Information for Retirees and Survivor Annuitants About the Federal Employees Health Benefits Program

This pamphlet has important information about the Federal Employees Health Benefits (FEHB) Program for:

- Persons retired under the Civil Service Retirement System (CSRS) or the Federal Employees' Retirement System (FERS).
- Widow(er), Children of Deceased Federal Employees, or Retirees.
- Former Spouses of Federal Employees or Retirees (Whose Marriages Terminated Before the Employees' or Retirees' Deaths).

Your plan's brochure has detailed information about your health benefits coverage. Keep the brochure and this pamphlet handy and refer to them if you have a question.

This pamphlet reflects legislation and regulations in effect through July 1996.

Retirement & Insurance Service
Office of Retirement Programs
Theodore Roosevelt Building
1900 E Street, NW
Washington, DC 20415-0001

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Contacting Us At OPM

You can call us about your health benefits enrollment. Our telephone number is (202) 606-0500. There are voice mail boxes available at this number 24 hours a day. With the exception of Federal holidays and weekends, you can stay on the line and speak to one of our service representatives between the hours of 7:30 a.m. and 5:30 p.m. Eastern time. Persons with hearing impairments who have TDD equipment should call (202) 606-0551.

We will make the following changes in your health benefits enrollment based on a telephone call:

- Change from family to self-only enrollment.
- Change plans when you have moved out of the service area of a prepaid plan.
- Change to a less expensive plan because you are 65 and are eligible for Medicare.
- Cancel or suspend your enrollment; we will ask you to confirm this in writing.

If you prefer, you can write to:

US Office of Personnel Management
Health Benefits Branch
PO Box 14172
Washington, DC 20044-4172.

Anytime you contact us, be sure to give us your CSA or CSF claim number. This number is on the correspondence from us. Also, give us your date of birth and be sure to sign your correspondence. If you are a survivor annuitant or if you are a widow(er) of a deceased employee paying premiums directly to OPM, provide the name of the former Federal employee on whose service your annuity is based, as well as your survivor annuity claim number (CSF number). If you are a former spouse of a Federal employee and you are paying health benefits premiums directly to OPM, you should also provide your Social Security Number.

Deferred Annuitants

If you separated from Federal service before you could retire and are now receiving a deferred annuity which started when you were 62, you are not eligible to enroll in the Federal Employees Health Benefits Program. You may have coverage under the program as a family member based on your spouse's enrollment, but you can never have an enrollment based on your deferred annuity.

There are two types of enrollment in each plan:

1. ***Self Only*** - This enrollment provides benefits only for you.

2. ***Self and Family*** - This enrollment provides benefits for you and for all eligible family members.

If You Are a Retiree

A Self and Family enrollment covers you, your spouse, and your unmarried dependent children under age 22 (see below for information on disabled children), including your legally adopted children and recognized children born out of wedlock. A recognized child born out of wedlock must live with you in a regular parent-child relationship. Such a child may also be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child. Your stepchildren and foster children can also be included if they live with you in a regular parent-child relationship. (Your stepchildren and foster children may receive health benefits coverage after your death only if they were living with you in a regular parent-child relationship at the time of death).

Other relatives, such as parents or a grandchild (unless the grandchild qualifies as a foster child; see discussion on page 2), are not eligible for coverage as family members even if they live with and are dependent on you.

Your monthly premium for a Self and Family enrollment is the same amount regardless of the number of family members covered by the enrollment. If a family member loses eligibility for coverage, your premium is not reduced. However, if you become the only person eligible for coverage, you should contact us at (202) 606-0500 or write to:

US Office of Personnel Management
Health Benefits Branch
PO Box 14172
Washington, DC 20044-4172.

We will change your enrollment to less expensive Self Only coverage.

Disabled Children Age 22 and Over

An unmarried child incapable of self-support because of a disability which began before age 22 (and which is expected to last more than one year) may continue to be covered as a family member after reaching age 22. If you have a child so disabled and have already established the fact with your former employing office, you need take no further action unless we ask for another medical certificate.

If you have a child who is disabled but have not yet established that fact, call us as (202) 606-0500. We will send you a form which you and the child's doctor must complete. If you prefer, you may write to:

US Office of Personnel Management
Health Benefits Branch
PO Box 14172
Washington, DC 20044-4172.

Foster Children

A foster child for health benefits purposes is a child who is financially dependent on you, who lives with you in a regular parent-child relationship, and who is not married. There must be an expectation that you will continue to raise the child into adulthood. A grandchild who meets these criteria may be covered as a foster child. A child temporarily living with you is not a foster child; neither is one placed in your home by a welfare or social service agency which retains control of the child and pays for maintenance.

New Family Members
If you have a Self and Family enrollment, any new eligible family member - such as a new spouse, if you are a retired employee - is automatically covered by your health plan. You need take no action to include the new family member in your enrollment. However, if you submit a claim for medical expenses for a new spouse, your plan may ask for proof of termination of the previous marriage (if applicable) and your remarriage, and the name and date of birth of your new spouse so they can update their records. If you are enrolled for Self Only and acquire a new family member, you may change to a Self and Family enrollment as shown on pages 12 and 13.

If You Are a Widow(er) Survivor Annuitant or Are Receiving the FERS Basic Employee Death Benefit
A Self and Family enrollment provides coverage for you and all eligible family members of the deceased employee or retiree, as described above.

If you remarry before age 55, your coverage will terminate (see page 16). If you remarry on or after age 55, your coverage will continue, but your new spouse and his or her dependents cannot be included in your enrollment.

If you are also receiving an annuity as a retiree based on your own Federal career, you may be eligible to transfer the enrollment to your retirement annuity in order to cover your new spouse and his or her eligible children. If you wish to do so, call us or send a written request (being sure to provide your retirement and survivor annuity claim numbers) to:

US Office Personnel Management
Health Benefits Branch
PO Box 14172
Washington, DC 20044-4172.

We will determine if you are eligible to transfer your enrollment after we receive your request. The request must be filed within 31 days before to 60 days after the date of remarriage or during a health benefits open season.

If You Are a Former Spouse Survivor Annuitant

If you have FEHB coverage as a former spouse (*i.e.*, your marriage terminated before the employee's or retiree's death), a Self and Family enrollment covers you and any unmarried dependent child or adopted child under age 22 from your marriage to the employee or retiree. (See *Disabled Children Age 22 and Over*, page 2, if applicable.) You cannot include any foster child or grandchild in this coverage. If you remarry, your new spouse and his or her children cannot be included in your enrollment. If you remarry before age 55, your enrollment will terminate (see page 16).

When a Family Member Loses Eligibility for Coverage

- Your spouse will lose eligibility for coverage under your Self and Family enrollment upon divorce or annulment of the marriage.
- A child loses eligibility for coverage at marriage or attainment of age 22, whichever occurs first. Children whose marriage ends in divorce or annulment before they reach age 22 again become eligible for coverage from the date of the divorce or annulment until they reach age 22 or remarry.
- A disabled child age 22 or over loses eligibility for coverage at marriage or recovery of ability for self support.

If your family member loses eligibility for coverage for any of the above reasons, his or her coverage will continue for 31 days after the terminating event. During this 31-day period, the family member can convert to a nongroup contract offered by your insurance carrier. To do this, the family member needs to contact the carrier. See page 22 for information about Temporary Continuation of Coverage for children and certain former spouses who lose eligibility for coverage.

Changing Your Plan

Factors to Consider When Changing Your Enrollment

Because health insurance needs vary with each person, the Office of Personnel Management cannot provide specific advice on which plan or enrollment is best for you. You should consider the composition of your family, your financial situation, the condition of your health and your medical needs, as well as the health of any eligible family member, and your eligibility for Medicare (see page 23), when deciding which coverage is best in your particular situation. You should also consider what type of plan is best for you and your family. You should compare the benefits offered by the plans available to you.

Each plan has a brochure that describes its benefits. You can obtain these brochures by writing to the particular plan in which you are interested. Do not write to OPM for a brochure because they are not available at OPM. However, you can obtain an FEHB Guide by calling (202) 606-0500 or by writing to:

US Office of Personnel Management
Health Benefits Branch
PO Box 14172
Washington, DC 20044-4172.

The FEHB Guide provides general information about the major features of each plan in the FEHB Program. However, before you make a final decision about changing plans, you should carefully review the official brochures for the plan or plans in which you are interested. When comparing plans, remember that the true cost of your health care protection includes both the premiums and your out-of-pocket costs for any of the following:

- deductibles *(the amount of covered charges you must incur before the plan pays benefits)*,
- coinsurance *(a percentage of covered charges you must pay for a service or benefit provided by the plan)*,
- co-payments *(a fixed dollar amount you must pay for a service or benefit provided by the plan)*, and
- charges for examinations and other physician services, laboratory tests, prescriptions drugs, *etc.*, not covered or only partially covered by the plan.

What Types of Plans Are Available

There are two basic types of health benefit plans available to you under the FEHB program, prepaid plans and fee-for-service (FFS) plans.

Prepaid Plans

In prepaid plans, your covered health services are pre-funded by your premium and the Government's contribution toward the cost of your health insurance. Prepaid plans, also called Comprehensive Medical Plans or Health Maintenance Organizations (CMPs or HMOs), meet your health care services through specified plan physicians, hospitals and other providers at designated locations.

Fee-for-Service Plans
FFS plans reimburse you or your physician or hospital for covered services rather than provide or arrange for services as prepaid plans do. FFS plans allow you to choose your own physicians, hospitals, and other health care providers.

Medicare-sponsored Coordinated Care Plans (MCCP)

Medicare-sponsored coordinated care plans are an option for anyone who is age 65 or older. These plans are generally prepaid plans (CMPs or HMOs). If you join such a plan, you may suspend your FEHB enrollment and later you may reenroll in the FEHB Program. Ask your local Social Security office for the names of the Medicare-sponsored coordinated care plans in your area.

You may find that a Medicare-sponsored plan is less expensive and meets your needs very well. Medicare makes a monthly payment to the plan.

If you wish to suspend your FEHB enrollment because you have joined a Medicare-sponsored coordinated care plan, send us a copy of the document that shows your enrollment date and ask us to suspend your FEHB enrollment. You must send this to us within the period beginning 31 days before and ending 31 days after the Medicare-sponsored plan enrollment takes effect.

If you move out of the service area of the Medicare-sponsored coordinated care plan, you may reenroll in FEHB the beginning of the month in which you move. However, if you decide to cancel your Medicare-sponsored coordinated care plan, you must wait until the next FEHB open season to reenroll in the FEHB Program. Open season usually begins in mid-November each year. Thus, you should not cancel your Medicare-sponsored coverage until the FEHB open season enrollment effective date, which is January first of the next year.

If You Want to Cancel Your Enrollment

You may voluntarily cancel your enrollment at any time. However, if you cancel your enrollment, you and any family member under your enrollment will not be able to convert to a nongroup contract or enroll for temporary continuation of coverage described on page 22. Generally, voluntary cancellation of enrollment ***permanently bars*** reenrollment in the FEHB Program. If you ask us to cancel your enrollment, we will give you a complete explanation of the effect of a cancellation on your rights under the FEHB Program.

If You Want to Suspend Your Enrollment

You may want to suspend your enrollment. Usually, enrollments are suspended because the enrollee wants to join a Medicare-sponsored coordinated care plan or be covered as a family member under another person's Self and Family FEHB Program enrollment.

If You Want to Reactivate Suspended Coverage

To reactivate suspended coverage you need to contact us ***as soon as you decide to make the change*** so you will know the time limits that apply to you. If you want to change from a Medicare-sponsored coordinated care plan to FEHB Program coverage, follow the instructions on page 7. To reactivate coverage after you lose coverage under someone else's FEHB Program enrollment, contact us ***within 31 days after*** the event. Other situations may have different time limits.

Families Where Both Spouses Are Eligible to Enroll in the FEHB Program In Their Own Right

If one spouse is retired and eligible to continue FEHB enrollment in retirement and the other spouse is a Federal employee eligible for FEHB enrollment (or if both are retired and each is eligible for enrollment as a retiree), the couple may decide to have two Self Only enrollments or one Self and Family enrollment. The cost of the plans will probably be the determining factor. Of course, if there are children, the decision will probably be for one spouse to cover everybody under a Self and Family enrollment.

Changes in such coverage may be made at Open Season or on the occasions specified on pages 12 and 13.

Direct Payment of Premiums by Annuitants

Sometimes the amount of annuity payable is less than the amount of the health benefits premiums. To prevent the loss of this important benefit, we will arrange for annuitants and survivor annuitants to make the premium payments to us if this occurs. We make this arrangement only when we are not able to withhold the premiums from the monthly payments. After direct payments have been set up, the health benefits premiums cannot be deducted from the monthly annuity even if the annuity increases to an amount that is higher than the health benefits premiums.

If you are to make direct premium payments, OPM will send you an FEHB Guide and a health benefits registration form to change or enroll in a plan.

The cost of your FEHB coverage is the same as it would be if OPM could withhold your premiums from your monthly annuity. You will pay only the enrollee share to OPM. A letter providing payment instructions and a set of health

benefit premium coupons will be forwarded to you with the verification of your enrollment change or new enrollment. Premium payments are due the first of each month.

To apply to pay premiums directly to OPM, you should write to the following address:

US Office of Personnel Management
Health Benefits Branch
Attn: Direct Pay Coordinator
PO Box 14172
Washington, DC 20044-4172.

How to Change Your Enrollment

To change your enrollment, contact us at (202) 606-0500. Be sure to give your retirement claim number or your survivor annuity claim number. If you are a former spouse of a Federal employee and you are paying health benefits premiums directly to OPM, you should also provide your Social Security number. If you prefer, write to:

US Office of Personnel Management
Insurance Services Branch
PO Box 14172
Washington, DC 20044-4172.

Whether you write or call, we need to know the change you wish to make, the event which permits the change, and the date on which that event occurred.

Before we can process a request to cancel your enrollment, we will send you a letter which must be signed and returned to us, unless your ***signed*** request includes the following:

1. A statement that you understand you are not entitled to a 31-day extension of coverage.

2. A statement that you understand you cannot reenroll in any plan under the FEHB Program at a later date. (However, if you are suspending because you are covered under your spouse's Self and Family enrollment or to join a Medicare-sponsored coordinated care plan, you may be eligible to reenroll as discussed on page 7.)

Effective Dates for Enrollment Changes

Generally, the effective date of the changes shown on pages 12 and 13 will be the first day of the month ***after*** the month in which we receive your request for a change. (For example, if we receive your request to change to Self Only coverage on May 5, the effective date for the change is June 1.)

However, if you requested the cancellation of your enrollment and your properly completed request is received on or before the 15th day of the month, the cancellation is effective at the end of that month. If your properly completed request is received after the 15th day of the month, it is effective at the end of the following month. (For example, if we receive your properly completed cancellation request on June 5, the effective date is June 30; if we receive your properly completed cancellation request on June 19, the effective date is July 31.)

When you look for your premiums to change, remember that the annuity payment you receive on the first business day of the month pays your annuity and insurance premiums for the previous month.

Events Which Permit Change	From Self Only to Family
Change from Self and Family to Self Only	No
Open season.*	Yes
Change in retiree's marital status.	Yes
Other change in family status (for example, birth of a child).	Yes
You are enrolled in a prepaid plan (CMP/HMO) and move from the area it serves.****	Yes
Your enrollment in an employee organization plan is terminated because the plan terminates your membership.	No
Your plan stops participating in the FEHB Program.****	Yes
Retiree's Federally employed spouse is enrolled for Self Only but loses this coverage because his or her agency terminates the enrollment.	Yes
You become eligible for Medicare.*	No
Your Medicare-sponsored Coordinate Care Plan (MCCP) coverage has ended and you want to reenroll in the FEHB Program. You will have to include with your reenrollment request evidence of your loss of MCCP coverage which shows the ending date of your MCCP coverage.	Yes
Your eligible child(ren) loses coverage under someone else's enrollment under the FEHB Program.	Yes
Your spouse involuntarily loses his or her non-Federal health insurance coverage, or coverage for his or her dependents; or your eligible child (or children) loses non-Federal coverage under the other parent's health plan because the other parent involuntarily loses coverage for his or her dependents. (Not applicable to former spouses.)	Yes

***** To make this change call us on (202) 606-0500 as explained on page iii of this booklet or write to us. You may call us to discuss other changes you wish to make. We will tell you what you need to send us to enable us to make the change for you.

From One Plan or Option to Another	Time Limit In Which Election to Change Must Be Filed With OPM
No	At any time.
Yes	As announced by OPM.
Yes	From 31 days before to 60 days after change in marital status.
No	Within 60 days after the event.
Yes	When you notify your retirement system of your change of address.
Yes	Within 31 days after your enrollment ends.
Yes	As set by the Office of Personnel Management.
No	Within 31 days after spouse's enrollment is terminated.
Yes	30 days before you become eligible for Medicare or any time thereafter.
Does not apply	Within 30 days of your loss of MCCP coverage if the loss was involuntary, or during the next Open Season enrollment period if the loss of coverage was at your request.
No	Within 31 days after the child loses coverage.
No	Within 31 days before or after spouse's or dependent's loss of coverage; or within 31 days before or after the child's (or children's) loss of coverage.

Continuation of Coverage for Survivors After Enrollee's Death

If you should die while enrolled for Self and Family, all survivors who meet the definition of "family member" will automatically be able to continue your enrollment as long as any one of them receives a survivor annuity. Their share of the cost of the plan is the same amount you are paying and will be deducted from their annuity payment. If there is only one survivor annuitant and no other family member is eligible for continued coverage, we will change the enrollment to the less expensive Self Only coverage.

Some FERS survivors may be entitled to continue their health benefits enrollment even if they will not receive a monthly survivor annuity benefit. Widow(er)s who are entitled to receive the FERS Basic Employee Death Benefit and child survivors whose FERS survivor annuity benefits are reduced by the amount of any Social Security benefit payable may continue their health benefits enrollment by paying premiums directly to OPM, if they are entitled to continued health benefits coverage.

Widow(er) Survivor Annuitants Who Are Also Federal Employees

If you are a widow(er) who is, or becomes a Federal employee, and you elect to enroll in a plan as an employee, immediately notify the Office of Personnel Management to suspend your survivor annuitant enrollment. (You cannot be enrolled in two plans at the same time.) If your enrollment as a Federal employee terminates for any reason (other than by cancellation), it may be reinstated as a survivor annuitant enrollment

if you are still receiving an annuity. To request such reinstatement, write to:

US Office of Personnel Management
Health Benefits Branch
PO Box 14172
Washington, DC 20044-4172.

Give the name and address of your last employing office and your survivor annuity claim number (CSF number). You should also provide copies of your health benefits registration forms (SF 2809 and SF 2810) with your request for reinstatement. If we receive your letter within 60 days after the event which terminated your coverage, your reinstatement will be effective on the day after your enrollment terminated. If your letter is received more than 60 days after the event, your reinstatement will be effective on the first day of the month after we receive your letter.

What Events Terminate Health Benefits Coverage

If You Are a Retiree

If your annuity terminates (for example, when a disability retiree recovers or is restored to earning capacity), your enrollment will end on the last day of the month for which you are entitled to an annuity. However, coverage will be extended for 31 days without cost to you (see page 19).

If you are a disability retiree whose annuity terminated as described above, you will retain your health benefits coverage if you are entitled to apply for an immediate annuity, *i.e.*, one that begins when your disability annuity stops. You will receive complete information concerning your right to do so if your disability annuity terminates.

If you are under age 60 and your disability annuity is reinstated (after December 31, 1983) due to loss of earning capacity or a recurrence of the disability for which you retired, you will be given an opportunity to have health benefits coverage reinstated if you were enrolled at the time your disability annuity previously terminated.

If you are entitled to a deferred annuity after your disability annuity terminates, you cannot retain your health benefits coverage as a retiree.

Under certain conditions, your annuity will terminate if you are reemployed in the Federal service. If this occurs, your health benefits enrollment will be transferred to your employing agency. If you are so reemployed, you should immediately notify:

US Office of Personnel Management
PO Box 45
Boyers, PA 16017-0045.

Be sure to refer to your retirement claim number (CSA number) and provide us with a copy of the personnel document showing your appointment, if possible, or the full name and address of your employing agency.

If You Are a Widow(er) or Former Spouse Survivor Annuitant

If you remarry before age 55, your survivor annuity and health benefits enrollment will end on the last day of the month preceding the month in which you remarry (subject to the extension of coverage, see page 19). If you are enrolled in Self and Family coverage, the enrollment will continue for any eligible children as long as one of them is entitled to receive a survivor annuity (but you will not be covered). If you remarry before age 55, you must immediately notify:

US Office of Personnel Management
PO Box 45
Boyers, PA 16017-0045.

Be sure to provide us with a copy of your marriage certificate and refer to your survivor annuity claim number (CSF number).

If you remarry after age 55, your survivor annuity and health benefits coverage will continue. Your new spouse and his or her children cannot receive health benefits coverage under your survivor annuitant enrollment. (However, if you are a widow(er) survivor annuitant who is also receiving an annuity based on your own Federal career, you may be eligible to transfer your enrollment to your retirement annuity in order to provide coverage for your new spouse and his or her children; see page 3 for information.) If you are receiving health benefits coverage as a ***former spouse***, your coverage will also terminate if:

1. You lose entitlement to survivor annuity benefits under the terms of the court order which provided your benefits; or

2. you do not pay the full cost of the enrollment by the payment due date (if premiums are not being withheld from your survivor annuity).

If you are a ***widow(er)*** whose annuity and health benefits coverage terminated due to remarriage before age 55, see below for information on how your coverage and annuity can be reinstated if the marriage ends. If you are a ***former spouse*** whose annuity and health benefits coverage terminated due to remarriage before age 55, your survivor annuity and health benefits coverage ***cannot*** be reinstated if your marriage ends.

If You Are a Child Surivor Annuitant

If you have FEHB coverage because you are a child, your coverage ends when you marry or reach age 22, whichever occurs first. It is your responsibility to notify us if you marry before you are 22. If your marriage ends before you are 22, you may again be eligible for coverage. Contact us for information about reenrollment.

If you are receiving a monthly annuity and you lose coverage because the survivor who was paying for the coverage cancels or changes the family enrollment to Self Only, we will offer you the opportunity to continue your coverage.

Reinstatement of Widow(er)'s Health Benefits Coverage If Remarriage Ends

If you remarry before age 55, your survivor annuity and health benefits coverage terminate at the end of the month preceding the one in which you remarry. If your remarriage ends due to death, divorce, or annulment, your survivor annuity will be reinstated after we receive proof that your remarriage ended. If you had health benefits coverage on the date your annuity terminated due to remarriage, you will be given the opportunity to reenroll in an FEHB plan when your survivor annuity is reinstated. If your remarriage ends, you should immediately notify:

US Office of Personnel Management
PO Box 45
Boyers, PA 16017-0045.

You must send us proof your remarriage ended. You should also be sure to refer to your survivor annuity claim number (CSF number) and the full name of the deceased employee or annuitant on whom your benefits are based.

If Health Benefits Coverage Ends

31-Day Extension of Coverage

In order to give you the opportunity to convert to a nongroup health benefits contract, your coverage will continue for 31 days after your enrollment ends for any reason except voluntary cancellation. If you are confined to a hospital on the 31st day of your extension, your benefits will continue while you are confined, up to a maximum of 60 additional days. These extensions are without cost to you. They also apply to any family member who loses coverage under your enrollment for any reason except your voluntary cancellation of the enrollment.

Conversion to a Nongroup Contract

If you are:

- a retiree,
- a widow or widower survivor annuitant,
- a former spouse survivor annuitant, or
- a child of a deceased Federal employee or retiree who has coverage under the FEHB Program in your own name,

and your enrollment terminates for any reason other than by your voluntary cancellation, you are entitled to convert to a nongroup health benefits contract issued by the carrier of the plan in which you were enrolled. Nongroup conversion policies are issued without evidence of insurability. You must pay the entire premium for a nongroup contract.

Normally, within 60 days of the date your enrollment terminates, OPM will send you a notice of termination and your right to convert. (**Note:** This does not apply to family members who lose eligibility for coverage under a Self and Family enrollment; see below.) If you are interested in conversion, you must apply to the nearest office of your plan for information about the nongroup contract within 31 days of the date of the termination notice.

If the notice of termination is not sent to you within 60 days of the date your enrollment ends, or you are unable for reasons beyond your control to make a timely request for conversion, you may make a belated request by writing directly to your carrier within six months after your enrollment ended. You must provide proof that your entitlement to coverage ended. (For example, you should submit a copy of your marriage certificate if you are a widow(er) or former spouse who lost coverage because of remarriage before age 55.) You must also show that (1) you were not notified of the termination of your enrollment and your right to convert, and were not otherwise aware of it, or (2) that you were unable to convert for reasons beyond your control.

If you make a belated request for conversion as described in the preceding paragraph, the health benefits carrier will determine if you are eligible to convert to a nongroup contract. If you are eligible to convert, you must do so within 31 days after receiving the carrier's notice of your right to convert. If the carrier determines that you are not eligible to convert, you may ask OPM to review that decision by writing:

US Office of Personnel Management
Office of Insurance Programs
Retirement and Insurance Service
PO Box 436
Washington, DC 20044-0436.

If a member of your family loses eligibility for coverage under your Self and Family enrollment (for example, when a child reaches age 22 or you are divorced from your spouse), that family member is entitled to convert to a nongroup contract with the plan during the 31-day extension of coverage period described on page 20. ***You will not be notified by OPM when a family member loses eligibility.*** The affected family member will not be notified by OPM that he or she is no longer eligible for health benefits coverage.

When this occurs, and if the affected family member wants to convert, he or she should apply, within 31 days after eligibility for coverage ends, to the nearest office of the plan in which you are enrolled for information about a nongroup contract. However, if a family member loses coverage because you cancel your enrollment, he or she cannot convert to a nongroup contract.

The effective date of the conversion contract is the day after the 31-day extension of coverage period expires. The person buying the nongroup contract must pay the premiums due for any retroactive period under the conversion contract.

Note: Many plans do not provide the same benefits under the converted nongroup contract that they provide under the Federal employee group plan, and the premium rates for converted nongroup contracts are generally higher because there is no Government contribution toward the cost of the enrollment. This may be an important consideration if you are thinking of changing plans and have a family member who will lose coverage at some time in the near future. If you need to know the benefits and cost of the converted nongroup contract, get in touch with your plan.

Temporary Continuation of FEHB Coverage

On and after January 1, 1990, children who lose FEHB coverage as family members and former spouses who lose coverage because of divorce or annulment and who are not eligible to enroll in the FEHB Program under the Spouse Equity law may, under certain circumstances, qualify for temporary continuation of coverage for up to 36 months after the qualifying event occurs. The cost of temporary coverage is the full health benefits premium (both the enrollee and Government shares) plus an additional administrative charge of 2 percent of the total premium.

If temporary continuation of coverage is desired for your child or former spouse, ***OPM must be notified when the child or former spouse becomes eligible.*** For a child, ***you*** must contact us within 60 days after the qualifying event, *e.g.,* child reaches age 22. For a former spouse, ***you or the former spouse*** must contact us within 60 days after the former spouse's change in status, *e.g.,* former spouse remarries before reaching age 55. The correspondence must include the name and address of the child or former spouse, as well as your name and claim number. Write to:

US Office of Personnel Management
Temporary Continuation of FEHB Coverage
PO Box 14172
Washington, DC 20044-4172.

How Medicare Affects Your Health Benefits Coverage

Because many people covered by FEHB plans also have Medicare coverage (or other group health insurance or no-fault automobile protection), all FEHB plans have a coordination of benefits (COB) or double coverage provision. The purpose of this provision is to enable enrollees and covered family members to recover as much of their health care expenses as their total coverage permits, but not more than the actual charges for the care. Under the COB, or double coverage provision, one plan normally pays its benefits in full as the ***primary payer*** and the other plan pays a reduced benefit as the ***secondary payer*.**

Generally, if you have Medicare and you (1) are age 65 or over and (2) are not employed in the Federal service, Medicare is the primary payer of your health benefits expenses, and your FEHB plan is the secondary payer. Medicare is also the primary payer if you are age 65 or over and are enrolled in Medicare Part B (Medical Insurance) only, regardless of your employment status. If you are a Federal retiree with Self and Family coverage and your covered spouse is age 65 or over and has Medicare coverage, Medicare is the primary payer of your spouse's health benefits expenses unless you or your spouse are employed in the Federal service and your spouse has Medicare Part A (Hospital Insurance).

Note: The Health Care Financing Administration (HCFA), which administers Medicare, has determined that the following information applies if you or a covered family member are under age 65 and are eligible for Medicare benefits on the basis of disability:

- If you are employed in the Federal service, your FEHB plan is the primary payer of health benefits expenses and Medicare is the secondary payer of benefits.
- If you are not employed in the Federal service, Medicare pays primary benefits and your FEHB plan is the secondary payer of benefits.

Contact your local Social Security Administration office for assistance if you have any questions concerning whether your FEHB plan or Medicare is the primary payer of your or a covered family member's health benefits expenses.

All FEHB plans will adjust any benefits payable so that they supplement rather than duplicate Medicare benefits. If Medicare is the primary payer, it will generally pay its allowable benefits in full, and your FEHB plan will pay a reduced benefit as the secondary payer. The combined amount paid by both will usually equal 100 percent of covered or allowable expenses. Although 100 percent of covered or allowable expenses may be paid, there may be remaining medical expenses incurred which are not covered by either Medicare or your health benefits plan.

You are responsible for paying any noncovered expenses. You should consult your Medicare handbook (available from the Social Security Administration) and your health benefits plan brochure for information about covered and non-covered expenses.

If Medicare is the primary payer of claims for health expenses, you must first submit your claim to Medicare for payment consideration. This is because your health benefits plan cannot process a claim until after Medicare has paid any expenses they cover. Always submit the Explanation of Benefits you receive from Medicare to your FEHB plan along with your claim.

If you (and your spouse) have both parts of Medicare (Part A Hospital Insurance and Part B Medical Insurance) and you are also in a high option plan (or a plan with only one option), you may be paying for more coverage than you need. You may wish to consider changing to a less expensive plan or option. Generally, the standard options (or a plan with only one option which is comparable to a standard option) adequately supplement both parts of Medicare at less cost to you than the high options. If your spouse or other eligible family members do not have both parts of Medicare, you may need a high option Self and Family enrollment to protect them.

Note: The monthly premium for your health benefits enrollment is not reduced if you (or your spouse) have Medicare coverage. However, you can change your enrollment to any option of any plan (for which you are eligible) beginning on the 30th day before you become eligible for Medicare.

Medicare Premiums

OPM can withhold monthly premiums for Medical Insurance (Part B of Medicare) from your annuity under certain conditions. You should contact your local Social Security office (not OPM) if you want Medicare premiums withheld from your annuity. You will need to provide them with your CSA or CSF number. If you are eligible, your local Social Security office will notify the Social Security Administration headquarters in Baltimore, Maryland, which will notify OPM to begin withholding premiums from your annuity. We can take no action to withhold these premiums (or to cancel Medicare premiums being withheld from your annuity) unless we are notified to do so by the Social Security Administration's headquarters in Baltimore. You should always contact your local Social Security office if you have any questions concerning this matter.

How to File Claims for Medical Expenses

Refer to your health benefits plan brochure for instructions on completing and submitting claims to your plan for payment consideration. ***Your completed claim form should not be sent to OPM.*** If you need claim forms, you may obtain them by contacting your health benefits plan.

If Your Claim for Medical Expenses is Denied

If a claim for payment or for service is denied, your plan will reconsider its denial on receipt of a written request within one year of the denial. The written request should state, in terms of applicable brochure provisions, the reasons you believe that the denied claim for payment or service should have been paid or provided. Within 30 days after receipt of your request for reconsideration, the plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If this information is not supplied within 60 days, the plan will base its decision on the information it has on hand.

If the plan affirms its denial, you have a right to a review by OPM to determine whether the plan has acted in accordance with its contract. ***Before seeking OPM review of a claim, these are some things you should keep in mind:***

- Submit bills from providers for payment to the plan along with the appropriate claim form; do not send bills to the address below or any other office within OPM except in connection with a disputed claim.
- Providers may use this procedure only on behalf of and with the specific written consent of the member and are required to demonstrate that the member has assigned all of his or her rights to the provider with regard to that particular claim.
- You should first check with your provider or facility to be sure the plan was billed correctly; for instance, that the correct procedure code(s) was used, complications were correctly indicated on the billing or operative reports, *etc.*
- Along with your request for review, you must send a copy of the plan's reconsideration decision.

OPM review may be obtained by writing to:

US Office of Personnel Management
Retirement and Insurance Service
Office of Insurance Programs
PO Box 436
Washington, DC 20044-0436.

OPM must receive a request for review, along with a copy of your letter to the plan and its reply within 90 days of the plan's affirmation of the denial.

You may ask OPM for a review if the plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or the date you were notified that the Plan needed additional information. In your request for review, show (a) the date of your request to the plan, or (b) the dates the plan requested and you provided additional information.

If you decide to seek judicial review of the denial of a claim, you must file suit no later than December 31 of the third year after the year in which the care or service was provided. Suits may not be brought prior to exhaustion of the administrative remedies provided in 5 C.F.R., Section 890.105. Federal law governs claims for relief that relate to benefits under the plan. Damages recoverable under Federal law are limited to the amount of benefits in dispute. Such legal actions must be brought against the Office of Personnel Management. These actions are limited to the record that was before OPM and that was the basis of the OPM decision to disallow the benefit, thus affirming the plan's decision.

Privacy Act Statement. If you request OPM to review a denial of a claim for payment or service, OPM or its contractors are authorized by Chapter 89 of title 5, United States Code, to use the information collected from you and the plan to determine if the plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the plan in support of OPM's decision on the disputed claim.

How to Obtain a Health Benefits Identification Card

OPM does not provide health benefits identification cards. If you have lost your ID card, you must contact your health benefits plan for a replacement. If you change your enrollment or change plans, your plan will send you a new identification card. This generally takes 60 to 90 days from the date you receive OPM's notice that we have processed your change.

If you should need health services before you receive your new ID card, you may show the OPM notice you received to the doctor or hospital to verify your new enrollment. Be sure to refer to your Social Security Number and date of birth when contacting your plan. If you are a survivor annuitant, you should also refer to the full name of the deceased employee or annuitant on whose service your benefits are based and give his or her Social Security Number and date of birth.

Special Information for Compensationers

If your annuity has been suspended because you are eligible for and are receiving compensation benefits from the Office of Workers' Compensation Programs, U. S. Department of Labor, you must contact your compensation office if you want to change or cancel your health benefits enrollment. That office maintains your health benefits enrollment. If your compensation terminates and you are eligible to have your annuity reinstated, your health benefits enrollment will be transferred to OPM and premiums for your enrollment will be withheld from your reinstated annuity.