-88USOPMRET (1-888-767-6738) or (202) 606-0500 from the metropolitan Washington area, or you can write to OPM's Retirement Operations Center, P.O. Box 45, Boyers, PA 16017-0045.

Questions from agency personnel offices and field installations must be directed to the agency headquarters Benefits Officer.

Designated headquarters Benefits Officers can direct their questions to OPM, Retirement and Insurance Service, Office of Insurance Programs, Insurance Policy and Information Division, Washington, DC 20415. Questions also may be sent through the e-mail address on the OPM web site.

CUSTOMER SERVICE STANDARDS

Our customers include Federal employees and retirees, or their survisors, who are eligible to enroll in the FEHB Program. This is our commitment to our health benefits customers:

- Your choice of health benefits plans will compare favorably for value and selection with the private sector.
- When you use the FEHB Guide and plan benefit brochures, you will find they are clear, factual and give you the information you need.
- When you change plans or options, your new plan will issue your identification card within 15 calendar days after it gets your enrollment form from your agency or retirement system.
- Your fee-for-service plan should pay your claims within 20 work days; if more information is needed, it should pay within 60 calendar days.
- If you ask us to review a claim dispute with your plan, our decision will be fair and easy to understand, and we will send it to you within 60 calendar days. If you need to do more before we can review a claim dispute, we will tell you within 14 work days what you still need to do.
- When you write to us about other matters, we will respond within 30 calendar days after we get your letter. If we need time to give you a complete response, we will let you know.

Cost of Insurance

SHARED COST

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: (1) 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 (2) 75 percent of the total premium for the particular plan an enrollee selects.

OPM must determine the FEHB program-wide weighted average of premiums no later than October 1 immediately preceding each FEHB contract year. The law directs OPM, first, to multiply each health plan premium for the upcoming year by the number of enrollees enrolled in that health plan as of the previous March 31 who received a Government contribution. OPM will then divide the total of premiums associated with self only enrollments and with self and family enrollments, respectively, by the

corresponding total number of eligible individuals with each type of enrollment, to derive the weighted average of premiums.

The Government contribution for eligible employees is paid out of agency appropriations or other funds available for payment of salaries. OPM receives an annual appropriation to cover Government contributions for eligible annuitants.

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.

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 I 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 I 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.

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**:

- 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 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:

1. Take the number of years you will participate in premium conversion (from now until your estimated retirement) and divide by 35.
2. Multiply this by your current annual FEHB premium
3. 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.

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.

MAKING WITHHOLDINGS AND CONTRIBUTIONS Continued

Part-time Career Appointment

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.

Example

Faith is scheduled to work 36 hours during a biweekly pay period, and the Government contribution for her health benefits plan is $61.38 biweekly for full-time employees. The Government contribution for her health benefits is as follows:

36 (Hours scheduled during pay period) ÷ 80 (Hours worked by full-time employees) = .4500

$61.38 (Government contribution/full-time employees) x .4500 = $27.62 (Government contribution/part-time employee).

Since the total premium (Government and employee share) for her health benefits plan is $92.35, Faith's share of premiums is $64.73 ($92.35 - $27.62).

Chart of Government Contribution Factors for Part-Time Career Employees

The following chart shows the factor used to determine the amount of Government contribution for health benefits for part-time career employees who, if in a full-time position, would work 80 hours during a biweekly pay period (the amount considered as full-time employment for most positions).

If the comparable full-time position would require you to work a tour of duty other than 80 hours per biweekly pay period, or if you are paid on a monthly or semimonthly basis, divide the actual number of hours or days you are scheduled to work on the part-time schedule by the number of hours or days required for a full-time employee in the same position to determine the Government contribution factor.

Hours worked on a regular biweekly schedule	Factor	Hours worked on a regular biweekly schedule	Factor
32	0.4000	49	0.6125
33	0.4125	50	0.6250
34	0.4250	51	0.6375
35	0.4375	52	0.6500
36	0.4500	53	0.6625
37	0.4625	54	0.6750
38	0.4750	55	0.6875

39	0.4875	56	0.7000
40	0.5000	57	0.7125
41	0.5125	58	0.7250
42	0.5250	59	0.7375
43	0.5375	60	0.7500
44	0.5500	61	0.7625
45	0.5625	62	0.7750
46	0.5750	63	0.7875
47	0.5875	64	0.8000
48	0.6000	<32 or > 64	1.00

Former Spouse Enrolled under Spouse Equity Provisions

If you are a former spouse enrolled under the spouse equity provisions, you must pay both the employee and Government shares of your health benefits premium. You will normally make your payments directly to your ex-spouse's employing office.

Temporary Employees

If you are a temporary employee enrolled under 5 U.S.C. 8906a, you must pay both the employee and Government shares of the health benefits premium. (Exception: if you have a provisional appointment under 5 CFR 316.403, an interim appointment under 5 CFR 772.102, or if you continue coverage after your employment status changes from nontemporary to temporary without a break in service exceeding 3 days, you receive a Government contribution.)

Temporary Continuation of Coverage

If you enroll under the temporary continuation of coverage (TCC) provisions, you usually must pay the full amount of the premiums (both the employee and Government shares) plus an administrative charge of 2 percent of the total premium. You make your payments directly to your servicing employing office.

Former Department of Defense employees who qualify for TCC based on a separation described in 5 U.S.C. 8905a (d)(4) continue to pay the normal employee share of premiums.

Leave Without Pay Status And Insufficient Pay

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.

REMITTANCE TO OPM

When Remittance is Due

Your employing office must remit health benefits withholdings and contributions to OPM on the same date it pays its payroll.

Remittance Procedures

The method for remitting payments and supporting accounting information to OPM is the Retirement and Insurance Transfer System (RITS).

OPM will credit the total amount reported for health benefits to the Employees Health Benefits Fund.

ADJUSTING ERRORS

- Errors in Withholdings and Contributions
- Errors Involving Current Employees - Overdeductions
- Errors Involving Current Employees - Underdeductions
- Errors Involving Separated Employees

Errors in Withholdings and Contributions

Payroll offices must adjust errors in withholdings and contributions on a subsequent payroll and must include the adjustments in a subsequent withholdings and contributions report.

Your employing office must ensure that your individual payroll record shows not only the regular (current) deductions for health benefits withholdings, but also the adjustments.

Where annual appropriations are involved and the fiscal year changes between the processing of the erroneous withholdings and/or contributions and the processing of the adjustment, the proper appropriation must be adjusted.

When you participate in premium conversion, IRS rules require that no adjustments to taxable income be made as a result of an error correction (even when the employing

office is at fault). When your employing office processes a correction, the actual amount of FEHB premiums deducted from your pay will receive pre-tax treatment.

Example

Wendy has $100 per pay period deducted from her pay for FEHB. Her employing office mistakenly deducted $150 during the last pay period before the effective date of her election to participate in premium conversion. To correct the error, the agency deducts $50 for FEHB from Wendy's pay in the following pay period, during which she becomes a premium conversion participant. Although if not for the error, $100 would have been deducted from her pay, only $50 is treated on a pre-tax basis.

Errors Involving Current Employees - Overdeductions

When too much money has been withheld from your pay, or when withholdings have been made when you are not enrolled, your payroll office must adjust the withholdings on a subsequent payroll on which your name appears. This adjustment automatically corrects any excess agency contribution.

Errors Involving Current Employees - Underdeductions

When too little or no money has been withheld from your pay for health benefits withholdings, your employing office must send the correct payment to OPM no later than 60 calendar days after it determines the amount of the underdeduction. This payment must be made to OPM regardless of whether or when the underdeduction is recovered by your employing office.

The underdeduction represents an overpayment of your pay. Your employing office must determine whether to waive collection of the overpayment (up to $1,500), in accordance with 5 U.S.C. 5584. The law provides that an employing office can waive recovery of the overpayment if, in its judgment, you are without fault and recovery would be against equity and good conscience. (If the employing office involved is excluded from the provisions of 5 U.S.C. 5584, it can use any applicable authority to waive the collection.)

If the employing office waives the collection of the unpaid health benefits withholdings, it must remit the payment, along with any applicable Government contributions, out of its own funds.

Waiver is not available for unpaid withholdings when you are in leave without pay status or when your pay is insufficient to make the withholding.

Errors Involving Separated Employees

When an adjustment in withholdings is necessary after you have separated from service, your payroll office must make the adjustment in your final pay (or payment to your beneficiary or estate).

REPORTING NUMBER OF ENROLLEES COVERED

Semiannual Headcount Report

Employing offices must submit a semiannual headcount report on OPM Form 1523 for the last payroll paid during the 1st through the 15th of March and September. It must also report the number of enrollees from whom it made withholdings (or who paid directly or through advanced pay) for that particular pay period for each enrollment code. An enrollee for whom more than one payroll deduction was made in that pay period should be counted only once.

Separate supplemental reports are required for:

- former spouses enrolled under the spouse equity provisions;
- temporary employees enrolled under 5 U.S.C. 8906a; and
- temporary continuation of coverage (TCC) enrollees.

Quarterly Report of Enrollees

Each payroll office is required to generate a quarterly report for each plan that lists enrollee names, enrollment code, and total money (withholdings and contributions) submitted to OPM for each enrollee. This report gives enrollment information for the payroll paid during the 1st and 15th of the last month of each quarter. If there are two payrolls paid during that period, the enrollment information for the second payroll paid is reported.

The plans must be listed in enrollment code order and the enrollees within each enrollment code must be listed in the order of their social security numbers. There must be subtotals for each enrollment code and grand totals for each plan.

NATIONAL FINANCE CENTER

Some agencies have agreements with the Department of Agriculture's National Finance Center (NFC) in New Orleans, Louisiana to perform the payroll functions for enrollees who are making direct payments under the spouse equity and temporary continuation of coverage (TCC) provisions. These agencies have the same responsibilities regarding FEHB enrollments as the agencies that retain the payroll function for these enrollees; however, NFC acts as their agent in servicing these enrollments. The agency must resolve any disputes between NFC and enrollees; OPM will not intervene. The agency's responsibility in both initial and reconsideration decisions about enrollees' enrollment complaints is explained in "Initial Decision and Reconsideration."

Health Plans

TYPES OF PLANS

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 plans include:

- The Governmentwide Service Benefit Plan, administered by the Blue Cross and Blue Shield Association on behalf of Blue Cross and Blue Shield Plans, and is open to everyone eligible to enroll under the FEHB Program.
- Plans sponsored by unions and employee organizations. Some of these plans are open to all Federal employees who hold full or associate memberships in the organizations that sponsor the plans; others are restricted to employees in certain occupational groups and/or agencies. Generally, the employee organization requires a membership fee or dues paid directly to the employee organization, in addition to the premium. This fee is set by the employee organization and is not negotiated with OPM.

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) provide or arrange for comprehensive health care services on a prepaid basis through designated plan physicians, hospitals, and other providers in particular locations. Each HMO sets a geographic area for which health care services will be available, called its service area. This area is described in the plan's brochure. You may join a particular HMO if you live within its service area. Some plans also accept enrollments from employees who work in the area even though they live elsewhere. If you have questions about whether you live or work within a HMO's service area, you should contact the plan before you enroll in it.

Generally, you must choose a primary care physician and have all care coordinated through that physician. Your physician is responsible for obtaining any pre-certification required for inpatient admissions or other procedures.

The three types of HMOs are:

- Group Practice Plans. These plans provide care through groups of physicians who practice at medical centers.
- Individual Practice Plans. These plans provide care through participating physicians who practice in their own offices.
- Mixed Model Plans. These plans are a combination of Group Practice and Individual Practice plans.

Point of Service

Some fee-for-service plans and HMOs offer a point of service product. This gives you the choice of using a designated network of providers or using non-network providers at an additional cost to you. If you don't use network providers, you must pay substantial deductibles, coinsurance, and copayments.

DESCRIPTION OF PLANS

- FEHB Guide
- Brochures
- Participating Provider Directories

FEHB Guide

Each year prior to Open Season, OPM publishes an FEHB Guide for distribution through employing offices to enrollees and eligible persons. The Guide lists all participating plans in the FEHB Program, the premiums required, and other information, including quality indicators. You can also access the FEHB Guide from the FEHB home page.

Brochures

The benefits, cost, exclusions, limitations, and other major provisions of each participating plan are described in the brochure for that particular plan. You can get copies of the brochures for the various plans that you are eligible to join so you can make an informed choice among them. You can access all plan brochures from the FEHB home page. You can also get brochures from your employing office, and by contacting the plans directly at phone numbers listed in the FEHB Guide. You need to keep your selected plan's current brochure as a continuing source of information on the benefits that your plan provides.

Participating Provider Directories

Each HMO and each fee-for-service plan with preferred provider arrangements publishes a participating provider directory that lists its participating physicians, hospitals, and other providers. Before you enroll in a plan, you should review its participating provider directory. Every year during Open Season, you should ask for an updated directory and contact your chosen providers to see if they will continue to participate in the plan. Many plans have their provider directories on their web sites. These can be accessed directly or from the FEHB home page.

Providers sometimes cease participation during an FEHB contract year; if you enroll in a fee-for-service plan, you should verify the provider's participation status before you receive services.

The continued participation of any provider with a health plan is not guaranteed. You are not eligible to change plans outside of an Open Season or other qualifying event solely because a particular health care provider stops participating with your plan.

PARTICIPATING PLANS

Before each Open Season begins, OPM provides agencies with an updated list of the names, addresses, and telephone numbers of all fee-for-service plans and HMOs that currently participate in the FEHB Program.

COORDINATION OF BENEFITS

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

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.
- Part 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. You may also find information on the Medicare Web Site at www.medicare.gov.

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 2001, the States designated as medically underserved areas are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, and Wyoming.

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.

Eligibility for Health Benefits

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.

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
- Student Employees

- Intermittent Employment
- Mixed Tour of Duty

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.

ELECTION PROCEDURES

- Election Required
- Health Benefits Election Form

- Social Security Number
- Change in Election
- Temporary Employees

Election Required

If you are eligible to enroll in the FEHB Program, you must complete an election either to enroll in a plan or not to enroll. You must do this within 60 days after you become eligible. Your employing office must remind you of the 60-day deadline and ensure that you make your election on a timely basis. If you don't make an election, you are considered to have declined coverage.

Health Benefits Election Form

Generally, you will make elections--to enroll, not to enroll, to change enrollment, or to cancel enrollment-- on the Health Benefits Election Form (SF 2809). The SF 2809 may be in either paper or electronic format. However, your employing office may allow or require you to make open season changes through "Employee Express" or another electronic method which does not involve an SF 2809. You should check with your employing office to see if this is available for your use.

Social Security Number

All carriers use your social security number as your identification number for enrollment purposes. Your social security number must be shown on all enrollment or disenrollment documents.

Change in Election

If you want to change your election before the election period ends, your employing office must accept the change.

Temporary Employees

If you are a temporary employee, your employing office must establish a potential FEHB eligibility date for you. Your employing office must notify you as soon as you are eligible to enroll and give you 60 days to make an election.

FREE CHOICE OF PLANS

- Employing Office Responsibility
- Materials to be Given
- Plan Selection
- Plans Sponsored by Unions and Employee Organizations

Employing Office Responsibility

You will be given a full opportunity to make a free choice among the plans available to you. Your employing office will explain the FEHB Program to you as soon as you become eligible; give you informational material; caution you against cancellation of any private health insurance you may already have before coverage under this Program becomes effective; and urge that you study the material and decide which plan is best suited to meet your health care needs.

Materials to be Given

Your employing office will give you the following materials before, or as soon as possible after, you become eligible for FEHB coverage:

- Guide to Federal Employees Health Benefits Plans. This booklet, which is updated each year, contains general enrollment information, lists all FEHB plans and gives your share of the premium rates, and gives the major features of each fee-for-service plan.
- Health Benefits Election Form (SF 2809). You will be asked to complete and return this form, regardless of whether you elect to enroll or not to enroll in the FEHB Program.
- Health Plan Brochures. Your employing office will allow you to review the brochures of the plans you are eligible to enroll in. Your employing office will allow you to keep the brochure of the plan you select.

Plan Selection

Only you can decide which plan is best suited for your individual needs. Your employing office will not make comparisons between benefits offered by various plans and will not show favoritism toward a plan. They should not in any other way try to influence your final selection of a plan. However, your employing office will answer your questions about the FEHB Program.

Plans Sponsored by Unions and Employee Organizations

You may elect to enroll in a plan sponsored by a union or employee organization if you are a member of the organization or if you promptly take steps to become a member. Some employee organizations will allow your enrollment in its plan if you become an associate member (where you are enrolled in that organization only for health benefits purposes). Certain plans are open only to specific groups of employees.

Your employing office will not verify whether you are a member of the organization when it accepts your Health Benefits Election Form enrolling in the organization's plan; the organization will verify your membership when it receives your election form. However, your employing office will make sure that you understand that membership in the organization that sponsors the plan is necessary to be an enrollee in the plan.

LATE ELECTION

Accepting Late Elections

If, for reasons beyond your control, you were unable to make an election within the required time limits, your employing office may allow you to make a late election. You must make your election within 60 days after your employing office notified you of its decision.

Your employing office will decide whether your failure to make a timely election was beyond your control. Your error in judgment or failure to read information are not considered causes beyond your control. Some examples of cause beyond your control are:

- You were on service elsewhere when you ordinarily would have been able to make the election.
- You are a new employee and your employing office didn't give you information about health benefits.
- Your employing office told you in error that you were not eligible to enroll.
- You are an employee, formerly covered under another person's enrollment, and were belatedly informed of that coverage's termination.

Documenting Late Elections

If your employing office accepts a late election from you, it records its determination that you were unable to make the election on a timely basis for reasons beyond your control, giving the date you were notified of the determination, in the Remarks section of the Health Benefits Election Form (SF 2809). If you are electing to enroll, it is especially important that this be documented on the SF 2809 for purposes of meeting the requirements for continuing enrollment after retirement. Your employing office must state the reason for your failure to make the election on a timely basis on either the SF 2809 or on a memo attached to the Official Personnel Folder copy of the SF 2809.

Effective Date

Late elections are effective prospectively, except for belated open season elections, as explained in "Correction of Errors."

Election by Proxy

Your employing office may permit your representative to make an election for you with your written authorization. This may by done when you are unable to make an election on a timely basis; for example, when you will be on extended travel in a remote location, or you expect to be hospitalized during the next election opportunity. Your representative must sign his or her own name on the Health Benefits Election Form (SF 2809) and add after it "For: (*your name*)." Your employing office attaches the written authorization to the Official Personnel Folder copy of the SF 2809 and writes "Authorization attached" in the Remarks section.

ELECTION NOT TO ENROLL

Your Responsibility

It is your responsibility to ensure that your Health Benefits Election Form (SF 2809) correctly reflects your intentions. When you elect not to enroll you certify by your signature on the SF 2809 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.

Change in Election Not to Enroll

If you want to change your election before the election period ends, your employing office must accept the change.

Effect of Transfer on Election not to Enroll

If you transfer to another employing office without a break in service of more than 3 calendar days, your election not to enroll is also transferred and you may not enroll as a new employee of the gaining agency. If you have a break in service of more than 3 calendar days, you must elect either to enroll or not to enroll, the same as a new employee.

Employing Office Action when You do not Make an Election

If you don't make an election, your employing office will contact you before the election period ends and urge you to make an election. If you still don't make an election, you are considered to have elected not to enroll.

If you are an eligible temporary employee who doesn't enroll, your employing office will document in your Official Personnel Folder your date of eligibility, the date it sent notification of your eligibility, and the date of its follow-up contact urging you to make an election.

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.

See "Opportunities to Enroll or Change Enrollment" for the events that allow enrollment or changes in enrollment and the time frames within which changes may be made.

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
- OPM

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.

PROCESSING ELECTIONS

Generally, the responsibility for processing health benefits actions is divided between the personnel and payroll offices.

References in this section to Standard Forms 2809 and 2810 apply to the August 1992 and June 1995 editions respectively.

Prompt Action on Elections

Your personnel and payroll offices must process your election within one week after their receipt. This is very important to protect your eligibility for benefits (especially when you

are enrolling in an HMO), to keep health plan carriers fully informed of the status of its enrollments, and to avoid retroactive adjustments in withholding and contributions.

Health Benefits Forms

Health benefits actions are taken on either the Health Benefits Election Form (SF 2809) or the Notice of Change in Health Benefits Enrollment (SF 2810). Each of these forms contains instructions explaining its use.

Remarks

Both the SF 2809 and SF 2810 contain space for remarks. Your employing office will use this space to give information needed to support any action that is not apparent from the completed form. For example, to show that as a new employee, you are enrolling on a timely basis, your employing office will note "Appointed (date)", or "Converted to eligible type of appointment (date)". It should not include information that is not relevant to your health benefits, such as the reason for separation, or title and grade of your position.

Special entries in the Remarks section are required if you are a temporary continuation of coverage (TCC) enrollee or a temporary employee eligible under 5 U.S.C. 8906(a).

SF 2809

The Health Benefits Election Form (SF 2809) is used to enroll, to decline enrollment, to change your enrollment, or to cancel your enrollment. The SF 2809 may be in either paper or electronic format. Whenever the use of the SF 2809 is discussed in this section, it refers to either the paper or electronic format.

Employing Office Review of SF 2809

Upon its receipt of your Health Benefits Election Form (SF 2809), your employing office will:

- note in part H the date it received the completed form;
- make sure that you are eligible to enroll;
- check that you are not already covered as a family member under another FEHB enrollment;
- review the form for completeness, consistency, signature, accuracy, and legality of the action, and check all copies for legibility;
- discuss with you any inconsistencies or situations not permitted by the law or regulations (e.g., not filed within the required time limits; enrollment in a plan not serving your area; name of plan and enrollment code do not agree; code number indicating Self Only enrollment when family members are listed; listing of persons not eligible for family coverage.) If you are enrolling in an employee organization plan, your employing office must accept your enrollment but also

advise you that you must become a member of the organization, if you are not already a member;
- obtain a medical certificate from you if you have listed a child age 22 or over as a family member. Your employing office will record its determination of capability for self-support in the Remarks section on all copies of the form (e.g.,"[name] is incapable of self-support--permanent" or "certificate expires on [date])", and will attach the documentation to the Official Personnel Folder copy of SF 2809 (in a sealed envelope if preferred). If coverage is approved for a limited period of time, your employing office will prepare a follow-up notice to remind you in writing, at least 60 days before the certificate expires, that it must be renewed. If your employing office doesn't approve coverage, it will remove the child's name from the listing of family members;
- if you are a temporary employee enrolling under 5 U.S.C. 8906a, enter in the Remarks section: "Temporary employee eligible under 5 U.S.C. 8906a; must pay the full premium amount with no Government contribution.";
- if you have properly completed the SF 2809 and you are eligible to enroll, enter in part H the effective date of your enrollment, payroll office number (or the agency location code, if different from the payroll office number), and the name, title, address, signature, and telephone number of the authorized agency official. These entries may be made by rubber stamp, overprint, or facsimile signature;
- file a copy on the right or permanent side of the Official Personnel Folder (or its equivalent);
- send the new carrier and payroll office copies of SF 2809 to the payroll office for transmission to the carrier and for posting to the payroll records, respectively. (If it prefers, your employing office may send *all* copies except the enrollee copy to the payroll office for its action and later return of the Official Personnel Folder copy for filing.) It will discard the old carrier copy if it is a new enrollment;
- give you the enrollee copy, so you can use it as proof of enrollment until the carrier sends you an identification card.

Processing an Election not to Enroll

Your employing office will process your election not to enroll in the FEHB Program by following the applicable instructions under "Employing Office Review of SF 2809," except that the carrier copies should be destroyed.

Processing an Election Change

Your employing office will process your election change as outlined in "Employing Office Review of SF 2809" and take these additional steps:

- if you are changing from one option or type of enrollment to another in the same plan, your employing office will use the new carrier copy of SF 2809 to notify your carrier of the change. It will discard the old carrier copy;

- if you are changing plans, your employing office will use the new carrier copy of SF 2809 to notify the gaining carrier, and the old carrier copy to notify the losing carrier;
- if you are changing plans, the correct transmittal document report number must be entered on each carrier's copy.

SF 2810

Your employing office uses the Notice of Change in Health Benefits Enrollment form (SF 2810) to record certain changes in an enrollment not requiring your signature. It is used for an enrollment termination (but not a cancellation), reinstatement, change in payroll office, and a name change. In case of an enrollment termination, the back of the original (enrollee) copy of the SF 2810 serves as your official notice of the 31-day extension of coverage and conversion right. The back of the form also explains other rights you may have (continuation of enrollment on transfer, retirement, death, or entitlement to compensation under the Federal Employees' Compensation law).

IMPAIRED RELATIONSHIP (Continued)

- Temporary Employee's Change in Employment Status
- Name Change
- Reinstatement of Enrollment

Temporary Employee's Change in Employment Status

If your employment status changes from a temporary employee enrolled under 5 U.S.C. 8906a to a position in which you become eligible to receive the Government contribution, your employing office will document the change on the Notice of Change in Health Benefits Enrollment (SF 2810). The SF 2810 documents the change in premium withholding and when your enrollment begins to count toward the requirement for continuation after retirement. (You may change your enrollment if you wish.)

Your employing office will complete parts A, G, and H of the SF 2810, and enter the following remark in Part G: "Employee has been converted/appointed to a position in which (he)(she) participates in a retirement system and is eligible for the Government contribution to the premium."

Name Change

If your name changes but your enrollment does not, your employing office must report it to your carrier. Your employing office prepares a Notice of Change in Health Benefits Enrollment (SF 2810) and notes in the Remarks section the reason and date of the change (e.g., "Employee married [date])."

Reinstatement of Enrollment

When your enrollment is reinstated, your employing office will complete parts A, D, and H of Notice of Change in Health Benefits Enrollment (SF 2810). It will note in the Remarks section the event permitting reinstatement (e.g., "Returned from military service", "Employee reinstated", or "Correction of erroneous termination of enrollment").

Your employing office will send you the enrollee copy, file a copy on the right side of the Official Personnel Folder, and send the carrier and payroll office copies to the payroll office for transmission to the carrier and posting to the payroll records, respectively.

TRANSFER BETWEEN PAYROLL OFFICES

Continued Coverage

Your enrollment and coverage continue without change when you transfer from one payroll office to another without a break in service of more than 3 days. Your employing office will promptly take action to transfer your enrollment. See "When You Transfer to a Different Payroll Office (Daily Proration Rule)" for information on each payroll office's responsibility for withholdings and contributions.

Gaining Employing Office Actions

Your gaining employing office will perform a record check on SF 75 before you enter on duty to establish your current enrollment status, enrollment code number, and Social Security number.

When you enter on duty, your employing office will:

- review SF 75 with you to confirm its accuracy. It will inform you of any opportunities you may have at that time to change your enrollment (e.g., if you moved out of your HMO's service area);
- complete a Notice of Change in Health Benefits Enrollment (SF 2810), including parts C and H, transferring the enrollment to the gaining employing office;
- give you the enrollee copy of the new SF 2810. It will keep a file copy for your Official Personnel Folder, and send the carrier and payroll office copies to the payroll office for transmission to the carrier and posting to the payroll records, respectively;
- verify the transfer-in action on the basis of the health benefits documents located in your Official Personnel Folder. If the action was correct, it will file a copy of SF 2810 on the right side of the Official Personnel Folder (or its equivalent). If the action was not correct, it will correct the error. (If the losing office

erroneously terminated your enrollment, the gaining employing office will use part D to show a reinstatement of the enrollment rather than part C to show a transfer in.)

Mass Transfers

When you are part of a group of 25 or more employees enrolled in the same plan to be transferred on the same day from one payroll office to another payroll office, your employing office doesn't need to prepare a separate transfer-in Notice of Change in Health Benefits Enrollment (SF 2810) for each of you. The gaining employing office may make a list of all the employees involved in the transfer and attach several copies to only one SF 2810 documenting the mass transfer in. It will post the change in payroll office number on the latest SF 2809 in each of your Official Personnel Folders so that the payroll office number is up to date.

The gaining employing office will prepare the list in three columns, with column 1 for the employee's name, column 2 for the Social Security Number, and column 3 for the enrollment code number.

VOIDING HEALTH BENEFITS ACTIONS

When Voiding is Appropriate

Voiding is appropriate only when an incorrect health benefits action must be withdrawn and your enrollment status must revert to what it was before the incorrect action was taken. Voiding has the effect of removing the incorrect action as though it never occurred.

Procedure

To void an action, your employing office marks "VOID" in bold letters on the Official Personnel Folder and payroll office copies of the form on which the incorrect action was taken (either the SF 2809 or SF 2810), and explains the action in the Remarks section. Additional remarks are required when an erroneous enrollment is voided.

If your employing office had sent the carrier's copy of the form, it will send the voided payroll office copy to the carrier with the next regular transmittal. If the action being voided is a change in plan, it will send a copy of the voided SF 2809 to both the old and new carrier. Your employing office will keep a copy in your Official Personnel Folder (OPF). If a copy had not been sent to the carrier, it will destroy all but one copy to be retained in your OPF.

CORRECTION OF INFORMATION ON FORMS

Your employing office must correct and report to your carrier erroneous information given on the Health Benefits Election Form (SF 2809) or Notice of Change in Health Benefits Enrollment form (SF 2810) that would affect your entitlement to benefits.

Significant errors include errors in your name, enrollment code, Social Security number, the effective date of a health benefits action, or a listing of family members when there are none.

Your employing office will make a correction on SF 2809 or SF 2810 (depending on which of these forms contains the erroneous information), and clearly label the form "CORRECTION." The corrected form must give your name, Social Security number, and other identifying data. The form may show only the specific item(s) being corrected, or your employing office may substitute another complete corrected form for the one previously submitted. Your employing office will send the corrected form to your carrier with the next regular transmittal. If the erroneous information was sent to both the old and the new carriers, each will be sent a corrected form.

REPORTING ENROLLMENTS AND CHANGES IN ENROLLMENT TO CARRIERS

Delegation of Authority

Title 6 of the General Accounting Office Manual for Guidance of Federal Agencies, which provides principles and standards for payroll office operations, delegates to OPM the authority to prescribe the principles and standards for the FEHB Program.

Timely Processing of Transmittals to Carriers

On at least a weekly basis, your payroll office will send copies of Health Benefits Election forms (SF 2809) and Notice of Change in Health Benefits Enrollment forms (SF 2810) to the appropriate carrier with the transmittal document. Your payroll office cannot accumulate health benefits forms for longer than one week.

Verification

Before transmitting a copy of a health benefits form to a carrier, your payroll office must verify that the payroll action required by the form can be taken (e.g., that you were in pay status during the pay period before the effective date, if it is a requirement for that action). A copy of the form can be released to the carrier before payroll action is completed to adjust the health benefits control or to note the individual pay record.

Preparing Transmittal Report

Your payroll office will prepare an original and two copies of the transmittal report. It will send the original and one copy to the carrier with the carrier copies of Health Benefits Election forms (SF 2809) and Notice of Change in Health Benefits Enrollment forms (SF 2810). It will hold the second copy until the carrier returns a certified copy.

Carrier addresses for fee-for-service plans and HMOs are provided to payroll offices by OPM before the start of each annual open season. The carrier code is the first two characters of the carrier's enrollment code number.

Payroll Office Number

Each agency payroll office that reports FEHB withholdings and contributions uses a unique eight digit identification number. The first two digits represent the agency (assigned by the U.S. Treasury Department) and the last six digits identify the payroll office within the agency. Agency headquarters must notify OPM of any establishment of or change in payroll office number.

The payroll office number must be provided on every health benefits form (SF 2809, 2810, and transmittal document). In most cases, the agency office that maintains the Retirement and Insurance Transfer System (RITS) also maintains the FEHB enrollment. When different offices are responsible for maintaining RITS and FEHB enrollment, OPM maintains a payroll office directory, containing the addresses and phone numbers of agency offices that prepare RITS and FEHB enrollment information. It is important that agencies promptly report changes to OPM so this directory is kept current. Carriers must also be notified of changes so they can update their records. This is done in the same way as a mass transfer.

Report Number

Your payroll office must enter a report number on each Transmittal Report that it prepares. The first two digits designate the calendar year and the remaining digits run in numerical sequence, starting with number 1. Thus, 99-1 is the number of the first transmittal sent on or after January 1, 1999; 99-2 is the number of the second transmittal in that year, etc. A new series starting with number 1 begins each calendar year.

Your payroll office will enter the transmittal report number in the appropriate space on each Health Benefits Election Form (SF 2809) and Notice of Change in Health Benefits Enrollment form (SF 2810) sent with that transmittal and on the corresponding payroll office copies.

Transmittal

Your payroll office will show the number of Health Benefits Election Forms (SF 2809) and Notice of Change in Health Benefits Enrollment forms (SF 2810) sent with that transmittal to carrier in the space provided.

Carrier Enrollment Records

OPM does not require a specific enrollment records system for carriers. Carriers must maintain their records in a way that allows for easy determination of the number and identity of enrollees served by individual payroll offices for control and statistical reporting and for reconciliations.

RECONCILIATION

- Joint Payroll Office- Carrier Reconciliation
- Use of Social Security Number in Reconciling
- Enrollments
- Disenrollment
- Other Disenrollment Actions

OPM requires the quarterly reconciliation of carrier enrollment records with agency personnel and payroll records. These reconciliations are critical to ensure that enrollees receive the health benefits to which they are entitled.

Joint Payroll Office-Carrier Reconciliations

Each payroll office will reconcile the names and numbers of enrollees in a particular plan with the carrier's records. OPM urges payroll offices and carriers to fully cooperate to maintain accurate and up-to-date enrollment files.

Each payroll office is required to generate a quarterly report for each plan that lists enrollee names, enrollment code, and total money (withholdings and contributions) submitted to OPM for each enrollee. This quarterly report includes enrollment data for the payroll paid during the 1st through the 15th of the last month in each quarter. If two payrolls are paid during that period, enrollment data for the *last* payroll paid is reported.

The carrier has the responsibility for initiating reconciliations and doing the actual matching of names, but the payroll office must be responsive and cooperate with the carrier. When the carrier finds individual names on its enrollment records that are not on the employing office's enrollment report, the carrier must ask the employing office for documentation to resolve the discrepancy. If the carrier cannot reconcile its records or does not receive the requested information within 31 days of the request, it may proceed with disenrolling the individual.

If the carrier and the payroll office agree, the payroll office may do the detailed reconciliation. The carrier must keep the reconciliation results and workpapers for inspection by OPM and the General Accounting Office.

Use of Social Security Numbers in Reconciling Enrollments

Your carrier is required to use your Social Security number to reconcile enrollments. Social Security numbers must be clearly shown on any Health Benefits Election forms (SF 2809) and Notice of Change in Health Benefits Enrollment forms (SF 2810) processed and forwarded to the carriers. Social Security numbers must be available for use in the reconciliation process either within the payroll office or during the joint payroll office-carrier reconciliations.

If you object to giving your carrier your Social Security number, your employing office may make special provisions to accommodate your wishes. However, it may be difficult for the carrier to pay your claims or provide services without using your Social Security number as an identifier.

Disenrollment

When a carrier can not reconcile its records of your enrollment with the employing office's enrollment records, or when it does not receive the necessary documentation from the employing office to resolve the discrepancy within 31 days from its request, the carrier may proceed with your disenrollment.

The carrier must provide you with written notice that the employing office of record does not show you as enrolled in the carrier's plan and that you will be disenrolled 31 calendar days after the date of the notice unless you can provide documentation of your enrollment. This documentation may include:

- a copy of the Health Benefits Enrollment Form (SF 2809) or a letter confirming an electronic transaction;
- a Notice of Change in Health Benefits Enrollment (SF 2810) (or the equivalent electronic submission) transferring your enrollment;
- copies of earnings and leave statements or annuity statements showing withholdings for the plan; or
- a document or other credible information from your employing office stating that you are entitled to continued enrollment in the plan and that premiums are being paid.

After receiving your documentation, the carrier must notify you and your employing office of its decision on your information. If the carrier does not receive documentation of your enrollment within 31 calendar days from its notice, you will be disenrolled from its plan, without further notice.

You may request that your employing office reconsider the carrier's disenrollment decision. Your reconsideration request must be filed within 60 calendar days of the date of the carrier's disenrollment notice. Your employing office must notify the carrier when it receives such a request.

If, at any time after disenrollment, your employing office or OPM determines that you should be enrolled under another coverage provision, or if the carrier receives appropriate documentation showing that you should be enrolled, the disenrollment is void and coverage is reinstated retroactively.

Other Disenrollment Actions

A carrier also has the right to disenroll:

- an individual with a self only enrollment when it receives reliable information that the person has died;
- a child survivor annuitant with a self only enrollment when he/she reaches age 22, unless the carrier's records indicate that the child is incapable of self support due to a physical or mental disability;
- an enrollee who notifies the carrier that he/she has separated from Federal employment and is no longer eligible for FEHB enrollment.

Notice of disenrollment must be provided to a child survivor annuitant or a former employee. The notice must be provided to the child survivor annuitant prior to the disenrollment date.

A child survivor annuitant has the right to request that the retirement system reconsider the disenrollment decision.

If, at any time after disenrollment, the employing office or OPM determines that coverage should be extended under another coverage provision, or if the carrier receives appropriate documentation of the enrollment, the disenrollment is void and coverage is reinstated retroactively.

Enrollment

TYPES OF ENROLLMENT

Two types of enrollment are available:

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).

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.

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.

Both Husband and Wife Eligible to Enroll

If both you and your spouse are eligible to enroll, one of you may enroll for self and family to cover your entire family. If you have no eligible children to cover, each of you may enroll for self only in the same or different plans. Generally, you will pay lower premiums for two self only enrollments.

ENROLLMENT CODES

An enrollment code identifies the plan, the option (high or standard), and the type of enrollment (self only or self and family) you have chosen. The first two places in the three-digit code identify the plan, and the third place identifies the option and type of enrollment. Enrollment codes are found on the front cover of each plan's brochure and in the FEHB Guide.

OPPORTUNITIES TO ENROLL OR CHANGE ENROLLMENT

- Effective Date
- If I Participate in Premium Conversion Can I Still Change My Enrollment?
- New Appointment
- Change to Self Only
- What is a Qualifying Life Event?
- Open Season
- Change in Family Status
- New Spouse
- Divorce or Separation
- Former Spouse
- Change in Employment Status
- Return to Duty after 365 Days in Nonpay Status or Termination During Nonpay Status
- Reemployment after more than 3 Day Break in Service
- Return from Military Service
- Change from Temporary Appointment to Another Type of Covered Appointment
- Separating from Service
- Transfer to or from Overseas Employment
- Change to or from Part-time Career Employment
- You Lose Coverage under FEHB or Another Group Insurance Plan
- Former Spouse Loses Regular FEHB Coverage
- Former TCC Enrollee Loses Regular FEHB Coverage
- Termination of Membership in Employee Organization
- You are Enrolled in a Plan that is Discontinued

- Change to Position out of Commuting Area
- Loss of Coverage under Spouse's Non-Federal Plan
- Move from an HMO's Service Area
- You Become Eligible for Medicare
- Salary of Temporary Employee Insufficient to Pay Withholdings
- Continuation of Old Plan During Confinement

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 I 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.

What is a 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.

OPPORTUNITIES TO ENROLL OR CHANGE ENROLLMENT (Continued)

- Former Spouse
- Change in Employment Status
- Return to Duty after 365 Days in Nonpay Status or Termination During Nonpay Status
- Reemployment after more than 3 Day Break in Service
- Return from Military Service
- Change from Temporary Appointment to Another Type of Covered Appointment
- Separating from Service
- Transfer to or from Overseas Employment
- Change to or from Part-time Career Employment
- You Lose Coverage under FEHB or Another Group Insurance Plan
- Former Spouse Loses Regular FEHB Coverage

- Former TCC Enrollee Loses Regular FEHB Coverage
- Termination of Membership in Employee Organization
- You are Enrolled in a Plan that is Discontinued
- Change to Position out of Commuting Area
- Loss of Coverage under Spouse's Non-Federal Plan
- Move from an HMO's Service Area
- You Become Eligible for Medicare
- Salary of Temporary Employee Insufficient to Pay Withholdings
- Continuation of Old Plan During Confinement

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 Status or Termination During Leave Without Pay Status

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 an 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 are 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;
- you are under age 22, covered by your parent's enrollment, and become a parent.

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.

ANNUAL OPEN SEASON

- If You Don't Want to Make an Open Season Change
- Processing Open Season Changes

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 1.

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
- Reinstatement of Enrollment

- New Enrollment

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.

FOLLOWING SEPARATION FROM SERVICE

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.

Leave Without Pay Status and 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 INSUFFICIENT PAY STATUS

- Employing Office Notification
- Sample Notice

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

Sample Notice

FEDERAL EMPLOYEE
HEALTH BENEFITS (FEHB) OPTIONS
WHILE IN LEAVE WITHOUT PAY
OR INSUFFICIENT PAY STATUS

Name of Employee: *Date:*

You must respond within 31 days (45 days for employees residing overseas) of this notice or your FEHB enrollment will automatically terminate.

Each pay period you are enrolled in the FEHB Program, you are responsible for payment of the employee share of the premium. When you enter leave without pay status, or your pay is insufficient to cover the premium, you must

- *terminate the enrollment; or*
- *continue the enrollment and agree to pay the premium or incur a debt or prepay premiuims (optional).*

TERMINATING THE ENROLLMENT: If you elect to terminate your enrollment (or the enrollment automatically terminates), the termination will take effect at the end of the last pay period in which premiums were withheld from pay. FEHB coverage will continue at no cost to you for an additional 31 days. During the 31 days, you and your covered family members may convert to an individual contract with your insurance carrier. The termination is not considered a break in the continuous coverage necessary for continuing FEHB coverage into retirement. However, the period during which the termination is in effect does not count toward satisfying the required 5 years of continuous coverage. When you return to pay and duty status, or at the end of the first pay period your pay becomes sufficient to cover your premium, you must reenroll within 60 days if you want FEHB coverage.

CONTINUING THE ENROLLMENT AND AGREEING TO PAY THE PREMIUM: If you elect to continue your coverage, you must elect to pay the premiums directly or to incur a debt in the amount of the unpaid premiums, or to pre-pay premiums (optional). If you elect to pay directly, mail a check or money order payable to ***(name)*** *. Include on the check your name, social security number, a note that the payment is for "FEHB premium", and the pay period for which the payment is being made. Mail to: (address) .*

If you elect to incur a debt, or if you elect to pay directly but fail to pay the entire amount due, you will receive a notice stating the total amount due. The notice will be sent when you return to pay status, your pay becomes sufficient, or you separate from employment. By electing to continue coverage you agree to repay the resulting debt in full and to allow the debt to be collected by withholdings from any salary payments to you from the Federal Government, up to ***(amount)*** *. If the amount due cannot be withheld in full from salary, it will be recovered 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.*

If you elect to pre-pay your premiums, the amount you prepay in advance may either be deducted from your pay or you may pay out-of-pocket.

Please check the appropriate space(s) below, sign, and return this notice to your employing office at: (address) .

After reading and understanding the above, I elect to:

- *Continue the enrollment (Check one):*

  _____ *Submit direct payments*
  _____ *Incur a debt*
  _____ *Pre-pay premiums*

_____ _____
(Signature) *(Date)*

- *Terminate the enrollment.*

_____ _____
(Signature) *(Date)*

Refer questions to: (Name) *(Telephone)*

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. See "Employing Office Notification" for notification requirements when you enter leave without pay status or when your pay becomes insufficient to make the withholdings.

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. See chapter 4 of the CSRS and FERS Handbook for Payroll and Personnel Offices.

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

- Effect of Termination

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
- Active Duty Military Service
- While Receiving Compensation
- Part Time Employees
- Temporary Appointments
- Family and Medical Leave
- Appointments to Employee Organizations
- Appointment to State or Local Governments or Institutions of Higher Education, Indian Tribal Government, or other Organizations
- Transfers to International Organizations
- If You Pay Your FEHB Premiums Over Less than 12 Months

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. See www.opm.gov\oca\leave and 5 CFR Part 630 for information about family and medical leave.

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.

Termination, Conversion and 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
- Family Members

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 18 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
- By Termination of Membership in Employee Organization
- For Other Reasons

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.

31-DAY EXTENSION OF COVERAGE AND CONVERSION (Continued)

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 Withholdings were Made
- If Withholdings were not Made

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

- Employee
- Child
- Former Spouse
- Persons not Eligible

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.

Child

Your child is eligible for temporary continuation of coverage when he/she:

- has been covered as an unmarried dependent child under your enrollment as an employee, former employee, or annuitant; and
- stops meeting the requirements for being considered your unmarried dependent child; and
- would not otherwise be eligible to continue FEHB coverage (not counting the 31-day extension of coverage).

This includes a child who:

- Marries before reaching age 22;
- Loses coverage because he/she reaches age 22;

- No longer meets coverage requirements as a stepchild, foster child, or a recognized natural child;
- Was covered as a disabled child age 22 and older, and marries, recovers from his/her disability, or becomes self-supporting;
- Loses FEHB coverage upon the death of an employee or annuitant because he/she does not qualify for a survivor annuity;
- Loses FEHB coverage because his/her survivor annuity as a dependent of the deceased stops (for any reason, including because he/she is no longer a full-time student).

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.

TEMPORARY CONTINUATION OF COVERAGE (Continued)

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. This information is included in plan brochures and the booklet *Temporary Continuation of Coverage under the Federal Employees Health Benefits Program* (RI 79-27).

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

- Sample Notice for Separating Employee
- Notification Requirements for Children
- Sample Notice for Child
- Notification Requirements for Former Spouses
- Sample Notice for Former Spouse
- Receipt of Notice

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 *Date*

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

- Guardian may File
- Late Election
- Election Options
- Covered Family Members
- Election Procedures

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.

TEMPORARY CONTINUATION OF COVERAGE (Continued)

Time Limits for Electing Temporary Continuation of Coverage (Continued)

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.

Example:

Employee: Archibald M. Higgenbottom, SSN 123 45 6789, DOB 12/12/55. Eligibility ends: 4/20/97. Former spouse.

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
- Child

- Former Spouse
- Length of Coverage Based on Qualifying Event
- Separating Employee
- Child or Former Spouse

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.

Example

Laura separates from service on February 3, 1998. She is no longer an employee on February 4. Her period of TCC coverage expires on August 3, 1999.

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.

Example 1

Robert's child turns 22 on April 22, 1997. She is considered to have turned 22 at midnight on April 21 and on April 22 is no longer a family member. She enrolls under TCC; her TCC eligibility ends on April 21, 2000.

Example 2

Laura separates from service on February 3, 1998. She enrolls under TCC for a self and family enrollment. Her child turns 22 on April 22, 1998 and enrolls under TCC. Her child's TCC eligibility ends on February 3, 2001.

Former Spouse

Your former spouse's TCC eligibility 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.

Example 1

Paul (the employee) and Betsy divorce becomes final on December 10, 1998. She is considered to no longer be a family member on December 11. She enrolls under TCC; her TCC eligibility ends on December 10, 2001.

Example 2

Maria separates from service on September 1, 1998 and enrolls under TCC for a self and family enrollment. On December 10, 1998, her divorce from Eugene becomes final. Eugene enrolls under TCC; his TCC eligibility ends on September 1, 2001.

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.

Example

Tyra separates from service on January 15, 1999. She enrolls under TCC and changes her enrollment to a different health benefits plan. Her enrollment with her previous plan continues for the first 31 days after separation. Her TCC coverage with the new plan begins on February 16, 1999. Her TCC eligibility time period ends on July 15, 2000. Her 31-day extension of coverage ends on August 16, 2000.

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.

Example

Caroline turns age 22 on October 1, 1999 and loses coverage under her father's self and family enrollment. She elects TCC coverage and decides to enroll in the same plan that she was enrolled in under her father's coverage. Her 31-day extension of coverage ends on October 31, 1999 and her TCC eligibility time period ends on September 30, 2002. Her second 31-day extension of coverage ends on October 31, 2002.

TEMPORARY CONTINUATION OF COVERAGE (Continued)

Premium Payments

- Nonpayment of Premiums
- Sample Notice for Delinquent Premiums

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

- Change to Self Only
- Open Season
- Change in Family Status
- Reenrollment under TCC
- Loss of FEHB Coverage or Coverage under Another
- Group Insurance Plan
- Move from an HMO's Service Area
- You Become Eligible for Medicare

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.

TEMPORARY CONTINUATION OF COVERAGE (Continued)

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.

Example

Nick and Nora's divorce becomes final on June 1, 1998. Nora applies for FEHB coverage under the spouse equity provisions and under TCC. She is covered under TCC until her spouse equity application is approved. Nora remarries on October 15, 1999, and since

she is under age 55, her spouse equity coverage ends. She reenrolls under TCC provisions, and her coverage expires on June 1, 2001.

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.

Example

Janice is covered as a family member under her mother's FEHB enrollment. She turns age 22 on May 15, 1998, and elects TCC coverage. Her eligibility period under TCC ends on May 14, 2001 (36 months). She later becomes employed by the Federal government and elects to carry regular FEHB coverage, so her TCC coverage is terminated. She leaves Federal service on April 20, 1999, and is eligible to elect TCC as a separated employee. Her eligibility period would end on October 20, 2000 (18 months). She chooses instead to resume her original TCC coverage since this would give her a longer eligibility period.

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.

Example 1

Joan elected FEHB coverage on February 11, 1990, and had a break in service from January 1, 1994 through January 1, 1996. Upon her return to service, she again elected to enroll. She retires on December 31, 1997. She is eligible to continue her health benefits coverage into retirement, since she has been continuously enrolled for the 5 years of service prior to retirement.

Example 2

Eduardo elected not to enroll in the FEHB Program upon his employment. He left Federal service in 1993. He was rehired in 1993, and elected to enroll. When he retired in 1996, he was not eligible to continue health benefits into retirement since he was not covered for the five years of service before his retirement. His 1993 rehire date does not count as his first opportunity to be insured because of his prior employment in which he elected not to enroll.

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.

Example

Anne's employing office notified her on March 20, 1993 that she could make a late election to enroll in the FEHB Program. She promptly enrolled, and on January 1, 1998, she retired. She is able to continue her health benefits coverage into retirement, since March 20, 1993, is considered to be her first opportunity to enroll.

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.

Annuitants and Compensationers

ELIGIBILITY FOR HEALTH BENEFITS AFTER RETIREMENT Continued

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.

OPM would approve these types of waiver requests:

Examples

Sean drops coverage in the FEHB Program for a period of time, but reenrolls later. He is later forced to retire because of a disability before meeting the 5-year participation requirement. (Employees who retire voluntarily although they have a medical condition that would make them eligible for disability retirement are considered as disability retirees for the purpose of granting waivers.)

Lilly does not meet the participation requirement, but had been covered under FEHB for a substantial number of years during her career, including 3 years immediately before retirement. She is forced to retire because of an involuntary separation.

Jill had a break in coverage during the 5 years of service immediately before retirement because her Federally employed spouse changed from a Self and Family enrollment to a Self Only enrollment without telling her. She enrolled at the first opportunity after learning of the loss of coverage.

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 (but see "Current Waiver Policy" for exceptions).

OPM generally wouldn't approve these types of waiver requests:

Examples

Keesha loses non-Federal coverage, enrolls for FEHB at the earliest opportunity thereafter, and then retires voluntarily before meeting the participation requirement.

Jim does not meet the 5-year participation requirement. Although his employing office didn't specifically inform him that FEHB coverage wouldn't continue after retirement, it did prepare a Notice of Change in Health Benefit Enrollment (SF 2810) terminating his enrollment at retirement.

Sara doesn't meet the 5-year participation requirement and retires under an early optional retirement authority.

Robert claims to be unaware of the 5-year 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 and Insurance Service, Office of Retirement Programs, Retirement Benefits Branch - Waiver Request, P.O. Box 14172, Washington, D.C. 20044-4172.

Previous Waiver Policies
Waiver Policy for Retirements on and after March 30, 1994

Public Law 103-226, the Federal Workforce Restructuring Act of 1994 (FWRA), authorized certain Federal agencies to offer voluntary separation incentive payments (VSIPs) or buyouts to their employees who retired during the period from March 30, 1994, to March 31, 1995. Congress instructed OPM to consider the widespread use of early voluntary retirement authorizations and VSIPs as exceptional circumstances that warrant the use of its waiver authority.

OPM granted a waiver to any Executive agency employee who received a VSIP during this time period (or if the employing office retained the employee due to its need, not later than March 31, 1997). During the same period, OPM also granted waivers to any employee authorized a buyout by similar legislation (such as the Department of Defense program) for the period beginning March 30, 1994 and ending at the termination of the buyout period applicable to the agency. *To be eligible for a pre-approved waiver, you must have been enrolled in FEHB as of March 30, 1994.*

During the same period, OPM also granted a waiver if you:

- Took early optional retirement as a result of early-out authority in your agency, or

- Took 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.

Waiver Policy for Retirements On and After October 1, 1996

OPM revised the waiver policy on October 1, 1996 to cover VSIPs authorized by Public Law 104-208. Under the revised policy, OPM granted a pre-approved waiver to any Executive agency employee who *separated for retirement on or after October 1, 1996, who was covered under the FEHB Program on and after October 1, 1996, and who:*

- received a voluntary incentive payment under P.L. 104-208; or
- during the statutory buyout period (October 1, 1996, through December 30, 1997), took early optional retirement as a result of early out authority in the agency; or>
- during the statutory buyout period (October 1, 1996, through December 30, 1997), took 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.

To the extent that these statutes allowed a postponement of your departure, if you separated after the statutory buyout period and received a buyout, you were eligible for a waiver under this policy. If you separated after the statutory buyout period and didn't receive a buyout, you weren't eligible for a waiver under this policy.

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.

EMPLOYING OFFICE PROCEDURES Continued
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.

SURVIVOR ANNUITANTS Continued

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

- Change in Family Status Due to Acquisition of an Eligible Child
- Restoration of Survivor Annuity
- Spouse
- Child

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

- Restoration of Compensation Payments

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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Military Service

ENTRY INTO 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 18 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 6 months of the 18-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 18-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 18-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 6 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 18 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.

Family Members

FAMILY MEMBERS ELIGIBLE FOR 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 unmarried dependent children under age 22, including legally adopted children and recognized natural (born out of wedlock) children who meet certain dependency requirements. Your stepchildren and foster children are included 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. 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.

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.

Dependency Requirement

Your child must be financially dependent upon you to qualify as an eligible family member. Your child is automatically considered to be financially dependent upon you if the child is:

- your legitimate child;
- your adopted child;
- your stepchild, foster child, or recognized natural child who lives with you in a regular parent-child relationship; or
- your recognized natural child for whom a judicial determination of support has been obtained or to whose support you make regular and substantial contributions.

If you submit proof to your employing office that you don't live with or contribute to the support of your child, then the child is not considered an eligible family member. If the child is an eligible employee, he/she may enroll in the Program in his/her own right.

Proof of Recognized Natural Child's Dependency

If you want to provide coverage for a recognized natural child who doesn't live with you in a regular parent-child relationship and isn't protected by a court determination of support, you must establish dependency by submitting proof of your regular and substantial support of the recognized natural child to your employing office. Your employing office will determine whether financial dependency has been established.

The following are some examples of proof of dependency (more than one of these may be required):

- evidence of eligibility as a dependent child under other State or Federal programs;
- proof that you included the child as a dependent on previous tax returns;
- canceled checks, money orders, or receipts for periodic payments made by you for or on behalf of the child;
- evidence of goods or services that show you made regular or substantial contributions; or
- any other significant proof of support or of paternity.

When Your Child's Marriage Ends

If your married child under age 22 or over age 22 and incapable of self-support becomes divorced or widowed, he/she may again be covered under your self and family enrollment as an eligible family member.

If your child's marriage is annulled and he/she is under age 22, his/her family member status is restored. In the case of a voidable marriage (one that was legal when performed but was annulled; e.g., for fraud or lack of consummation), coverage is made retroactive to the effective date of the annulment decree. If the marriage was void initially (ab initio - it was illegal from the beginning ; e.g., one of the partners was already married), coverage is made retroactive to the date of the marriage so that there is no break in family member status.

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 legitimate or adopted child, or child born out of wedlock is considered to be your stepchild. However, your spouse's stepchild (by a previous marriage) is not your stepchild.

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 unmarried and under age 22 (if the child is over age 22, he/she must be incapable of self-support);
- the child must live with you;
- the parent-child relationship must be with you, not the child's biological parent;
- you must 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 sign a certification stating that your foster child meets all the requirements and that you will notify your employing office if the child marries, moves out of the home, or stops being financially dependent on you.

Sample Statement

You may use the following pattern statement 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.

CERTIFICATION FOR FOSTER CHILDREN

I have been informed of the following requirements for coverage of a foster child under the Federal Employees Health Benefits Program and/or Option C of the Federal Employees' Group Life Insurance Program:

1. The child must be unmarried and under age 22. (If the child is over age 22, he/she can only be covered if he/she is incapable of self-support because of a disabling condition that began before age 22. I must provide documentation of this to my employing office.)
2. The child must be living with me.
3. The parent-child relationship must be with me, not with the biological parent. This means that I am exercising parental authority, responsibility, and control; I am caring for, supporting, disciplining, and guiding the child; I am making the decisions about the child's education and health care.
4. I must be the primary source of financial support for the child.
5. I must expect to raise the child into adulthood.

I understand that if the child moves out of my home 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, or unless I obtain a court order taking parental responsibility away from the biological parent.

This is to certify that: (name of child) lives with me; I have a regular parent-child relationship with (name of child), as described above; I am the primary source of financial support for (name of child); and I intend to raise (name of child) into adulthood.

I will immediately notify both my employing office and the health benefits carrier if the child marries, moves out of my home, or ceases to be financially dependent on me.

(Print name of employee/annuitant) (Social Security Number)

(Signature of employee/annuitant) (Date)

FAMILY MEMBERS ELIGIBLE FOR COVERAGE (Continued)

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 marries, reaches age 22, becomes capable of self-support if age 22 or over, or is no longer living with and financially dependent on 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 stepchild or 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 stepchild or 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.

CHANGE IN FAMILY STATUS

- Election Opportunities
- Events Considered to be Changes 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 22 or the acquisition of a foster child under age 22;
- your child under age 22 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

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 standard option of the Blue Cross and Blue Shield Service Benefit Plan (enrollment code 105).

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 Blue Cross and Blue Shield Standard Option.

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 I Don'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 standard option of the Blue Cross and Blue Shield Service Benefit Plan (enrollment code 105).

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 Blue Cross and Blue Shield Standard Option.

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 Blue Cross and Blue Shield Standard Option.

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 H, 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 I am 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, 2000, 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, 2000 (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, 2000, Chester's employing office completes an SF 2809 enrolling him for self and family coverage in the Blue Cross and Blue Shield standard option. The effective date would be December 17, 2000 (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 2 on the SF 2809 blank. The health plan will obtain the information from the custodial parent.

What Happens If I Go into a Nonpay Status or My 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 My Employing Office Enrolls Me, Can I Later Make Enrollment Changes?

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 I 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 I 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 22.

If the court/administrative order states that coverage must continue until a specific age--and that age is over age 22--the coverage must continue until the last child reaches age 22. Unless they meet the requirements for being incapable of self support, children cannot continue FEHB coverage beyond age 22, 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 22--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 during the next open season after the last 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 I 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 coverage,
- change to self only, or
- change to an HMO that doesn't provide full benefits where the children live.

What If My Employing Office Gets More Than One Court/Administrative Order for Me?

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 Blue Cross and Blue Shield standard option. It will attach copies of all court/administrative orders to the SF 2809.

CHANGES THAT DO NOT AFFECT ENROLLMENT

- Family Members
- Name Changes

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 22 or marries, 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 22, unless he/she is incapable of self support;
- Your child marries; or
- Your stepchild or foster child stops living with you in a regular parent-child relationship.

CHILD INCAPABLE OF SELF SUPPORT

- Coverage
- Requirements
- Financial Dependency
- Determination of Incapacity for Self-Support
- When Employing Office Must Make Determination
- When Carrier May Approve Coverage
- Medical Certificate
- When to Submit Certificate
- Use of Physicians
- Duration and Approval of Incapacity for Self Support
- Renewal of Medical Certificate

- Late Certificates

Coverage

Your self and family enrollment covers your unmarried dependent child age 22 or over who is incapable of self-support because of a physical or mental disability that existed before the child reached age 22.

Requirements

Your child age 22 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 22 that doesn't result in incapability for self-support until age 22 or after doesn't qualify a child for continued coverage as a family member.

Financial Dependency

Your child incapable of self-support because of a mental or physical disability that existed before age 22 must also be dependent upon you to qualify for health benefits coverage. In addition, your stepchild or foster child incapable of self-support must live with you in a regular parent-child relationship to qualify.

Determination of Incapacity for Self-Support
When Employing Office Must Make Determination

Your employing office is responsible for determining whether your dependent child age 22 or over is incapable of self-support because of a mental or physical disability that began before age 22 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 22, you don't need to ask your employing office for approval of continued coverage after your child reaches age 22. 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.

CHILD INCAPABLE OF SELF-SUPPORT (Continued)

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 22, 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 22 and that can be expected to continue for more than one year. In addition, the certificate must include the following information:

- 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 or at any time in which your child is covered under your self and family enrollment, but no later than 60 days before your child reaches age 22.

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, before your child reaches age 22. 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, Retirement and Insurance Service, Office of Insurance Programs, 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). Your employing office must also confirm that your child meets the financial dependency requirement.

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 22 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 22, your employing office must determine whether the disability existed before age 22. 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 22.

Former Spouses

This section provides information for Federal employees and annuitants on FEHB benefits available under the Spouse Equity provisions of FEHB law. In this section:

- "you" means the Federal employee or annuitant; and
- "divorce" includes certain annulments.

INFORMATION FOR EMPLOYEES

SPOUSE EQUITY ACT

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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INFORMATION FOR FORMER SPOUSES (Continued)

ENROLLMENT (Continued)

- Type of Enrollment
- Where You Apply
- Application to Enroll
- Time Limit
- Deferred Enrollment
- Determination of Future Entitlement to Annuity
- Retirement System Addresses
- Determining Your Eligibility
- Employing Office Decision
- Enrollment Procedures
- Certification
- Sample Certification
- Health Benefits File
- Effective Date

Retirement System Addresses

Employee's 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	You must obtain that retirement system's certification of your eligibility to a portion of the employee's future annuity or a former spouse survivor annuity, and must submit the certificate to OPM when applying for eligibility to enroll.

Determining Your Eligibility

When you apply for eligibility to enroll under the spouse equity provisions, the employing office must first verify that the employee was employed by the agency at the time of your divorce. If the employee separates from Federal service before becoming eligible for an immediate annuity, you are eligible to enroll only if your marriage ended before he/she left Federal service.

The employing office must then determine if you are eligible to enroll. To be eligible, you must meet all of the following requirements:

- You must not have remarried before age 55;
- You must have been covered as a family member in an FEHB plan at least one day during the 18 months before your marriage ended;
- You must provide documentation from OPM (or the CIA or Foreign Service retirement system, if applicable) of entitlement to a portion of the employee's future annuity, or a former spouse survivor annuity.

If the employee worked for the CIA, you could qualify to enroll based on his/her CIA employment, if you were married for at least 10 years during his/her 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 the employee worked for the Foreign Service, you could also qualify to enroll based on his/her Foreign Service employment if you were married for at least 10 years during his/her Government service, and your marriage ended before May 7, 1985.

Employing Office Decision

If you are eligible for health benefits coverage, the employing office will send written confirmation of its decision to you and give you a premium payment schedule and a certification for you to sign and date stating the requirements for continued enrollment.

If you are not eligible for health benefits coverage, the employing office will notify you in writing and give the reason for the denial. It will also explain that you have a right to request that the employing office reconsider its decision.

Enrollment Procedures

If you didn't submit a Health Benefits Election Form (SF 2809) or other enrollment request as your application to enroll, you must complete one to enroll. You must put your own name, date of birth, and Social Security number on Part A of the SF 2809. The employee, former employee, or annuitant's name and date of birth must be entered in the Remarks section.

Certification

When you elect health benefits coverage under the Spouse Equity provisions, you must certify that you will notify the employing office within 31 days of an event that would terminate your eligibility. The employing office keeps the original certification in your health benefits file and gives you a copy.

Sample Certification

The employing office will require that you sign and date the following certification:

"I understand that I must notify the office maintaining my enrollment within 31 days after the occurrence of any of the following events that would end my eligibility for enrollment in the Federal Employees Health Benefits Program:

(1) The court order ceases to provide my entitlement to a portion of a retirement annuity or a former spouse survivor annuity under a retirement system for Government employees.

(2) I remarry before age 55.

(3) The employee on whose service my benefits are based dies and no former spouse survivor annuity is payable.

(4) The separated employee on whose service my benefits are based dies before meeting the requirements for a deferred annuity.

(5) The employee on whose service my benefits are based leaves Federal service before establishing title to an immediate annuity or a deferred annuity.

(6) The retirement system pays a refund of retirement contributions to the separated employee on whose service my health benefits are based."

Signature *Date*

Health Benefits File

The employing office must establish and maintain a health benefits file for you, even when it has denied eligibility for coverage.

Effective Date

The effective date of your 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 you request 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.

Except as specified in this section, an enrollment change is effective on the first day of the first pay period beginning after the date the employing office receives the SF 2809.

OPPORTUNITIES TO ENROLL OR CHANGE ENROLLMENT

- Belated Enrollment
- Enrollment by Proxy
- Change to Self Only
- Open Season
- Change in Family Status
- Loss of Other FEHB Coverage or Coverage under Another Group Insurance Plan
- Move from an HMO's Service Area
- On Becoming Eligible for Medicare
- Annuity Insufficient to Pay Withholdings
- Former Spouses with Other FEHB Coverage
- When Both You and Your Former Spouse have FEHB Enrollments
- When You Lose Coverage as an Employee and Enroll as a Former Spouse
- When You are Covered as a Family Member and become Eligible as a Former Spouse
- Cancellation of a Former Spouse Enrollment

When the employing office determines that you are eligible, you may enroll at any time.

Belated Enrollment

When the employing office determines that you weren't able to enroll or change enrollment within the required time frame for reasons beyond your control, you may do so within 60 days after the employing office's determination.

Enrollment by Proxy

The employing office may permit your representative to enroll or change your enrollment 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. A change to a self only enrollment is effective on the first day of the first pay period beginning after the employing office receives the Health Benefits Election Form (SF 2809). At your written request and with proof that there was no family member eligible for coverage, the employing office may make the change retroactive to the first day of the pay period following the one in which there were no remaining eligible family members.

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. With a self and family enrollment, the only eligible family members are the natural or adopted children of you and the Federal employee or annuitant on whose service your coverage is based.

If you:

- suspended your spouse equity enrollment to enroll in a Medicare managed care plan or Medicaid (or a similar State-sponsored program of medical assistance for the needy); and
- later voluntarily disenroll,

you may reenroll under the spouse equity provisions during Open Season provided you:

- still qualify for a spouse equity enrollment; and
- you had informed the employing office of the other enrollment when you suspended the FEHB enrollment.

If you involuntarily lose this coverage, you can immediately reenroll.

An Open Season reenrollment or change in enrollment is effective on the first day of the first pay period beginning in January of the following year. When the employing office accepts a belated Open Season reenrollment or change in enrollment it takes effect on the date it normally would have been effective if it had been received on time.

Change in Family Status

You may change from self only to self and family, from one plan or option to another, or make any combination of these changes from 31 days before to 60 days after the birth or acquisition of a natural or adopted child of you and the Federal employee or annuitant on whose service your coverage is based. The change to self and family coverage is effective on the first day of the pay period in which the child is born or becomes an eligible family member.

Loss of Other FEHB Coverage or Coverage under Another Group Insurance Plan

You may change 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 child loses other FEHB coverage or coverage under another group health benefits plan. Unless stated otherwise, you must change the enrollment from 31 days before to 60 days after the loss of coverage.

Examples of loss of coverage include:

- 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 because membership in an employee organization sponsoring or underwriting an FEHB plan was terminated;
- Loss of coverage because an FEHB plan was discontinued in whole or in part. If the discontinuation is at the end of the contract year, you must change the enrollment during the Open Season, unless OPM sets a different time frame. If the discontinuation is at a time other than the end of the contract year, OPM will set the time and effective date for changing the enrollment. If the whole plan is discontinued and you don't change within the set time frame, you are considered to have canceled your enrollment. If only one option of a two-option plan is discontinued and you don't change within the set time frame, you are considered to be enrolled in the remaining plan option.
- Loss of coverage under the Medicaid program (or similar State-sponsored program of medical assistance for the needy);
- Loss of coverage under a non-Federal health plan.

OPPORTUNITIES TO ENROLL OR CHANGE ENROLLMENT (Continued)

- Belated Enrollment
- Enrollment by Proxy

Move from an HMO's Service Area

If you are enrolled in an HMO and move or become employed outside the plan's service area (or, if already outside this area, move or become employed further away) you may change the enrollment. If a covered family member moves outside the HMO's service area (or if already outside this area, moves further away), you may also change the enrollment. The enrollment change is effective on the first day of the pay period beginning after the employing office receives the Health Benefits Election Form (SF 2809) or other enrollment request.

On Becoming Eligible for Medicare

You may change enrollment from one plan or option to another at any time beginning 30 days before becoming eligible for Medicare coverage. An enrollment change based on becoming eligible for Medicare may be made only once.

Annuity Insufficient to Pay Withholdings

If you are receiving an annuity and it is insufficient to pay the premiums for your health plan, your retirement system will provide you with information on lower cost plans and will give you the opportunity to either:

- pay your premiums directly to the retirement system; or
- enroll in a plan with a premium less than your annuity.

If you elect to change to a lower-cost plan, the change is effective immediately upon your loss of coverage in the prior plan.

If you are enrolled in the high option of a two-option plan, and don't make one of the elections noted above, your enrollment will be changed to the standard option of the same plan (unless your annuity won't cover the cost of the standard option). If you are enrolled

in a one-option plan, and don't make one of the elections, your coverage will be terminated.

Former Spouses with Other FEHB Coverage

Once you have established eligibility for FEHB coverage, you may defer enrolling as a former spouse if you are already enrolled in FEHB.

When you lose regular coverage under FEHB, you may enroll as a former spouse from 31 days before to 60 days after the covering enrollment terminates, as long as you continue to meet the eligibility requirements. You may enroll in any available plan.

When Both You and Your Former Spouse Have FEHB Enrollments

If both you and your spouse have your own FEHB enrollments and become divorced, 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 its 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.

When You Lose Coverage as an Employee and Enroll as a Former Spouse

When your enrollment as an employee terminates, your current employing office must terminate your enrollment on the Notice of Change in Health Benefits Enrollment (SF 2810) and note the time limits for enrolling as a former spouse with other FEHB coverage. You then must notify the employing office responsible for your spouse equity enrollment of your intent to enroll as a former spouse. That employing office will verify that you are still eligible under spouse equity provisions, and if so, enroll you based on your submission of a Health Benefits Election Form (SF 2809). The employing office will also give you a certification to sign and date.

The employing office responsible for your spouse equity enrollment will note on the SF 2809 that you were previously covered as an employee and you are enrolling as a former spouse under the same Social Security number. Once your spouse equity coverage begins, you must pay both the employee and Government shares of the premium.

If the employing office determines that you are no longer eligible to enroll under spouse equity, it will deny your enrollment, explain your right to request reconsideration, and place a copy of your request for enrollment and its denial in your former spouse health benefits file.

When You are Covered as a Family Member and become Eligible as a Former Spouse

If you are covered as a family member under another person's FEHB enrollment when you are determined eligible for health benefits under spouse equity provisions, the employing office responsible for your spouse equity enrollment must note in your health benefits file that you are deferring the spouse equity enrollment until you lose coverage as a family member. When you lose the family member coverage and request enrollment, that employing office will process the spouse equity enrollment.

Cancellation of a Former Spouse Enrollment

You may cancel your spouse equity enrollment at any time. With one exception noted below, the cancellation is effective on the last day of the pay period in which the employing office receives the Health Benefits Election Form (SF 2809) cancelling the enrollment. You and your family members are not entitled to the 31-day extension of coverage and may not convert to an individual contract when the enrollment is canceled. You may not reenroll, unless you suspended your spouse equity enrollment to enroll in a Medicare managed care plan or Medicaid (or a similar State-sponsored program of medical assistance for the needy).

If you suspend your enrollment to enroll in a Medicare managed care plan, the suspension is effective on the day before coverage under the Medicare managed care plan takes effect. You must submit documentation of your new enrollment to the employing office from 31 days before to 31 days after the enrollment takes effect.

PREMIUM PAYMENTS

You must pay the employee and Government shares of the premium for every pay period during which you are enrolled. There is no Government contribution. The employing office will establish a premium payment schedule and is responsible for collecting the premiums.

When You Do Not Pay Your Premium

If the employing office doesn't receive a 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) after you receive the notice for your coverage to continue. The notice must state that if

you don't make payment within this time frame, you are considered to have voluntarily canceled the enrollment.

If you don't make further payments, the employing office processes a cancellation 60 days (90 days if you live overseas) after the date of the notice.

Your employing office's notice will ask if you have obtained other coverage as described below. It will explain in the notice that you may resume coverage under spouse equity provisions when this other coverage ends only if you inform the employing office of the other coverage now. It will place a copy of the notice and your response in your health benefits file.

You must inform the employing office if you obtain FEHB coverage as an employee or as a family member under another person's FEHB enrollment, or have coverage under a Medicare managed care plan or Medicaid (or a similar State-sponsored program of medical assistance for the needy). This notice will preserve your right to continue the spouse equity enrollment if you lose the other coverage.

Cancellation Because You Did Not Pay Premiums

If your coverage is canceled because you didn't pay premiums:

- you are not entitled to the 31-day extension of coverage;
- you can not convert to an individual contract;
- you can not enroll under temporary continuation of coverage; and
- you may not reenroll based on the same former spouse entitlement unless nonpayment was for reasons beyond your control.

If you were unable to make timely payment for reasons beyond your control, you may write to the employing office to ask that your coverage be reinstated. This request must be filed within 30 calendar days from the cancellation date and must provide proof that nonpayment was beyond your control. The employing office determines if you are eligible for reinstatement of coverage. If the employing office decides to allow reinstatement, it will be restored retroactively to the cancellation date upon receipt of the back premiums. If the employing office denies the reinstatement request, you may request that the employing office reconsider its initial decision.

TERMINATION OF A FORMER SPOUSE ENROLLMENT

- Belated Extension of Coverage
- Eligibility to Enroll under Temporary Continuation of Coverage
- Termination of Eligible Child's Coverage

Your spouse equity enrollment terminates, subject to the 31-day extension of coverage, at midnight of the last day of the pay period in which:

- A qualifying court order ceases to provide entitlement to a portion of a retirement annuity or a former spouse survivor annuity under a retirement system for Government employees;
- You remarry before age 55;
- You die;
- The employee on whose service your benefits are based dies and no survivor annuity is payable;
- The separated employee on whose service your benefits are based dies before meeting the requirements for a deferred annuity;
- The employee on whose service your benefits are based leaves Federal service before establishing title to an immediate annuity or a deferred annuity; or
- The retirement system pays a refund of retirement contributions to the separated employee on whose service your benefits are based.

The enrollments of certain former spouses of CIA and Foreign Service employees can only be terminated if you die or remarry before reaching age 55.

The employing office must give you a copy of the Notice of Change in Health Benefits Enrollment (SF 2810) terminating your enrollment as soon as possible. This will allow you to convert to individual coverage within the 31-day time limit. The employing office must also advise you that when your enrollment terminates, you cannot later reenroll under the Spouse Equity Act. If you were enrolled in an employee organization plan and the enrollment terminates because your membership in the sponsoring employee organization terminates, your employing office will allow you to change to another plan.

Belated Extension of Coverage

When you belatedly learn that your enrollment under spouse equity has terminated because:

- The employee on whose service your benefits were based separates from service with no future entitlement to annuity; or
- The separated employee on whose service your benefits were based dies before becoming eligible for a deferred annuity;

you are allowed an extension of coverage of 31 days after the employing office's notice that coverage has terminated, during which you may convert to individual coverage.

You must pay the full premium during the extended period, except for the 31-day period following the notice.

Eligibility to Enroll under Temporary Continuation of Coverage

You are eligible to enroll under temporary continuation of coverage (TCC) when your spouse equity enrollment terminates during the first 36 months after your divorce or annulment because:

- there is no longer a qualifying court order; or
- you remarry before reaching age 55.

Termination of Eligible Child's Coverage

An eligible child's coverage under your spouse equity enrollment terminates, subject to the 31-day extension of coverage and conversion rights, at midnight of:

- the day on which he/she is no longer an eligible family member: or
- the day your enrollment terminates.

The child is not eligible for temporary continuation of coverage (TCC) beyond the original 36-month period from the date of your divorce.

If you cancel your spouse equity enrollment, the child's enrollment also ends on the same date with no extension of coverage or conversion rights.

REENROLLMENT

When You are Enrolled as a Former Spouse and become a Federal Employee
You are Enrolled as a Former Spouse and become Covered as a Family Member
When Coverage under Medicare Managed Care Plan or Medicaid Ends

If you are enrolled under the spouse equity provisions and become covered under another FEHB enrollment (either as an employee or a family member), you may suspend the spouse equity enrollment while covered under the other enrollment. You may reenroll when the other FEHB coverage ends.

When You are Enrolled as a Former Spouse and become a Federal Employee

If you are enrolled as a former spouse and then become eligible to enroll as a Federal employee, you must notify the employing office responsible for your spouse equity enrollment that you are enrolling as a Federal employee. This employing office will terminate your spouse equity enrollment on the Notice of Change in Health Benefits Enrollment (SF 2810), and note in the Remarks section that you are entitled to enrollment as a former spouse. It will file the Official Personnel Folder copy of the SF 2810 in your former spouse file and note that your spouse equity enrollment is being suspended while you are covered as a Federal employee.

Your current employing office will enroll you on the Health Benefits Election Form (SF 2809). It must note in the Remarks section that you were previously covered as a former spouse and are now enrolling as an employee under the same Social Security number. When your health benefits coverage as an employee terminates, you and the employing offices involved should follow the procedures in "When You Lose Coverage as an Employee and Enroll as a Former Spouse."

When You are Enrolled as a Former Spouse and become Covered as a Family Member

If you are enrolled under the spouse equity provisions and become covered as a family member under another person's FEHB enrollment, the employing office responsible for the spouse equity enrollment will terminate it on the Notice of Change in Health Benefits Enrollment (SF 2810). It will note in the Remarks section that the enrollment is being terminated because you are covered as a family member under another FEHB enrollment, and give the enrollee's name, Social Security number, and the effective date of coverage. The spouse equity enrollment is suspended until you lose coverage as a family member. When you lose family member coverage and request reinstatement, the employing office that was previously responsible for the spouse equity enrollment will again be responsible for the enrollment.

When Coverage under Medicare Managed Care Plan or Medicaid Ends

If you postponed enrolling or suspended your spouse equity enrollment to enroll in a Medicare managed care plan or Medicaid (or a similar State-sponsored program of medical assistance for the needy), you may later reenroll under the spouse equity provisions if enrollment in the Medicare managed care plan or Medicaid ends and you still qualify for a spouse equity enrollment. You must have informed the employing office of your Medicare managed care plan or Medicaid enrollment when you postponed or suspended your spouse equity enrollment.

If your Medicare managed care plan or Medicaid enrollment ends involuntarily, you can immediately reenroll under the spouse equity provisions 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.

If you voluntarily disenroll from the Medicare managed care plan or Medicaid, you may reenroll under the spouse equity provisions during the following Open Season.

Information for Employing Offices

- SPOUSE EQUITY ACT
- ELIGIBILITY
- ENROLLMENT
- OPPORTUNITIES TO ENROLL OR CHANGE ENROLLMENT
- PREMIUM PAYMENTS
- RMINATION OF A FORMER SPOUSE ENROLLMENT
- REENROLLMENT

This section provides information for Federal employing offices on determining eligibility for and servicing of former spouses of Federal employees and annuitants under the Spouse Equity provisions of FEHB law. In this section:

- "you" means the employing office personnelist; and
- "divorce" includes certain annulments.

SPOUSE EQUITY ACT

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

A former spouse is eligible to enroll under spouse equity provisions if he/she:

- was divorced from a Federal employee or annuitant during employment or receipt of annuity;
- was covered as a family member under an FEHB enrollment at least one day during the 18 months before the marriage ended (Note: This requirement is also met when both spouses have FEHB enrollments);
- is entitled to a portion of the Federal employee's annuity or to a former spouse survivor annuity; and
- has not remarried before age 55.

Loss of Coverage as a Family Member

A former spouse loses coverage as a family member upon divorce, subject to a 31-day extension of coverage. However, 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, the former spouse has two options. He/she 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 the former spouse will seek coverage under spouse equity provisions, it is advisable for him/her to stay with the same plan.

If the former spouse act promptly, he/she may request retroactive enrollment once you have approved the application for enrollment under the spouse equity provisions. For enrollment to be retroactive, you must receive an appropriate request and satisfactory proof of eligibility from the former spouse within 60 days after the date of divorce.

ENROLLMENT

Enrolling under the spouse equity provisions is a three-step process. First, the former spouse must apply to enroll within the required time limit. Second, he/she must establish eligibility to enroll. Third, the actual enrollment can take place only after the first two steps have been completed.

Type of Enrollment

The former spouse may elect a self only or self and family enrollment. A self and family enrollment covers only the former spouse and any unmarried dependent natural or adopted children of the former spouse and the Federal employee or annuitant on whose service coverage is based.

Where Former Spouses Apply

If the marriage ends before the employee's retirement, the former spouse must apply and pay premiums to the employing office of the agency for which the employee worked when the marriage ended. If the application is approved, this will be the employing office until he/she begins receiving annuity payments, even if the employee transfers to another employing office.

The former spouse must apply and pay premiums to the retirement system responsible for his/her annuity payment if:

- he/she is receiving a portion of a retirement benefit or a former spouse survivor annuity;
- the divorce occurred after the employee's retirement; or

- the divorce occurred before May 7, 1985, and the employee or former employee worked for the Central Intelligence Agency (CIA) or the Foreign Service.

OPM is the employing office if the employee or former employee is receiving compensation from the Office of Workers' Compensation Programs (OWCP), and his/her health benefits enrollment had been transferred to OWCP before the marriage ended.

Application to Enroll

The 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. The former spouse's name, date of birth, and Social Security number is entered on Part A of the SF 2809. The employee, former employee, or annuitant's name and date of birth must be entered in the Remarks section.

If the former spouse has a mental or physical disability that prevents him/her from applying for benefits, a court appointed guardian may file the application.

Time Limit

The former spouse must apply to the employing office in writing by the latest of:

- 60 days after the 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 the employee's 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 eligibility to enroll based on entitlement to a former spouse annuity under another retirement system for Government employees.

If the former spouse does not apply to the employing office in person, use the postmark date on the application to determine if the time limit is met.

Deferred Enrollment

Once the 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 you receive an application for benefits, advise the former spouse that he/she must send a written request to the retirement system for a determination of entitlement to either:

- a portion of the employee's 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);
- the employee's name, date of birth, Social Security number, and last employing agency.

Unless the employee is 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. The former spouse can not enroll until OPM makes its determination.

OPM will send the former spouse a written decision. If the decision is favorable, he/she will submit the decision to you.

Retirement System Addresses

Employee's 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	The former spouse must obtain that retirement system's certification of eligibility to a portion of the employee's 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 the former spouse applies for eligibility to enroll under the spouse equity provisions, you must first verify that the employee was employed by your agency at the time of the divorce. If the employee separates from Federal service before becoming eligible for an immediate annuity, the former spouse is eligible to enroll only if the marriage ended before the employee left Federal service.

To be eligible to enroll, the former spouse 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 the 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 the employee's future annuity, or a former spouse survivor annuity.

If the employee worked for the CIA, the former spouse could qualify to enroll based on the employee's CIA employment, if they were married for at least 10 years during the employee's CIA service, at least 5 years of which both spouses spent outside the United States, and the marriage ended before May 7, 1985.

If the employee worked for the Foreign Service, the former spouse could also qualify to enroll based on the employee's Foreign Service employment if they were married for at least 10 years during the employee's Government service, and the marriage ended before May 7, 1985.

Employing Office Decision

If you determine that the former spouse is eligible for health benefits coverage, send the following to the former spouse:

- written confirmation of your decision;
- a premium payment schedule; and
- a certification stating the requirements for continued enrollment for the former spouse to sign and date.

If you determine that the former spouse is not eligible for health benefits coverage, send the former spouse a notification in writing and give the reason for the denial. Explain that he/she has a right to request reconsideration of your decision.

Enrollment Procedures

If the former spouse didn't submit a Health Benefits Election Form (SF 2809) or other enrollment request as an application to enroll, he/she must complete one to enroll. The former spouse's name, date of birth, and Social Security number is entered on Part A of the SF 2809. The employee, former employee, or annuitant's name and date of birth must be entered in the Remarks section.

Certification

When the former spouse elects health benefits coverage under the spouse equity provisions, the former spouse must certify that he/she will notify the employing office within 31 days of an event that would terminate his/her eligibility. You must keep the

original certification in the former spouse's health benefits file. The former spouse should keep a copy.

Sample Certification

The former spouse must sign and date the following certification:

"I understand that I must notify the office maintaining my enrollment within 31 days after the occurrence of any of the following events that would end my eligibility for enrollment in the Federal Employees Health Benefits Program:

(1) The court order ceases to provide my entitlement to a portion of a retirement annuity or a former spouse survivor annuity under a retirement system for Government employees.

(2) I remarry before age 55.

(3) The employee on whose service my benefits are based dies and no former spouse survivor annuity is payable.

(4) The separated employee on whose service my benefits are based dies before meeting the requirements for a deferred annuity.

(5) The employee on whose service my benefits are based leaves Federal service before establishing title to an immediate annuity or a deferred annuity.

(6) The retirement system pays a refund of retirement contributions to the separated employee on whose service my health benefits are based."

Signature *Date*

INFORMATION FOR EMPLOYING OFFICES (Continued)
ENROLLMENT (Continued)

Health Benefits File

You must establish and maintain a health benefits file for the former spouse, even when you have denied eligibility for coverage. The file must be set up in the former spouse's name and must be separate from the employee's Official Personnel Folder. The front cover of the file will show the name and date of birth of the employee on whose service the spouse equity benefits are based.

Disclosure of the contents of the health benefits file must be consistent with OPM regulations concerning access to the OPM/CENTRAL-1, Civil Service Retirement and Insurance Records, system of records under the Privacy Act of 1974 [5 CFR, part 297]. The System Manager for this system of records is: Associate Director of Retirement and Insurance, Office of Personnel Management, 1900 E Street, NW., Washington, DC 20415.

File Contents

You must keep the following documents in the former spouse's health benefits file:

Documentation that the former spouse applied in writing or in person (this may be a brief statement signed by the former spouse, with the receipt date noted by the employing office) within the 60-day time limit;

- A copy (provided by the former spouse) of the court order used by the retirement system to determine eligibility;
- A copy of the retirement system's written notification verifying that the court order is acceptable;
- the employing office's letter approving or denying eligibility for health benefits coverage along with the documents it used to make its decision;
- the Official Personnel Folder copies of the Health Benefits Election Form (SF 2809) or other enrollment request for enrollment documenting the former spouse's enrollment, enrollment changes, or cancellation;
- the former spouse's certification that he/she will notify the employing office within 31 days of an event that terminates eligibility;
- the notice of premium amount and payment schedule;
- the Official Personnel Folder copy of the Notice of Change in Health Benefits Enrollment (SF 2810) terminating the enrollment;
- the employing office's copy of the letter transferring the enrollment to the retirement system;

- Any other correspondence regarding eligibility or enrollment, such as a letter requesting payment of overdue premium prior to terminating coverage; documentation of a child's disability existing before age 22; a court order terminating entitlement to a portion of a retirement annuity or a former spouse survivor annuity; a letter from the former spouse canceling enrollment; or a retirement system notice that a refund has been paid to the former employee or that he/she has died and no survivor annuity is payable.

File Disposition

You must keep the former spouse's health benefits file for as long as you maintain his/her spouse equity enrollment. (If he/she becomes a Federal employee eligible for an employee enrollment, his/her employing office maintains the enrollment as an employee, and you will continue to maintain the inactive former spouse enrollment.)

If the former spouse did not qualify for coverage under the spouse equity provisions, you must keep the file containing the records for at least one year from the date of notice stating that he/she did not qualify. You may then either destroy the file contents or return it to the former spouse.

Transfer to Retirement System

You will transfer the former spouse's health benefits file to the appropriate retirement system when:

- the former spouse cancels the enrollment;
- you terminate his/her enrollment;
- he/she begins receiving an annuity payment (a portion of the employee's retirement annuity or a former spouse survivor annuity). At that time the retirement system begins to withhold premiums from the annuity check and becomes the former spouse's employing office.

You will send the former spouse's health benefits file to the applicable retirement system address shown below:

Retirement System	Address
Civil Service Retirement System	Office of Personnel Management, Retirement and Insurance Service, Office of Retirement Programs, P.O. Box 45, Boyers, PA 16017
Federal Employees Retirement System	Federal Employees Retirement System, P.O. Box 200, Boyers, PA 16017
Foreign Service Retirement and Disability System	Department of State, Retirement Division, Room 1251, Washington, DC 20520

CIA Retirement and Disability System	Central Intelligence Agency, P.O. Box 1925, Washington, DC 20505

Effective Date

The effective date of the former spouse's enrollment is the first day of the first pay period after you receive the Health Benefits Election Form (SF 2809) and you have approved eligibility.

If the former spouse requests immediate coverage, and you receive the Health Benefits Election Form (SF 2809) and satisfactory proof of eligibility within 60 days after the date of the divorce, you may make the enrollment effective on the same day that temporary continuation of coverage would otherwise take effect.

Except as specified in this section, an enrollment change is effective on the first day of the first pay period beginning after the date you receive the SF 2809.

OPPORTUNITIES TO ENROLL OR CHANGE ENROLLMENT

- Belated Enrollment
- Enrollment by Proxy
- Change to Self Only
- Open Season
- Change in Family Status
- Loss of Other FEHB Coverage or Coverage under Another Group Insurance Plan
- Move from an HMO's Service Area
- On Becoming Eligible for Medicare
- Annuity Insufficient to Pay Withholdings
- Former Spouses with Other FEHB Coverage
- When Both Spouses have FEHB Enrollments
- When an Employee Loses Coverage and Enrolls as a Former Spouse
- Eligibility under Spouse Equity while Covered as a Family Member
- Cancellation of a Former Spouse Enrollment

When you determine that the former spouse is eligible, he/she may enroll at any time.

Belated Enrollment

When you determine that the former spouse wasn't able to enroll or change enrollment within the required time frame for reasons beyond his/her control, you may permit the former spouse to do so within 60 days after your determination.

Enrollment by Proxy

The former spouse's representative may enroll or change enrollment for the former spouse with his/her written authorization.

Change to Self Only

The former spouse may change his/her enrollment from self and family to self only at any time. A change to a self only enrollment is effective on the first day of the first pay period beginning after you receive the Health Benefits Election Form (SF 2809). At the former spouse's written request and with proof that there was no family member eligible for coverage, you may make the change retroactive to the first day of the pay period following the one in which there were no remaining eligible family members.

Open Season

During Open Season, the former spouse may change enrollment from self only to self and family, from one plan or option to another, or make any combination of these changes. With a self and family enrollment, the only eligible family members are the natural or adopted children of the former spouse and the Federal employee or annuitant on whose service coverage is based.

If the former spouse:

- previously informed you that he/she suspended the spouse equity enrollment to enroll in a Medicare managed care plan or Medicaid (or a similar State-sponsored program of medical assistance for the needy); and
- later voluntarily disenrolls,

he/she may reenroll under the spouse equity provisions during Open Season provided he/she still qualifies for a spouse equity enrollment. (If the former spouse involuntarily loses the Medicare managed care plan or Medicaid coverage, he/she can immediately reenroll.)

An Open Season reenrollment or change in enrollment is effective on the first day of the first pay period beginning in January of the following year. When you accept a late Open Season reenrollment or change in enrollment it takes effect on the date it normally would have been effective if it had been received on time.

Change in Family Status

The former spouse may change from self only to self and family, from one plan or option to another, or make any combination of these changes from 31 days before to 60 days after the birth or acquisition of a natural or adopted child of the former spouse and the Federal employee or annuitant on whose service coverage is based. The change to self and family coverage is effective on the first day of the pay period in which the child is born or becomes an eligible family member.

Loss of Other FEHB Coverage or Coverage under Another Group Insurance Plan

The former spouse may change from self only to self and family, from one plan or option to another, or make any combination of these changes when the former spouse or an eligible child loses other FEHB coverage or coverage under another group health benefits plan. Unless stated otherwise, he/she must change the enrollment from 31 days before to 60 days after the loss of coverage.

Examples of loss of coverage include:

- 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 because membership in an employee organization sponsoring or underwriting an FEHB plan was terminated;
- Loss of coverage because an FEHB plan was discontinued in whole or in part. If the discontinuation is at the end of the contract year, he/she must change the enrollment during the Open Season, unless OPM sets a different time frame. If the discontinuation is at a time other than the end of the contract year, OPM will set the time and effective date for changing the enrollment. If the whole plan is discontinued and he/she doesn't change within the set time frame, he/she is considered to have canceled the enrollment. If only one option of a two-option plan is discontinued and he/she doesn't change within the set time frame, he/she is considered to be enrolled in the remaining plan option.
- Loss of coverage under the Medicaid program (or similar State-sponsored program of medical assistance for the needy);
- Loss of coverage under a non-Federal health plan.

Move from an HMO's Service Area

If the former spouse is enrolled in an HMO and moves or becomes employed outside the plan's service area (or, if already outside this area, moves or becomes employed further away) he/she may change the enrollment. If a covered family member moves outside the plan's service area (or if already outside this area, moves further away), the former spouse may also change the enrollment. The enrollment change is effective on the first day of the pay period beginning after you receive the Health Benefits Election Form (SF 2809) or other enrollment request.

On Becoming Eligible for Medicare

The former spouse may change enrollment from one plan or option to another at any time beginning 30 days before becoming eligible for Medicare coverage. An enrollment change based on becoming eligible for Medicare may be made only once.

Annuity Insufficient to Pay Withholdings

If the former spouse's employing office is a retirement system:

If the former spouse's annuity is insufficient to pay the premiums, you must provide him/her with information and give the former spouse to either:

- pay premiums directly to the retirement system; or
- enroll in a plan with a premium less than the annuity amount.

If the former spouse elects to change to a lower cost plan, make the change effective immediately upon loss of coverage in the prior plan.

If the former spouse is enrolled in the high option of a two-option plan and does not make one of the elections noted above, change the enrollment to the standard option of the same plan (unless the annuity won't cover the cost of the standard option). If the former spouse is enrolled in a one-option plan, and doesn't make one of the elections, terminate the enrollment.

Former Spouses with Other FEHB Coverage

Once the former spouse has established eligibility for FEHB coverage, he/she may defer enrolling under spouse equity provisions if he/she is already enrolled in FEHB.

When the former spouse loses regular coverage under FEHB, he/she may enroll under spouse equity provisions from 31 days before to 60 days after the covering enrollment terminates, as long as he/she continues to meet the eligibility requirements. The former spouse may enroll in any available plan.

When Both Spouses have FEHB Enrollments

If both spouses have their own FEHB enrollments and divorce, it is important for each to establish his/her eligibility for FEHB coverage under spouse equity provisions within the required time frame. In this way each can protect a future entitlement to FEHB coverage under spouse equity provisions if one loses his/her own FEHB coverage. Each spouse must apply to his/her former spouse's employing office for the determination, not his/her own employing office.

If you determine that a Federal employee is eligible for coverage under spouse equity provisions, advise the employee that he/she must provide a copy of your determination to his/her current employing office. The current employing office must note on his/her Individual Retirement Record that he/she is eligible for FEHB coverage under spouse equity provisions. You must maintain a health benefits file for the former spouse and note that he/she is deferring enrollment under spouse equity provisions until he/she loses enrollment as an employee.

When an Employee Loses Coverage and Enrolls as a Former Spouse

When the former spouse's enrollment as an employee terminates, the current employing office must terminate his/her enrollment on the Notice of Change in Health Benefits Enrollment (SF 2810) and note the time limits for enrolling as a former spouse with other FEHB coverage. The former spouse then must notify you of his/her intent to enroll under spouse equity provisions. If he/she is still eligible as a former spouse, accept the enrollment based on the submission of a Health Benefits Election Form (SF 2809). Give the former spouse a certification to sign and date and a premium payment schedule.

Note on the SF 2809 that the former spouse was previously covered as an employee and is now enrolling under the same Social Security number under spouse equity provisions. Once the spouse equity coverage begins, you must collect both the employee and Government shares of the premium from the former spouse.

If you determine that the former spouse is no longer eligible to enroll under spouse equity provisions, deny the enrollment, explain his/her right to request reconsideration, and place a copy of the request for enrollment and your denial in the former spouse's health benefits file.

INFORMATION FOR EMPLOYING OFFICES (Continued)
OPPORTUNITIES TO ENROLL OR CHANGE ENROLLMENT (Continued)

- Belated Enrollment
- Enrollment by Proxy
- Change to Self Only
- Open Season
- Change in Family Status
- Loss of Other FEHB Coverage or Coverage under Another Group Insurance Plan
- Move from an HMO's Service Area
- On Becoming Eligible for Medicare
- Annuity Insufficient to Pay Withholdings
- Former Spouses with Other FEHB Coverage
- When Both Spouses have FEHB Enrollments
- When an Employee Loses Coverage and Enrolls as a Former Spouse
- Eligibility under Spouse Equity while Covered as a Family Member
- Cancellation of a Former Spouse Enrollment

Eligibility under Spouse Equity while Covered as a Family Member

If you determine that a former spouse is eligible for health benefits under spouse equity while he/she is covered as a family member under another person's FEHB enrollment, you must note in the former spouse's health benefits file that he/she is deferring the spouse equity enrollment until he/she loses coverage as a family member. You will

process the spouse equity enrollment when he/she requests enrollment upon losing the family member coverage.

Cancellation of a Former Spouse Enrollment

The former spouse may cancel the spouse equity enrollment at any time and in the same manner as an employee. With one exception noted below, the cancellation is effective on the last day of the pay period in which you receive the Health Benefits Election Form (SF 2809) cancelling the enrollment. The former spouse and his/her family members are not entitled to the 31-day extension of coverage and may not convert to an individual contract when the enrollment is canceled. The former spouse may not reenroll, unless he/she suspended the spouse equity enrollment to enroll in a Medicare managed care plan or Medicaid (or a similar State-sponsored program of medical assistance for the needy).

If the former spouse suspends his/her enrollment to enroll in a Medicare managed care plan, the suspension is effective on the day before coverage under the Medicare managed care plan takes effect. The former spouse must submit documentation of his/her new enrollment to you from 31 days before to 31 days after the Medicare managed care plan enrollment takes effect.

PREMIUM PAYMENTS

You must collect the employee and Government shares of the premium from the former spouse for every pay period during which he/she is enrolled. There is no Government contribution. You must establish a premium payment schedule and you are responsible for collecting the premiums.

Employing Office Submission of Premiums

You submit premium payments collected from former spouses along with the regular health benefits payments to OPM.

When the Former Spouse Does Not Pay Premiums

If you don't receive a premium payment from the former spouse by the due date, you must notify the former spouse in writing that he/she must make payment within 15 days (45 days if residing overseas) after he/she receives the notice. The notice must state that if the former spouse doesn't make payment within this time frame, he/she is considered to have voluntarily canceled the enrollment.

If you don't receive any further payments, process a cancellation 60 days (90 days if residing overseas) after the date of the notice.

Your notice should ask if the former spouse has obtained other coverage as described below. Explain in the notice that he/she may resume coverage under spouse equity when this other coverage ends only if you receive information about the other coverage now. Place a copy of the notice and any response in the former spouse's health benefits file.

The former spouse must inform you if he/she obtains FEHB coverage as an employee or as a family member under another person's FEHB enrollment, or has coverage under a Medicare managed care plan or Medicaid (or a similar State-sponsored program of medical assistance for the needy). This notice will preserve his/her right to continue the spouse equity enrollment if he/she loses the other coverage.

Cancellation Because the Former Spouse Did Not Pay Premiums

If you cancel the former spouse's coverage because he/she didn't pay premiums, he/she:

- is not entitled to the 31-day extension of coverage;
- can not convert to an individual contract;
- can not enroll under temporary continuation of coverage; and
- can not reenroll based on the same former spouse entitlement unless nonpayment was for reasons beyond his/her control.

If the former spouse was unable to make timely payment for reasons beyond his/her control, he/she may ask that you reinstate the coverage. This request must be filed within 30 calendar days from the cancellation date and must provide proof that nonpayment was beyond the former spouse's control. If you decide to allow reinstatement, you may restore coverage retroactively to the cancellation date upon receipt of the back premiums. If you deny the reinstatement request, you must notify the former spouse in writing, give the reason for the denial, and explain that he/she has a right to request reconsideration of your decision.

Actions to Complete Cancellation

If the former spouse does not make payment within the required time frame, you must cancel the enrollment on the Health Benefits Election Form (SF 2809). In part G, which would normally show the former spouse's signature, enter "Canceled due to nonpayment of premium." Enter "N/A" in item 2 of part H and enter the effective date of the cancellation in item 3. The effective date of the cancellation is 60 days (90 days for enrollees residing overseas) after the date of the notice advising that continuation of coverage depends on premium payment within 15 days (45 days for enrollees residing overseas). If the former spouse never made a payment, enter the enrollment effective date and state in the Remarks section: "This cancellation voids the prior SF 2809 enrolling this individual in your plan on the date in item 3."

TERMINATION OF A FORMER SPOUSE ENROLLMENT

A spouse equity enrollment terminates, subject to the 31-day extension of coverage, at midnight of the last day of the pay period in which:

- A qualifying court order ceases to provide entitlement to a portion of a retirement annuity or a former spouse survivor annuity under a retirement system for Government employees;
- The former spouse remarries before age 55;
- The former spouse dies;
- The employee on whose service benefits are based dies and no survivor annuity is payable;
- The separated employee on whose service benefits are based dies before meeting the requirements for a deferred annuity;
- The employee on whose service benefits are based leaves Federal service before establishing title to an immediate annuity or a deferred annuity; or
- The retirement system pays a refund of retirement contributions to the separated employee on whose service benefits are based.

The enrollments of certain former spouses of CIA and Foreign Service employees can only be terminated if they die or remarry before reaching age 55.

Give the former spouse a copy of the Notice of Change in Health Benefits Enrollment (SF 2810) terminating the enrollment as soon as possible. This will allow the former spouse to convert to individual coverage within the 31-day time limit. Advise the former spouse that he/she cannot later reenroll under spouse equity provisions. If the former spouse was enrolled in an employee organization plan and the enrollment terminates because his/her membership in the sponsoring employee organization terminates, you must allow him/her to change to another plan.

Belated Extension of Coverage

When the former spouse belatedly learns that his/her enrollment under spouse equity has terminated because:

- The employee on whose service benefits were based separates from service with no future entitlement to annuity; or
- The separated employee on whose service benefits were based dies before becoming eligible for a deferred annuity;

the former spouse is allowed an extension of coverage of 31 days after your notice that coverage has terminated, during which he/she may convert to individual coverage.

The former spouse must pay the full premium during the extended period, except for the 31-day period following the notice.

Eligibility to Enroll under Temporary Continuation of Coverage

The former spouse is eligible to enroll under temporary continuation of coverage (TCC) when his/her spouse equity enrollment terminates during the first 36 months after the divorce or annulment because:

- there is no longer a qualifying court order; or
- he/she remarries before reaching age 55.

Termination of an Eligible Child's Coverage

An eligible child's coverage under a spouse equity enrollment terminates, subject to the 31-day extension of coverage and conversion rights, at midnight of:

- the day on which he/she is no longer an eligible family member; or
- the day the former spouse's enrollment terminates.

The child is not eligible for temporary continuation of coverage (TCC) beyond the original 36-month period from the date of the divorce.

If the former spouse cancels his/her spouse equity enrollment, the child's enrollment also ends on the same date with no extension of coverage or conversion rights.

REENROLLMENT

- When a Former Spouse becomes a Federal Employee
- When a Former Spouse Becomes Covered as a Family Member
- When Coverage under Medicare Managed Care Plan or Medicaid Ends
- Notice to Retirement System of Former Spouse Enrollment
- Retirement System Notice to Employing Office

If a former spouse enrolled under the spouse equity provisions becomes covered under another FEHB enrollment (either as an employee or a family member), he/she may suspend the spouse equity enrollment while covered under the other enrollment. The former spouse may reenroll when the other FEHB coverage ends.

When a Former Spouse becomes a Federal Employee

If a former spouse becomes eligible to enroll as a Federal employee, he/she must notify you that he/she is enrolling as a Federal employee. Terminate the spouse equity enrollment on the Notice of Change in Health Benefits Enrollment (SF 2810), and note in the Remarks section that the former spouse is entitled to enrollment under spouse equity.

File the Official Personnel Folder copy of the SF 2810 in the former spouse file and note that the spouse equity enrollment is being suspended while he/she is covered as a Federal employee.

The office where the former spouse is currently employed will enroll him/her on the Health Benefits Election Form (SF 2809). It must note in the Remarks section that he/she was previously covered as a former spouse and is now enrolling as an employee under the same Social Security number. When health benefits coverage as an employee terminates, both employing offices involved should follow the procedures in " When an Employee Loses Coverage and Enrolls as a Former Spouse."

When a Former Spouse Becomes Covered as a Family Member

If a former spouse enrolled under the spouse equity provisions becomes covered as a family member under another person's FEHB enrollment, terminate his/her enrollment on the Notice of Change in Health Benefits Enrollment (SF 2810). Note in the Remarks section that the enrollment is being terminated because the former spouse is covered as a family member under another FEHB enrollment, and give the enrollee's name, Social Security number, and the effective date of coverage. The spouse equity enrollment is suspended until he/she loses coverage as a family member. When he/she loses family member coverage and requests reinstatement, you will again be responsible for the enrollment.

When Coverage under Medicare Managed Care Plan or Medicaid Ends

If a former spouse postponed or suspended the spouse equity enrollment to enroll in a Medicare managed care plan or Medicaid (or a similar State-sponsored program of medical assistance for the needy), he/she may later reenroll under the spouse equity provisions if enrollment in the Medicare managed care plan or Medicaid ends. He/she must have informed you about the Medicare managed care plan or Medicaid enrollment when he/she postponed or suspended the spouse equity enrollment and must still qualify for the spouse equity enrollment.

If the Medicare managed care plan or Medicaid enrollment ends involuntarily, the former spouse can immediately reenroll under the spouse equity provisions in any available plan at any time from 31 days before to 60 days after 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.

If the former spouse voluntarily disenrolls from the Medicare managed care plan or Medicaid, he/she may reenroll under the spouse equity provisions during the following Open Season.

Notice to Retirement System of Former Spouse Enrollment

When the employee on whose service spouse equity benefits are based separates, transfers, or retires, you must document on his/her Individual Retirement Record (SF 2806 or 3100) that a spouse equity enrollment exists. Include on the employee's Individual Retirement Record the former spouse's name, date of birth, Social Security number, and the name and address of the office maintaining the health benefits file.

If the Individual Retirement Record has already been forwarded to the retirement system, use a retirement record supplement (such as the SF 2806-1 or SF 3101) to notify the retirement system of the spouse equity enrollment, cancellation, or termination of enrollment.

Retirement System Notice to Employing Office

If the employee's retirement record shows that a former spouse is eligible for health benefits coverage under spouse equity, the retirement system will notify you when a lump-sum benefit or annuity becomes payable.

If a refund is being paid to the former employee, and/or when no survivor annuity is payable to the former spouse, terminate the former spouse's enrollment and forward the health benefits file to the retirement system. The file must note the former employee's name and date of birth.

If any annuity benefit is payable to the former spouse, forward the health benefits file to the retirement system. Note the date through which premiums have been paid so the retirement system can know the effective date of the transfer of enrollment and when to begin withholding premiums.

APPENDICES

- Forms and Brochures
- Glossary
- Table of Permissible Changes in Enrollment for SF 2809
- Chapter 89 of title 5, United States Code
- Part 890 of title 5, Code of Federal Regulations

Forms and Brochures

- FEHB BROCHURES
- STOCKING FORMS AND BROCHURES
- SUBSTITUTE FORMS
- ELECTRONIC FORMS
- EMPLOYEE EXPRESS

FORMS AND BOOKLETS

Each employing office must keep a supply of the following FEHB forms on hand to meet anticipated needs:

Forms for employee use:

- Health Benefits Election Form (SF 2809)
- Notice of Change in Health Benefits Enrollment (SF 2810)
- Guide to Federal Employees Health Benefits Plans (FEHB Guide) (RI 70-1 for Federal Civilian employees; RI 70-2 for Postal employees; RI 70-5 for spouse equity and TCC eligibles; RI 70-8 for temporary employees eligible to enroll under 5 U.S.C. 8906a; or RI 70-10 for visually impaired employees). This Guide is updated yearly.
- Temporary Continuation of Coverage (TCC) under the Federal Employees Health Benefits Program (RI 79-27)

Forms for employing office use:

- Report of Withholdings and Contributions for Health Benefits, Life Insurance, and Retirement (Lockbox) (SF 2812-L)
- Supplemental Semiannual Headcount Report (OPM Form 1523)

FEHB BROCHURES

Enrollee Brochures

The carrier of your plan will send you its brochure before the beginning of each contract year.

Employing Office Brochures

Your employing office must keep a supply of FEHB Program carriers' plan brochures on hand for your reference.

Since the FEHB Guide does not contain a complete description of plan benefits, you need to review the plan brochures so you will have enough information to make an informed choice.

On the Web

The OPM Web Site (www.opm.gov/insure) has helpful information about the FEHB Program. You can download the FEHB Guide and plan brochures. The Web Site also has links to carrier web sites.

STOCKING FORMS AND BROCHURES

Distribution of the FEHB Guide and Reference Brochures

Before the annual open season begins, OPM arranges to have supplies of the FEHB Guide (RI 70-1, RI 70-5, RI 70-8, or RI 70-10, as applicable) shipped to agency-designated distribution points, except for RI 70-2, which is printed and distributed by the U.S. Postal Service. The quantities are based on information the agency provides to OPM.

Each fee-for-service plan distributes a supply of reference brochures to each agency's designated distribution point. This distribution point then ships the brochures to the installations it serves throughout the world.

Agency installations order HMO brochures directly from the HMOs, in a quantity determined in accordance with information provided by OPM. The plans then ship these brochures directly to the installation where they are available to you for reference.

Obtaining Forms

Employing offices obtain Standard Forms 2809 and 2810 directly from GSA supply centers, just as they do other OPM Standard Forms. Agencies do not need to maintain an internal procurement and distribution network for FEHB forms.

Agencies may reproduce Standard Forms 2812-L and OPM Form 1523.

RI 79-27 is available to agencies by ordering from OPM riders issued at least annually.

SUBSTITUTE FORMS

Policy

The General Services Administration (GSA) allows the use of PC-based, agency-generated substitute forms, and OPM will accept substitute health benefits forms that meet GSA and OPM requirements.

General Requirements

Substitute forms must meet the general requirements established by GSA (41 CFR Part 201-9 and Bulletin B-3, 12g *Electronic Generation of Standard and Optional Forms*, as amended) and the requirements specified here. Substitute forms must be approved by OPM prior to their use.

The electronic reproduction must be complete, containing all instructions and questions that appear on the current official form. The wording and punctuation of all items, instructions, and identifying information must match exactly. No data element may be added to or deleted from the form. The sequence and format for each item on the form must be reproduced to the highest degree possible. Each item must print on the page in approximately the same location. The approval form must include the vendor/agency name and the OPM approval expiration date at the bottom of each page.

Form-Specific Requirements

Automated forms should be generated with black ink on white paper that is 8.5" wide and 11" long.

- Health Benefits Election form (SF 2809); no special requirements.

- Notice of Change in Health Benefits Enrollment (SF 2810); the instructions to Copy 1 (the Enrollee copy) must be on the reverse of Copy 1 or attached to it.

Copies

Agencies may photocopy standard forms that have carbon copies to create the needed copies when the original and the copy are identical. The original form must have an original signature. Copies may have a photocopy of the signature.

Approval Procedure

Agencies that develop substitute forms packages must submit a complete printed set of the forms and a fully functional copy of the program to OPM prior to actual use of the forms. OPM will issue approvals for one-year periods to ensure that the forms remain current.

Send requests for approval to Retirement and Insurance Service, Forms Analysis and Design, Room 4H28, 1900 E Street, NW, Washington, DC 20415.

Agencies that have developed, or plan to develop, automated forms that are populated from internal automated systems, and/or can store input to a data base, should contact OPM for information on direct data transmission via disk, tape, telephone or the Internet. Agencies may submit their plans to the address shown above, by email to cbenson@opm.gov, or call (202) 606-0623.

If a form is revised during the year, OPM will notify the substitute forms developer of the revision and the deadline for revision of the program.

ELECTRONIC FORMS

Adobe Acrobat versions of most FEHB forms are available on OPM's website at www.opm.gov/forms/index.htm.

EMPLOYEE EXPRESS

Your employing office may allow you to make Open Season and other health benefits changes though "Employee Express" or another electronic method. Call your employing office for more information

Glossary

Select a letter:

A C D E F G H I L M O P Q R S T W

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 Handbook, 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.

Table of Permissible Changes in Enrollment for SF 2809

(Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time)

If you are a United States Postal Service employee, these rules may be different. Consult your employing office or information provided by your agency.

Download Adobe Acrobat PDF Version of This Table

Events That Permit Enrollment or Change		***Change Permitted***			***Time Limits***
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
1	**EMPLOYEE**				
1A	Initial opportunity to enroll.	Yes	N/A	N/A	Within 60 days after becoming eligible.
1B	Open Season.	Yes	Yes	Yes	As announced by OPM.
1C	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce.	Yes	Yes	Yes	From 31 days before through 60 days after event.
1D	Change in employment status; for example: • Reemployment after a break in	Yes	Yes	Yes	Within 60 days of employment status change.

	service of more than three days; • Return to pay status following loss of coverage due to expiration of 365 days of LWOP status or termination of coverage during LWOP; • Return to pay sufficient to make withholdings after termination of coverage during a period of insufficient pay; • Restoration to civilian position after serving in uniformed services; • Change from temporary appointment to appointment that entitles employee receipt of Government contribution; • Change to or from part-time career employment.				
1E	Separation from Federal employment when the employee or employee's spouse is pregnant.	Yes	Yes	Yes	Enrollment or change must occur during final pay period of employment.
1F	Transfer from a post of duty within the United States to a post of duty outside the United States,	Yes	Yes	Yes	From 31 days before leaving old post through 60 days after arriving

	or reverse.				at new post.
1G	Employee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to self only of the covering enrollment; • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
1H	Employee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
1I	Loss of coverage under a non-Federal group health	Yes	Yes	Yes	From 31 days before the

	plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee.				employee leaves the com-muting area through 180 days after arriving in the new commuting area.
1J	Employee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside the area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
1K	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
1L	Temporary employee completes one year of continuous service in accordance with 5 U.S.C. Section 8906a.	Yes	N/A	N/A	Within 60 days after becoming eligible.
1M	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Within 60 days after receiving notice from employing office.
3	**FORMER SPOUSE UNDER THE SPOUSE EQUITY PROVISIONS**				
3A	Initial opportunity to enroll, Former spouse must be eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence	Yes	N/A	N/A	Generally, must apply within 60 days after dissolution of marriage. However, if a retiring employee elects to provide a

	Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).				former spouse annuity or insurable interest annuity for the former spouse, the former spouse must apply within 60 days after OPM's notice of eligibility for FEHB. May enroll any time after employing office establishes eligibility.
3B	Open season.	No	Yes*	Yes	As announced by OPM.
* Former spouse may change to self and family only if family members are also eligible family members of the employee or annuitant.					
3C	Change in family status based on addition of family members who are also eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after change in family status.
3D	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program and who later was involuntarily disenrolled from the Medicare HMO, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.
3E	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare-sponsored	May Reenroll	N/A	N/A	During open season.

	Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program and who later voluntarily disenrolls from the Medicare-sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program.				
3F	Former spouse or eligible child loses FEHB coverage due to termination, cancellation, or change to self only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.
3G	Enrolled former spouse or eligible child loses coverage under another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see 3D and 3E); • Loss of coverage under a non-Federal health	N/A	Yes	Yes	From 31 days before through 60 days after loss of coverage.

	plan.				
3H	Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
3I	Former spouse or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
3J	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare.
3K	Former spouse's annuity is insufficient to make FEHB withholdings for plan in which enrolled.	No	No	Yes	Retirement System will advise former spouse of options.
4	**TEMPORARY CONTINUATION OF COVERAGE (TCC) FOR ELIGIBLE FORMER EMPLOYEES, FORMER SPOUSES, AND CHILDREN.**				
4A	Opportunity to enroll for continued coverage under TCC provisions: • Former employee • Former spouse • Child who ceases to qualify as a family member	Yes Yes Yes	Yes N/A N/A	Yes N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, which-ever is later.
4B	Open season:	No	Yes	Yes	As announced by

	• Former employee • Former spouse • Child who ceases to qualify as a family member	No No	Yes* Yes	Yes Yes	OPM.
* Former spouse may change to self and family only if family members are also eligible family members of the employee or annuitant.					
4C	Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after event.
4D	Change in family status of former spouse, based on addition of family members who are eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after event.
4E	Reenrollment of a former employee, former spouse, or child whose TCC enrollment was terminated because of other FEHB coverage and who loses the other FEHB coverage before the TCC period of eligibility (18 or 36 months) expires.	May Reenroll	N/A	N/A	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage.
4F	Enrollee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or	No	Yes	Yes	From 31 days before through 60 days after loss of coverage.

	change to self only of the covering enrollment (but see event 4E); • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan.				
4G	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
4H	Enrollee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
4I	On becoming eligible for Medicare.	N/A	No	Yes	At any time beginning on the

	(This change may be made only once a lifetime.)				30th day before becoming eligible for Medicare.

Chapter 89 of title 5, United States Code
Part 890 of title 5, Code of Federal Regulations