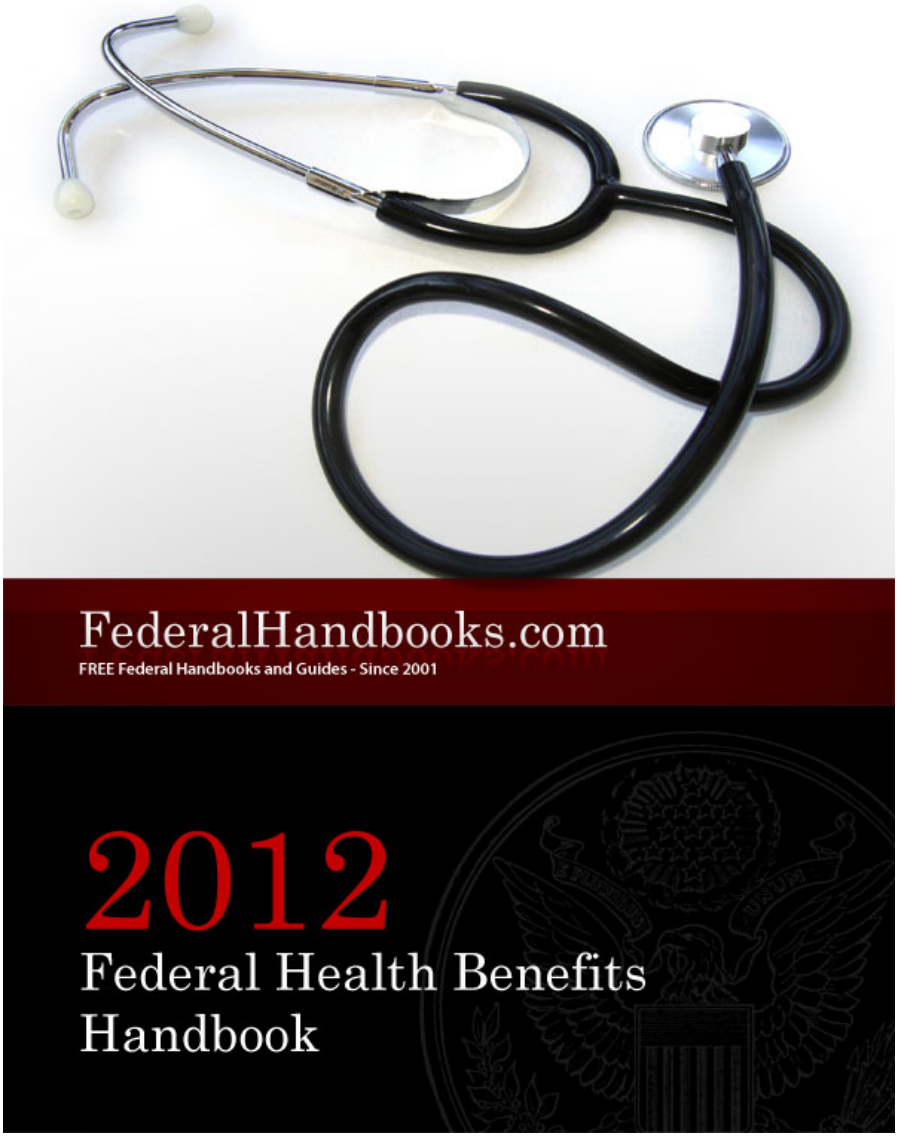

2012 Federal Health Benefits Handbook

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1

Overview

The Federal Employees Health Benefits (FEHB) Program is the largest employer-sponsored group health insurance program in the world, covering approximately 9 million people including employees, annuitants, and their family members, as well as some former spouses and former employees. The FEHB Program offers fee-for-service plans, and their Preferred Provider Organizations, or plans offering a Point of Service (POS) product, or Health Maintenance Organizations (HMOs) if you live (or sometimes if you work) within the area serviced by the plan. This chapter contains a basic overview of the FEHB program, including what the program offers, the cost of coverage, and premium conversion. Separate chapters cover topics such as eligibility, enrollment, finding a health plan, premium conversion, and the relationship between the FEHB Program and Medicare.

What the FEHB Program Offers

The FEHB Program offers:

- Group-rated premiums and benefits;
- A government contribution toward the cost of your plan;
- Your choice of plans and options;
- Annual enrollment opportunities (called Open Season);
- Guaranteed coverage that your plan can't cancel;
- No waiting periods, medical examinations or restrictions because of age or physical condition;
- Catastrophic protection against unusually large medical bills;
- Salary deduction for premiums;
- Temporary continuation of FEHB coverage or conversion to an individual contract after your enrollment or a family member's coverage ends;
- Continued group coverage into retirement or while you are receiving Workers' Compensation; and
- Continued group coverage for your family after you die.

Learning About Participating Health Plans

Before you enroll, your human resources office will give you a copy of the most current Guide to Federal Employees Health Benefits Plans. Use that to decide which health plans you are interested in, and request those plans' brochures from your human resources office. Read the brochures carefully to find out what each plan covers, its rules, its exclusions, and its limitations. Once you enroll, your health plan will send you an updated brochure every year that specifies changes for the upcoming year. If you want to continue your current enrollment, you don't have to do anything during Open Season. If your agency participates in Employee Express, you can make enrollment changes online during Open Season.

Cost of FEHB Coverage

You share the cost of your health benefits coverage with the government. Most full-time employees pay approximately 25% of the total premium. Premiums and the government contribution change yearly. If you are a part-time employee, your share of the premiums will be greater than for a full-time employee. Ask your human resources office for information about the cost of your enrollment. If you are a temporary employee, former spouse, or person enrolled under temporary continuation of coverage, the government does not contribute toward the cost of your enrollment. You must pay both the government and employee shares of the cost.

Premium Conversion

Premium conversion is a method of reducing your taxable income by the amount of your FEHB insurance premium. Section 125 of the Internal Revenue Code allows your employer to provide a portion of your salary in pre-tax benefits rather than in cash. The effect is that your taxable income is reduced. You save on:

- Federal income tax,

- Social Security tax,
- Medicare tax, and
- State and local income tax (in most States and localities).

Premium conversion has no effect on:

- statutory pay provisions,
- the General Schedule,
- the amount of your health insurance premium,
- the government contribution towards your FEHB premium, or
- your base pay for retirement, life insurance, or the Thrift Savings Plan.

You are automatically enrolled in premium conversion effective the first pay period on or after October 1, 2000, if you are an active employee of the Executive Branch of the federal government and you participate in the FEHB Program. If the Executive Branch does not employ you, or an Executive Branch agency does not issue your pay, you may participate in premium conversion if your employer offers it. The federal judiciary, the U.S. Postal Service, and some Executive Branch agencies with independent compensation-setting authority offer their own premium conversion plans.

You may only waive participation in premium conversion:

- At the initial premium conversion effective date;
- During an open season;
- When you are first hired or hired as a reemployed annuitant;
- When you leave federal service and are rehired in a different calendar year; or
- When you have a qualifying life event (whether or not you change your FEHB enrollment).

You can cancel your waiver and participate in premium conversion:

- When you have a qualifying life event; or
- During an open season.

Retirees and persons paying FEHB premiums directly (not by payroll deduction) are not eligible for premium conversion.

A qualifying life event includes:

- Addition of a dependent;
- Birth or adoption of a child;
- Changes in entitlement to Medicare or Medicaid for you, your spouse, or dependent;
- Change in work site;
- Change in your employment status or that of your spouse or dependent from either full-time to part-time, or the reverse;
- Death of your spouse or dependent;
- Divorce or annulment;
- Loss of a dependent;
- Marriage;
- Significant change in the health coverage of you or your spouse related to your spouse's employment;
- Start or end of an unpaid leave of absence by you or your spouse;
- Start or end of your spouse's employment.

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Eligibility

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

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

Temporary Employees

Eligibility to Enroll at Own Cost
If your position is excluded from coverage because your appointment is limited to one year or less, you will be eligible to enroll 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. There is an exception, however. 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.

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).

Office of Personnel Management; www.opm.gov
*Source

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Enrollment

Types of Enrollment

In the FEHBP, there are two types of enrollment available, self only and self and family enrollment.

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 or 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.

Opportunities to Enroll Or Change Enrollment

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

Changing Enrollment While Participating in Premium Conversion
You can change your enrollment even if you participate in premium conversion. There are two exceptions to this rule, though. 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 Non-appropriated Fund (NAF) employee who moves to Federal employment, you are eligible for coverage just as any other new employee, even if you have continued coverage under the NAF retirement system.

Change to Self Only

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

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

Example

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

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

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

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

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

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

Qualifying Life Events

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 a 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 yourself and family enrollment. To continue to provide health benefits coverage for your children, you must continue yourself and family enrollment. Upon a final divorce decree, your spouse is no longer an eligible family member and is not covered under your enrollment.

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

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

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

Return to Pay Status after 365 Days in Leave Without Pay 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,

then you may enroll for self only or self and family in any available plan or option when you return to pay status. If you were not enrolled at the time leave without pay status began, you may enroll upon return to pay status only if a qualifying event occurred while you were on leave without pay.

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

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

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

Your change in health benefits status is effective either:

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

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

Separating from Service

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

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

Although you can usually enroll for family coverage under temporary continuation of coverage (TCC) provisions, it does not become effective until the day after the 31-day extension of coverage. An enrollment election prior to separation will ensure that the baby's health care costs will be covered if he or 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 non-career 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 or 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 31st 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 an eligible temporary employee 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 yourself and family enrollment is 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 yourself 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 receives benefits under more than one plan, it is considered fraud and you are subject to disciplinary action.

Annual 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.

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.

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

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

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

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

If you do not have D.C. Government service prior to October 1, 1987, and you transfer to the D.C. Government, your enrollment is terminated because you are no longer an eligible employee. If you were first employed by the D.C.

Government on or after October 1, 1987, and you transfer to a Federal agency, you may enroll in the FEHB Program if you are otherwise eligible.

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

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

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

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

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

Restoration to Duty After Erroneous Removal Or Suspension

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

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

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

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

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

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

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, 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.

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Finding a Plan

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.

Descriptions of Plans

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. 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 on OPM's website at http://www.opm.gov. 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.

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.

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.

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Coordinating Benefits

If you or a covered family member is 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, those benefits will need to be "coordinated."

"Coordination of benefits" means that 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 the others pay 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. You must disclose information about the other source of benefits to your plan's Carrier.

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 Uniformed Services Facilities, DVA

The Uniformed Services Facilities and Department of Veterans Affairs (DVA) 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 Medicare

Medicare is generally for persons age 65 or over. It has four 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.
- Part C (Medicare Advantage) allows you to enroll in a Medicare Advantage plan to get your Medicare benefits. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries.
- Part D (Medicare Prescription Drug Coverage) is a monthly premium for Part D coverage. Most Federal employees do not need to enroll in the Medicare drug program, since all Federal Employees Health Benefits Program plans will have prescription drug benefits that are at least equal to the standard Medicare prescription drug coverage.

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 the 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 the 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 it 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.

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Cost

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, 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.

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 began in January 1999. This formula is known as the "Fair Share" formula because it maintains 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.

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.

Employee Contribution
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.

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.

Eligibility
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.

Be aware that under current law, annuitants and compensationers whose FEHB premiums are deducted from annuities and benefits are not eligible to participate in premium conversion. In addition, those enrolled through Temporary Continuation of Coverage and Spouse Equity are not eligible for premium conversion.

Premium conversion generally does apply to reemployed annuitants. If you are reemployed in a position that conveys FEHB eligibility, you may participate in premium conversion.

Enrolling

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.

You can choose not to participate in premium conversion by opting-out or waiving participation. To do this, you need to 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.

There are certain people who should not participate in premium conversion. 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.

Changing Premium Conversion Participation Status

You may change your premium conversion participation status, 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.

Be aware that premium conversion does not affect your other federal benefits. All Federal retirement, thrift savings and life insurance benefits are based on gross salary and are not affected by participation in premium conversion.

However, 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.

Premium Conversion and 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.

Premium Conversion and 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.

Premium Conversion and 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; and
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.

Making Withholdings and Contributions

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.

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.

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.

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. However, 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 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.

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Leave without Pay 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.

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.

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 premiums (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 Your Enrollment

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

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

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

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

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

- a lump sum payment of accrued leave;
- income tax refunds;
- amounts payable under the Civil Service Retirement System or Federal Employees Retirement System; or
- any other source normally available for the recovery of a debt due the United States.

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

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

The repayment of the amount owed will be treated on a pre-tax basis, if it's deducted from pay and you participate in premium conversion at the time the deduction is made. If you choose to repay the amount owed to your agency directly out-of-pocket your taxable income is not reduced.

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

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

IRS rules limit the amount you may prepay on a pre-tax basis. If your period of leave without pay will span two tax years, the amount that you may prepay on a pre-tax basis may not exceed the amount of FEHB premiums due for the remainder of the current tax year. If you wish to prepay the amounts due for the subsequent tax year as well, the

deductions must be made after-tax. You may use the "pay-as-you-go" or "catch-up" options for amounts due in the subsequent tax year.

Allowing Your Enrollment to Terminate

Your enrollment will terminate if you:

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

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

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

If you terminated your enrollment while your pay was insufficient, you may reenroll within 60 days after the end of the first pay period your pay becomes sufficient to cover the premium.

Your reenrollment takes effect the first day of the first pay period after your employing office receives your request to reenroll and that follows a pay period in which you were in pay status for any part of that pay period.

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

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

Special Circumstances

Student Trainees
If you are a student trainee with a career or career-conditional appointment, your enrollment continues during periods of leave without pay status as long as you are participating in the Student Career Experience Program. 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 Appointment
If you are a temporary employee enrolled for FEHB coverage, during periods of leave without pay status you must continue to pay both the employee and Government shares of the premiums.

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

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

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

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

FMLA leave usually runs concurrently with the 365 day period of coverage during leave without pay status allowed under the FEHB law. In these cases the regular rules for coverage during periods in leave without pay status apply. If you are granted leave under FMLA that exceeds the 365 days of continued coverage allowed under the FEHB law, you must pay your share of premiums directly to your employing office on a current basis during the period that exceeds 365 days. (This may happen if you have already used an extensive amount of leave without pay before you invoke your rights under FMLA).

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

Appointments to Employee Organizations

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

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

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

Your coverage will terminate if you do not pay your premiums within this time frame, subject to the 31-day extension of coverage and conversion right. Your coverage cannot resume until you enter in pay and duty status in Federal service. The exception is that 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 Govts or Institutions of Higher Education, Indian Tribal Govt, 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, 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. The exception is that 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. 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. The exception is that 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.

If You Pay Your FEHB Premiums Over Less Than 12 Months

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

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Termination, Conversion & Temporary Continuation of Coverage

Cancellation

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

- During the annual Open Season; or
- Within 60 days after you have a qualifying life event.

Your cancellation must be consistent with, and correspond to, your qualifying life event.

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.

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.

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

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

Termination

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

- the last day of the pay period in which you separate from service (unless you transfer, retire, or begin receiving Workers' Compensation benefits);
- the last day of the pay period in which you separate after you meet the requirements for an immediate annuity under the FERS MRA+10 provision and you postpone receipt of your annuity;
- the last day of the pay period in which you change to a position that is excluded from coverage;
- the last day of the pay period in which you die, unless you have a family member eligible to continue enrollment as a survivor annuitant;
- the last day of the pay period that includes the 365th day of continuous leave without pay status or the last day of leave under the Family and Medical Leave Act, whichever is later;
- the last day of the last pay period in pay status, if you haven't had 4 consecutive months of pay status after you exhausted the 365 days continuation of coverage in leave without pay status;

- the day you are separated, furloughed, or placed on leave of absence to serve in the uniformed services for duty over 30 days, if you elect in writing to have your enrollment terminated;
- the date that is 24 months after the date of your separation, furlough, or leave of absence to serve in the uniformed services for duty over 30 days, or the date your entitlement to continued coverage ends, whichever is earlier;
- the day on which your temporary continuation of coverage (TCC) expires;
- the last day of the pay period for which withholding was made when you are a temporary employee 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 or she is no longer an eligible family member.

You cannot continue coverage for your spouse under yourself and family enrollment upon your divorce. He or she may be eligible for his or 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.

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. However, you are not entitled to convert to an individual policy if you voluntarily canceled your enrollment or your plan was discontinued.

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

Conversion for Family Members

If a family member loses coverage under your enrollment (including as a result of your change to self only), he or 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.

Remember, though, that 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 or 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 or 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 or 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 is an inpatient in a hospital on the 31st day of extended coverage.

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

Termination of Erroneous Enrollment

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

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

If Withholdings Were Not Made
If no premium withholdings and contributions were made before your erroneous enrollment is discovered, your employing office must void your enrollment. 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. The exception to this rule is that 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.

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

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.

Your child is eligible for temporary continuation of coverage when he or 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 or 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 or her disability, or becomes self-supporting;
- Loses FEHB coverage upon the death of an employee or annuitant because he or she does not qualify for a survivor annuity;
- Loses FEHB coverage because his or her survivor annuity as a dependent of the deceased stops (for any reason, including because he or she is no longer a full-time student).

Your former spouse is eligible for temporary continuation of coverage when he or 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 or 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 or she qualifies as a foster child. For your child to enroll through TCC and cover his or her child, you must prove that he or she is no longer a dependent.

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 or 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 or 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.

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 or her rights. The notice must request a certified copy of the divorce decree or other document showing the date of the divorce or annulment. If he or she wants to elect TCC, he or 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.

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 is given the notice directly by your employing office, it will require that you acknowledge receipt by signing a copy of the notice.

Time Limits for Electing Temporary Continuation of Coverage

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

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

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

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

- 60 days after the date of your divorce or annulment, if you or your former spouse did not notify your employing office within the required 60-day notification period (even if someone else provided notification); or
- 65 days after the date of your employing office's notice, if you or your former spouse notified your employing office within the required 60-day notification period; or
- 60 days after the date he or 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 does not notify your employing office within the 60-day period, your former spouse's opportunity to elect TCC ends 60 days after the divorce or annulment.

Guardian May File

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

Late Election

Your employing office may allow a late temporary continuation of coverage (TCC) election if it determines that you or your family member was 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 or 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 or she stops living with you. The stepchild then becomes eligible to enroll under TCC because he or 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.

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 or 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 or her coverage to an individual contract until the TCC enrollment can begin.

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

Length of Temporary Continuation of Coverage

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

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.

Office of Personnel Management – Termination, Conversion and Temporary Continuation of Coverage
*source

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

Separating Employee

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

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

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

Child or Former Spouse

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

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

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

Premium Payments

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

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

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

Unlike most enrollments, the beginning and ending dates of TCC enrollments are not always the same as the beginning and ending date of a pay period. In this case, your servicing employing office must prorate the premium charge. It must determine a daily premium rate by multiplying the monthly premium rate (including the administrative charge) by 12 and dividing the result by 365.

Nonpayment of Premiums

If your servicing employing office does not receive your premium payment by the due date, it must notify you in writing that you must make payment within 15 days (45 days if you live overseas) for your coverage to continue. If

you don't make payment within this time frame, you are considered to have voluntarily canceled your enrollment effective with the last day that you paid your premiums. If you don't make any payments within 60 days (90 days if you live overseas) after the date of the notice, your enrollment ends, effective with the end of the last pay period that you paid your premiums.

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

Effective Date of Enrollment Change

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

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

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

Opportunities to Change Your TCC Enrollment

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

Change to Self Only

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

Open Season

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

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

Change in Family Status

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

If you are an enrolled former spouse, you may change your enrollment from self only to self and family, from one plan or option to another, or make any combination of these changes within the period beginning 31 days before and ending

60 days after the birth or acquisition of a child of both you and the employee or annuitant on whose service your coverage was based.

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

Reenrollment Under TCC

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

Loss of FEHB Coverage or Coverage under Another Group Insurance Plan

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

- loss of coverage under another FEHB enrollment because the covering enrollment was terminated, canceled, or changed to self only
- loss of coverage under another Federally-sponsored health benefits program
- loss of coverage under the Medicaid program or a similar State-sponsored program of medical assistance for the needy
- loss of coverage under a non-Federal health plan
- loss of coverage because of termination of membership in an employee organization sponsoring or underwriting an FEHB plan
- loss of coverage because the FEHB plan is discontinued.

Move from an HMO's Service Area

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

You Become Eligible for Medicare

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

Termination of TCC Enrollment or Coverage

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

Your family member's coverage ends when your enrollment ends or when he or 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 or 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 who loses coverage is also eligible for TCC in his or 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.

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.

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 or 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.

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.

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.

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Annuitants and Compensationers

Eligibility for Health Benefits after Retirement

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

- 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).

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

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

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

Service
For purposes of continuing FEHB coverage into retirement, "service" means time in a position in which you were eligible to be enrolled. You are not required to have been an enrollee continuously, but you must have been continuously covered by an FEHB enrollment. This includes: time you are covered as a family member under another person's FEHB enrollment; time you are covered under the Uniformed Services Health Benefits Program (also known as TRICARE or CHAMPUS) as long as you were covered under an FEHB enrollment at the time of your retirement. (You must enroll in FEHB within 60 days after you lose coverage under the Uniformed Services Health Benefits Program for that time to be considered as part of continuous FEHB coverage.) Coverage under Medicare does not count in determining continuous coverage. Service as a Non-appropriated Fund employee does not count in determining continuous coverage since it is not Federal service and not subject to FEHB coverage.

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

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

Service with an International Organization
If you transfer to an International Organization and elect to continue FEHB coverage, the service with the International Organization is included in determining whether the 5 years of service requirement is met. If you don't elect to

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

Eligibility as a Temporary Employee

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

Eligibility Under Temporary Continuation of Coverage

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

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

OPM has 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.)

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:

1) 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.)

2) 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.

3) 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" below for exceptions).

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

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

2) 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.

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

4) 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 Benefits Branch, 1900 E Street, NW, Washington, D.C. 20415-3532.

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.

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.

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 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 or 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 or 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,

then 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,

then 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.)

Participating in Premium Conversion
Reemployed annuitants can participate in premium conversion. 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,

then 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 or 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 or her options and take whatever actions are requested.

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,

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

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

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

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

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

Deferred Annuity

Since you generally are not eligible for FEHB coverage when you are receiving a deferred annuity, your surviving spouse is not eligible for FEHB coverage as a survivor annuitant even if he or she had FEHB coverage as an employee. If he or 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 or her survivor annuity begins.

Opportunities for Survivor Annuitants to Change Enrollment

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

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

Restoration of Survivor Annuity

Spouse
If your surviving spouse's:

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

then he or 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 or 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 or 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 or her enrollment request and documentation of the end of the marriage.

Child
If your surviving child's:

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

then he or 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 or her enrollment request; or
- the date the survivor annuity is restored.

Compensationers

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

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

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

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

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

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

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

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

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

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.

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. 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.

Office of Personnel Management; http://www.opm.gov
*source

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,

then 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 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.

Office of Personnel Management; http://www.opm.gov
*source

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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 24 months. Or, you may elect to terminate your enrollment, effective 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 that you ended the enrollment.

If you keep your FEHB enrollment during military service, you may continue your enrollment for up to 12 months while you are on military duty. You are responsible for the enrollee share of the premium during this period, just like any other employee in leave without pay status. Current Federal law extends the 12-month period an additional 12 months. During this additional period, you must pay both the employee and the Government shares of the premium, plus an additional 2 percent of the total premium, on a current basis.

Your employing office may waive the requirement that you pay your share of FEHB premiums during all or any part of the 24-month period. If your employing office waives the premium, it must remit the full premium (employee and agency share) to OPM on a current basis.

Office of Personnel Management; http://www.opm.gov
*source

If You Are Separated
If you are separated to enter on active military service, you are considered to be on military furlough (in leave without pay status) for the 24-month period if you continue to be eligible for reemployment rights under 5 CFR Part 353 or similar authority. You are entitled to continued coverage for up to 12 months in leave without pay status whether or not your eligibility for reemployment rights continues. To be entitled to the additional 12 months of coverage, you must continue to be eligible for reemployment rights.

Office of Personnel Management; http://www.opm.gov
*source

Notice Required
If you enter military service for more than 30 days, your employing office must give you a notice explaining that your enrollment may continue for up to 24 months and that you are responsible for the employee share of the premiums for the first 12 months and for 102 percent of the premium afterwards. It must also explain that you must notify your employing office in writing if you decide to terminate your enrollment for the period of your military service.

Termination
If you elect to terminate your enrollment, it must be terminated effective on the day you are separated, furloughed, or placed on leave of absence for entering military service. This applies even if part of your military service is covered by

paid leave immediately followed by furlough or other leave without pay. You and your covered family members are entitled to a 31-day extension of coverage and to convert to an individual contract.

Return from Military Service After Enrollment Termination

Not in Exercise of Reemployment Rights
If you return from military duty after your enrollment terminated, but not in the exercise of reemployment rights, you must (if eligible for coverage) elect to enroll within 60 days after returning to civilian duty, the same as a new employee. You may elect to enroll for self only or for self and family in either option of any plan available.

In Exercise of Reemployment Rights
If you exercise reemployment rights upon returning 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.

Your reinstated 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.

Transitional Healthcare Benefits
If you exercise reemployment rights upon returning from military duty, you may be eligible to waive reinstatement of your terminated FEHB enrollment and keep your military health coverage (TRICARE) for 180 days after you are demobilized.

Former active duty and Reserve Component members who are eligible for transitional benefits include:

- Members involuntarily separating from active duty under honorable conditions and their eligible family members
- Reserve Component members separated from active duty after being called up or ordered in support of a contingency operation for an active duty period of more than 30 days and their family members.
- Members separated from active duty after being involuntary retained in support of a contingency operation and their family members
- Members separated from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation and their family members

Employees may ask their agencies to postpone reinstatement of their FEHB coverage from the day they are restored to their civilian positions until the day after their transitional TRICARE coverage ends, or any date within this timeframe.

Office of Personnel Management; http://www.opm.gov
*source

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,

then 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.

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Family Members

Family Members Eligible 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 or 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 or she may enroll in the Program in his or 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 or 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 or she is under age 22, his or 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 or 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

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 or 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 or 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.

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 or 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 or 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
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 Coverage For 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.

Changes Not Affecting Enrollment

Family Members
You don't need to report to your employing office any change in the number of family members that doesn't affect your health benefits enrollment. However, the carrier of your plan may request this information, including evidence of family relationship.

Your enrollment is not affected when:

- your child is born when you already have a self and family enrollment;
- your spouse dies or you divorce and you have children still covered under your self and family enrollment;
- your child reaches age 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. 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.)

Loss of Family Member Status

When a family member loses coverage because he or she is no longer an eligible family member, he or 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 or 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
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 or her physical or mental disability is expected to continue for at least one year and, because of the disability, he or 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
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 or she is certified by a state or federal rehabilitation agency as unemployable;
- he or 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 or 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 or 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 or she is incapable of self-support.

When Carrier May Approve Coverage
If your child has a medical condition listed, and he or 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.

List of Medical Conditions Causing Child To Be Incapable of Self-Support

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

Note that 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 or 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 or 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.

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Former Spouses

Spouse Equity Act

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 or 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 or she is entitled to a portion of your annuity or to a former spouse survivor annuity; and
- he or 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 or 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 or 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 or 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 or 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 or 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. 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.

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Office of Personnel Management; http://www.opm.gov
*source

Time Limit

Your former spouse must apply to his or 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 or her eligibility to enroll based on a qualifying court order awarding entitlement to a portion of your future annuity or to a former spouse survivor annuity; or
- 60 days after the date of the notice of his or 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 or she meets the time limit.

Deferred Enrollment

Once your former spouse has applied to enroll within the required time limit, he or 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 or her that he or 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 cannot enroll until OPM makes its determination.

OPM will send your former spouse a written decision. If eligibility is determined, he or 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 or 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 or she must meet all of the following requirements:

- He or she must not have remarried before age 55;
- He or 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 or 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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Health Care Flexible Spending Accounts

What is a Flexible Spending Account?
A Flexible Spending Account (FSA) is a tax-favored program offered by employers that allows their employees to pay for eligible out-of-pocket health care and dependent care expenses with pre-tax dollars. By using pre-tax dollars to pay for eligible health care and dependent care expenses, an FSA gives you an immediate discount on these expenses that equals the taxes you would otherwise pay on that money.

In other words, with an FSA, you can both reduce your taxes and get more for your money by saving from 20% to more than 40% you would normally pay for out-of-pocket health care and dependent care expenses with after-tax (as opposed to taxed) dollars.

FSAFEDS offers three types of FSAs:

- Health Care Flexible Spending Account (HCFSA) can be used to pay for qualified medical costs and health care expenses that are not paid by your Federal Employees Health Benefits (FEHB) plan or any other insurance, but cannot be used to pay for any type of insurance premiums, including long-term care insurance premiums.

- The Limited Expense Health Care Flexible Spending Account (LEX HCFSA) is only available to employees who enroll in a Federal Employees Health Benefits (FEHB) Program or under a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) . Expenses are limited to dental and vision care services/products that meet the IRS definition of medical care. By using a LEX HCFSA, you can preserve the funds in your Health Savings Account to use/save for other purposes.

- The Dependent Care Flexible Spending Account (DCFSA) can be used to pay for eligible dependent care expenses such as child care for children under age 13 or children who are physically or mentally incapable of self-care and, in some cases, elder care, so that you (and your spouse, if you are married) can work, look for work, or attend school full-time.

Your participation in any FSA is completely voluntary, and it's important to remember that unlike other Federal benefits, your FSA election is only effective for one Benefit Period. In other words, you must enroll each year that you choose to participate. If you do not enroll during Open Season, you will not participate in the next Benefit Period, unless you experience a Qualifying Life Event (QLE) that allows you to make an election outside of Open Season.

Open Season for FSAFEDS runs concurrently with the FEHB Open Season in November and December each year for enrollment in the following year. The FSAFEDS Benefit Period will always run from January 1 of the current Benefit Period through March 15 of the following year. This includes a 2 ½ month grace period from January 1 through March 15 of the following year. During the grace period, eligible expenses incurred from January 1 through March 15 of the following year can be applied towards your prior year's balance. The intent is to help account holders avoid forfeiting any of the funds they deposited in FSA accounts. It is important to carefully consider the amount you choose to elect.

OPM has adopted the grace period on behalf of all agencies and employees that are part of FSAFEDS and has also extended the filing deadline for claims against the prior year account (including claims incurred during the "grace period") to April 30, 2009 for the 2008 Benefit Period.

Eligible Health Care Expenses
FSAFEDS follows Internal Revenue Service (IRS) guidelines to determine eligible expenses and other requirements for participation in an FSA issued under Sections 105, 125, and 129 of the Internal Revenue Code.

Eligible HCFSA Expenses:

- cannot be taken as a deduction from your Federal Income Tax return in any tax year even though they qualify as eligible expenses that could be deducted. You may not take both options. You must either declare them on your tax return OR get reimbursed for those expenses through your FSA;
- are not covered, paid, or reimbursable from any other source;
- do not exceed the amount allotted for your HCFSA for the Benefit Period;
- do not include reimbursements for premiums for health insurance; and
- while not limited to the dollar amount in your HCFSA at the time a claim is reimbursed, are limited to the total amount you elected (minus any amounts you have been reimbursed for claims submitted earlier in the Benefit Period).

For a more detailed listing of eligible expenses, see http://www.fsafeds.com.

Eligibility to Participate

If you are an active employee of an Executive Branch agency, or an agency, commission, or other Federal entity that has adopted The Federal Flexible Spending Account Program, you are most likely eligible to enroll for at least one of the flexible spending accounts.

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Some Federal agencies do not participate in FSAFEDS, but may offer their own FSA program to their employees. These agencies include:

- Administrative Office of the U.S. Courts (The Federal Judiciary)
- District of Columbia Government
- Farm Credit Administration
- Farm Credit System Insurance Corporation
- Federal Deposit Insurance Corporation
- Federal Reserve System
- Office of the Controller of the Currency
- Office of Thrift Supervision
- Overseas Private Investment Corporation
- Presidio Trust
- U.S. Postal Service

Expenses Eligible For Reimbursement

Many of your typical out-of-pocket health care expenses may be reimbursed by a HCFSA. In general, services must be rendered by a health care professional appropriately licensed or certified in the state in which he or she practices, and performed within the scope of the health care professional's license.

Some common reimbursable expenses not covered by most FEHB plans are:

- Chiropractic services
- Co-insurance, co-pay amounts and deductibles, as long as they are not reimbursed by secondary insurance or any other source
- Contact lenses and cleaning solutions
- Dental care and procedures (including bridges, crowns, root canals, cleanings, X-rays, dentures, fillings, and orthodontia)
- Eyeglasses (including prescription sunglasses and over-the-counter reading glasses)
- Hearing aids and batteries
- Infertility treatments
- Over-the-counter medicines and supplies (including antacids, allergy medicines, cold medicines and pain relievers)

Note: Insurance premiums, including health insurance, life insurance, long-term care insurance, and Temporary Continuation of Coverage, are not eligible for reimbursement.

For more complete listings of eligible medical expenses, please go to http://www.fsafeds.com/fsafeds/eligibleexpenses.asp.

Expenses Eligible for Reimbursement Only If Medically Necessary
Some expenses are eligible for reimbursement only when a doctor or other licensed health care practitioner certifies that they are medically necessary. Your doctor's certification (note or letter) must indicate your specific medical disorder, the specific treatment needed, and how this treatment will alleviate your medical condition. Examples include:

- Air conditioners, air purifiers, and humidifiers for allergy relief
- Cosmetic surgery following an accident, disease or other surgery
- Hydrotherapy
- Massage therapy
- Water fluoridation
- Weight loss program for treatment of a specific disease (e.g., heart disease)
- Wigs for hair loss due to chemotherapy or radiation treatment

Expenses That Are Not Eligible For Reimbursement
The following is a list of common medical expenses not eligible for reimbursement:

- Insurance premiums, including those for health insurance, life insurance, long-term care insurance, and Temporary Continuation of Coverage
- Cosmetic surgery or procedures to improve or enhance appearance
- Expenses that have been reimbursed elsewhere
- Expenses not incurred during your period of coverage
- Personal use items (items ordinarily used for personal, living or family purposes such as household disinfectants)
- Physician charges for services that are not direct medical care, such as monthly fees for guaranteed access and quicker appointments (so-called "boutique practice fees")
- Prepayment for services not yet provided

For more complete listings of ineligible medical expenses, please go to http://www.fsafeds.com/fsafeds/eligibleexpenses.asp.

Limits For A HCFSA Contribution
As stated above, the maximum annual allotment for the FSAFEDS HCFSA is $5,000 per covered employee, or $10,000 for a "Federal couple," where both spouses are covered under the FSAFEDS program. However there is no household limit for a HCFSA, so you or your spouse may enroll through FSAFEDS or another plan. Thus, the aggregate HCFSA election for a couple may exceed the $5,000 FSAFEDS maximum.

Getting Reimbursed
You must file a claim form with FSAFEDS to be reimbursed for an eligible expense. The claim form is available on the FSAFEDS web site at www.fsafeds.com.

Tax Deductibility Of Expenses Paid With A HCFSA
If you use a HCFSA to pay for eligible health care expenses, you cannot deduct those same expenses on your Federal Income Tax return. However, your entire FSA allotment is pre-tax. If you itemize your medical expenses on your tax return, you can only deduct the amount of your total medical expenses that exceed 7.5% of your Adjusted Gross

Income (AGI). By contrast, when you use a HCFSA to pay for medical and health care expenses, you receive a tax deduction without having to meet the 7.5% AGI minimum. The money you allot to an FSA is also exempt from FICA (Social Security and Medicare) taxes, a deduction that is not available on your Federal Income Tax return. If your eligible medical expenses exceed the 7.5% threshold by a significant amount, you might want to consult with a tax professional to determine which option is best for you.

Note: If you are enrolled in the Civil Service Retirement System (CSRS), your tax savings will be decreased by 6.2%, since you do not contribute to Social Security. Please refer to the FSAFEDS Calculator on the FSAFEDS web site at www.fsafeds.com.

Grace Period for Incurring Eligible Expenses And Submitting Claims

In July 2005, FSAFEDS announced that those with HCFSAs now have until March 15th of the following year to incur eligible expenses for the current Benefit Period. While this does not eliminate the use-it-or-lose-it rule completely, you now have an additional advantage to avoid forfeiting unused funds.

FSAFEDS has also extended the deadline for submitting claims for eligible expenses. The deadline has been pushed back to accommodate the grace period change. You now have until April 30th following the end of the Benefit Period to submit claims for eligible expenses you incurred through March 15th.

Limited Expense FSAs

Federal Employee Health Benefits High Deductible Health Plan (HDHP)/Health Savings Account (HSA) enrollees now have the option of selecting a new limited expense health care flexible savings account (HCFSA) option during the Federal Benefits Open Season for the upcoming Benefit Period. You will have an opportunity to enroll in this new option if you choose to.

Defining A Limited Expense Health Care Flexible Savings Account

A Limited Expense Health Care Flexible Savings Account (LEX HCFSA) is a new money saving option available to employees who are enrolled in a Federal Employees Health Benefits (FEHB) Program high deductible health plan (HDHP) with a health savings account (HSA). You can go to http://www.opm.gov/insure/health/hsa/hsa.asp if you want to learn more about HDHPs and HSAs.

Covered Expenses

The FSAFEDS LEX HCFSA covers dental and vision care services/products that meet the IRS definition of medical care. Eligible expenses include your out-of-pocket costs for such services/products as:

Dental Care:

- Cleanings
- Fillings
- Crowns
- Orthodontics

Vision Care:

- Contact lenses
- Eyeglasses
- Refractions
- Vision correction procedures

along with any eligible dental or vision over-the-counter expenses, such as denture care products, contact lens cleaning and soaking solutions, etc.

Dental and vision care costs are the only reimbursable expenses covered under the FSAFEDS LEX HCFSA. Cosmetic services – whether dental or vision related - are not eligible expenses. All of the other expenses normally eligible under a "general" health care flexible spending account are NOT eligible under a LEX HCFSA.

How a LEX HCFSA Saves Enrollees Money

Normally, someone enrolled in a high deductible health plan with a health savings account cannot also have a general health care flexible spending account. IRS rules prohibit it. However, with a LIMITED expense HCFSA, you can have both accounts. Therefore, you can pay for your eligible out-of-pocket dental and vision care expenses with pre-tax salary dollars. Using pre-tax salary dollars gives you an immediate discount on these expenses that equals the taxes you would otherwise pay on that money. By using a LEX HCFSA, you can preserve the funds in your health savings account to use/save for other purposes.

Minimum and Maximum Amounts That Can Be Set Aside

You can set aside anywhere from a minimum of $250 up to $5,000 per year in pre-tax salary in your LEX HCFSA for dental and vision care expenses.

Dependent Coverage

All your dependents that you claim on your Federal Income Tax return, or with whom you jointly file your taxes, are covered under a LEX HCFSA.

Enrolling In A LEX HCFSA

You can enroll in a LEX HCFSA during the Federal Benefits Open Season for the upcoming Benefit Season, which occurs mid-November through mid-December each year.

Advantage Of Establishing An LEX HCFSA

Since employees are supposed to spend their HSA funds on dental and vision expenses, many have questioned why they would want an FSA account too. The answer is that by establishing an LEX HCFSA, you can save money on taxes by using FSA dollars for dental and vision care while preserving your HSA funds for other purposes, including simply saving those funds for the future.

For More Information

For more information on FSAFEDS, go to http://www.fsafeds.com.