

Table of Contents

	<i>Page</i>
What Is the Federal Employees Health Benefits (FEHB) Program?	1
Can I Enroll?	1
Do I Have to Join?	1
What Does the Federal Employees Health Benefits (FEHB) Program Offer?.	2
How Do I Stay Informed About FEHB and Participating Health Plans?	2
Do I Pay for Federal Employees Health Benefits (FEHB) Coverage?.	3
What Is Premium Conversion?.	3
What Types of Plans Are Available?.	5
Fee-for-Service Plans	5
Health Maintenance Organizations (HMOs)	6
Point of Service	7
What Types of Enrollment Are Available?	7
Self Only	7
Self and Family	7
Which Family Members Are Covered Under My Enrollment?	8
When Does My Family Member Lose Coverage?.	9
When Can I Change From a Self and Family Enrollment To a Self Only Enrollment?.	9
Can My Former Spouse Continue Federal Employees Health Benefits (FEHB) Coverage?	10
Can Someone Be Covered Under More Than One Federal Employees Health Benefits (FEHB) Enrollment?	11

When Can I Enroll in Federal Employees Health Benefits (FEHB) or Change My FEHB Enrollment?	12
What Are the Major Events That Permit Enrollment or Change in Enrollment?	13
When Does My Enrollment Become Effective?	14
What Is an Enrollment Request?	14
Can I Change My Enrollment if My Physician Stops Participating With My Plan?	15
When Will I Get an Identification Card?	15
What Happens When I Have Federal Employees Health Benefits (FEHB) Coverage and Medicare?	15
Can I Continue My Federal Employees Health Benefits (FEHB) Coverage After I Retire?	16
When Does My Enrollment Continue Automatically?	17
Transfer	17
Leave Without Pay.	17
Military Service	17
Workers' Compensation	18
What Happens to My Family's Coverage When I Die?	18
Can I Cancel My Enrollment?	18
When Will My Enrollment End?	19
Do I Get an Extension of Coverage After My Enrollment Ends?	20
Can I Continue FEHB Coverage After I Separate From Service?	20
How Do I Elect Temporary Continuation of Coverage?	21
Can My Family Members Continue Federal Employees Health Benefits (FEHB) Coverage?	21

How Do My Family Members Elect Temporary Continuation of Coverage? . . .	21
What About Premiums for Temporary Continuation of Coverage?	22
When Does My Temporary Continuation of Coverage Become Effective? . . .	22
Can I Convert to an Individual Policy?	23
How Do I Apply for an Individual Policy?	23
What Happens if I Miss the Deadline?	23
Can My Family Members Convert to an Individual Policy?	24
When Does the Individual Policy Become Effective?	24
I'm Leaving Federal Employment. Can I Get a Certificate of My FEHB Coverage?	24
Where Can I Get Information on How My Plan Processes Claims?	24
Will the Office of Personnel Management (OPM) Process or Pay My Claim?	25
What Can I Do if My Plan Won't Pay a Claim?	25
What Are My Rights and Responsibilities as a Federal Employees Health Benefits (FEHB) Enrollee?	25
What Are the Five Steps to Safer Health Care?.	27
Table of Permissible Changes in Enrollment	29
Employees.	29
Annuitants.	31
Former Spouse Under Spouse Equity Provisions.	33
Temporary Continuation of Coverage Enrollees	35

What is the Federal Employees Health Benefits (FEHB) Program?

The FEHB Program is the largest employer-sponsored group health insurance program in the world, covering almost 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, Health Maintenance Organizations (HMOs), and plans offering a Point of Service (POS) product.

Can I Enroll?

You can enroll in FEHB if you are:

- a permanent Federal employee with a regularly scheduled tour of duty;
- a temporary employee with an appointment for longer than one year; or
- a temporary employee with an appointment limited to one year or less, and you have completed one year of current continuous employment (excluding any break in service of 5 days or less).

You are not eligible to enroll if you are an intermittent employee (you don't have a prearranged regular tour of duty) or if your position is excluded from coverage by law or regulation.

Do I Have to Join?

No, you decide whether you want to participate in the FEHB Program. When you first become eligible, your human resources office will ask you to choose either to enroll or not to enroll. If you don't enroll when you first become eligible, you won't be able to enroll until open season or until another event permitting enrollment occurs.

What Does the Federal Employees Health Benefits (FEHB) Program Offer?

- 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;
- Continued group coverage for your family after you die.

How Do I Stay Informed About FEHB and 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 how it changes for the upcoming year. If you want to continue your current enrollment, you don't have to do anything during open season.

You can download Guides and plan brochures from our web site at www.opm.gov/insure. You can also compare health plans, link to plan web sites, and get information on plan quality. You can access the FEHB Handbook, which contains policies, procedures, and guidance for enrollees and employing offices on the FEHB Program. If your agency participates in Employee Express, you can make enrollment changes online during open season. Our web site has the most current information available to you.

Do I Pay for Federal Employees Health Benefits (FEHB) Coverage?

You share the cost of your health benefits coverage with the Government. Most full-time employees pay only 25% of the total premium.

Premiums and the Government contribution change yearly. You can find each plan's current premiums in the most recent *Guide to Federal Employees Health Benefits Plans* (available from your human resources office and at www.opm.gov/insure).

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.

What Is 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 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.

What Is Premium Conversion? (continued)

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 Federal Employees Health Benefits (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 already 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;

What Types of Plans Are Available?

- 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; or
- Start or end of your spouse's employment.

The types of plans that participate in the Federal Employees Health Benefits (FEHB) Program are:

Fee-for-Service Plans

This is a traditional type of insurance in which the health plan will either reimburse you or pay the medical provider directly for each covered medical expense after you receive the service. When you need medical attention, you visit the doctor or hospital of your choice. After receiving medical treatment, your provider or you file a claim to your health plan and it pays a benefit, but you usually must first pay a deductible and coinsurance or a copayment. These plans use some managed care features such as precertification and utilization review to control costs. Most also provide access to preferred provider organizations (PPOs), as described below. When you use a PPO, you do not have to file a claim. Using a PPO will save you money.

Fee-for-service plans include:

- Plans open to everyone eligible to enroll under the FEHB Program. Some of these plans are sponsored by unions or employee organizations that require you to hold full or associate membership in the sponsoring organization.

What Types of Plans Are Available? *(continued)*

- Plans sponsored by unions and employee organizations and restricted to employees in certain occupational groups and/or agencies.

Generally, a sponsoring organization will require you to pay a membership fee or dues, in addition to the premium. The employee organization sets and collects this fee, which is not negotiated with the Office of Personnel Management (OPM).

- ***Preferred Provider Organizations (PPO)***. A PPO is a fee-for-service option that allows you to see certain medical providers who reduce their charges to the plan, which means you pay less money out-of-pocket than when you use a non-PPO provider. When you visit a PPO you usually won't have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. For instance, the PPO agreement may not cover lab work and radiology services from independent practitioners within the hospital, but it would cover room and board charges.

Health Maintenance Organizations (HMOs)

An HMO is a health plan that provides care through a network of physicians, hospitals, and other providers in particular geographic areas. HMOs coordinate the health care services you receive. Your eligibility to enroll in an HMO is determined by where you live or, for some plans, where you work. Some HMOs have agreements with providers in other service areas for non-emergency care if you travel or are away from home for extended periods, called "reciprocity". Plans that offer such reciprocity discuss it in their benefit brochure under *Special Features*.

- The HMO provides a comprehensive set of services – as long as you use the doctors and providers in the HMO network. HMOs charge a copayment for primary physician and specialist visits and generally no deductible or coinsurance for in-hospital care.
- Most HMOs ask you to choose a doctor or medical group to be your primary care physician (PCP). Your PCP

What Types of Plans Are Available? *(continued)*

provides your general medical care. In many HMOs, you must get authorization or a “referral” from your PCP for you to be evaluated and/or treated by a different physician or medical professional. The referral ensures you see the right provider for the care most appropriate to your condition.

- Care you receive from a provider not in the HMO’s network is not covered unless it’s emergency care, you have obtained a proper referral for the care, or the plan has a reciprocity arrangement.

Point of Service

Some fee-for-service plans and health maintenance organizations (HMOs) offer a point of service product. You have the choice of using a designated network of providers or going outside of the network for care. If you use network providers, your out-of-pocket costs will be less than if you go out of network. If you don’t use network providers, you must pay higher out-of-pocket costs, including deductibles, coinsurance, and copayments.

What Types of Enrollment Are Available?

The Federal Employees Health Benefits (FEHB) Program offers two types of enrollment:

Self Only

A self only enrollment covers only you as the enrollee. If you have a self only enrollment and want to cover a new family member, you must change to a self and family enrollment.

Self and Family

A self and family enrollment covers you and all of your eligible family members. You can not exclude any eligible family member from coverage. You can not provide coverage for anyone who is not an eligible family member, even if they live with you and are dependent upon you.

What Types of Enrollment Are Available? *(continued)*

A new family member is automatically covered under your self and family enrollment. You do not need to report the addition of a new family member to your human resources office, but your plan may ask you for information (such as a marriage license or birth certificate) to verify the family member's eligibility. Your plan is not entitled to a new enrollment form as verification of the family member's eligibility.

Which Family Members Are Covered Under My Enrollment?

The family members covered under your self and family enrollment are:

- Your spouse;
- Your unmarried dependent children under age 22. In addition to natural children of a marriage, this includes:
 - Your legally adopted child;
 - Your recognized natural child, if you live together in a parent-child relationship, or the child is financially dependent upon you, or if there is a judicial determination of support;
 - Your stepchild, if you live together in a parent-child relationship; and
 - Your foster child, if you live together in a parent-child relationship and you expect to raise the child to adulthood (this may include a grandchild);
- Your unmarried dependent child age 22 or over who is incapable of self-support because of a disability that existed before age 22. You must expect the disability to continue for at least one year, and the disability must be the reason the child isn't capable of self-support.

The Federal Employees Health Benefits (FEHB) Handbook provides more detailed guidance on coverage requirements, including certifications that you must complete to cover a foster child or a child incapable of self-support (see www.opm.gov/insure/handbook/FEHB28.htm).

When Does My Family Member Lose Coverage?

Your spouse immediately loses coverage under your self and family enrollment when your divorce decree or annulment is final (according to state law).

Your child immediately loses coverage under your self and family enrollment when:

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

Your family member will get a 31-day extension of coverage. He/she will be eligible to elect temporary continuation of Federal Employees Health Benefits (FEHB) coverage or may elect to convert coverage to an individual contract. Your former spouse may be eligible to enroll for FEHB coverage under Spouse Equity provisions.

Your family members also lose coverage if you change from a self and family to a self only enrollment.

Neither your human resources office nor your plan will notify you when your family member loses eligibility.

You should immediately tell your plan when a family member loses coverage. If your plan pays for services received after your family member's coverage ends, you must repay the plan.

When Can I Change From a Self and Family Enrollment To a Self Only Enrollment?

If you participate in premium conversion, you may change to a self only enrollment during the annual open season or within 60 days after you have a qualifying life event. The change in enrollment must be consistent with your qualifying life event. For example, if you get divorced, changing to a self only enrollment would be consistent with that qualifying life event. If you adopt a child, a change from self and family to self only coverage would not be consistent with that qualifying life event.

When Can I Change From a Self and Family Enrollment To a Self Only Enrollment?
(continued)

Can My Former Spouse Continue Federal Employees Health Benefits (FEHB) Coverage?

If you have waived participation in premium conversion, you may change to a self only enrollment or cancel your enrollment at any time.

Your former spouse may be eligible to continue FEHB coverage under Spouse Equity if your former spouse:

- was divorced from you during your Federal employment or receipt of annuity;
- was covered as a family member under an enrollment at least one day during the 18 months before your marriage ended;
- is entitled to a portion of your annuity or to a former spouse survivor annuity; and
- does not remarry before age 55.

You or your former spouse must apply to your human resources office for Spouse Equity coverage within 60 days from the divorce. For more information on how your former spouse can enroll, ask your human resources office for *Benefits for Former Spouses under the Federal Employees Health Benefits Program* or see the FEHB Handbook at www.opm.gov/insure/handbook/FEHB31.htm.

If your former spouse is not eligible to enroll under Spouse Equity, he/she may be eligible to continue FEHB coverage under Temporary Continuation of Coverage provisions.

Can Someone Be Covered Under More Than One Federal Employees Health Benefits (FEHB) Enrollment?

Generally, you may not be covered under two plans at the same time. A human resources office may authorize a dual enrollment to:

- Protect children who would otherwise lose coverage as family members; or
- Allow an employee under age 22 covered under a parent's self and family enrollment to cover his/her dependent child.

No enrollee or family member may receive benefits under more than one FEHB enrollment. When your human resources office authorizes a dual enrollment, you must notify the plan(s) which family members are to be covered under each enrollment.

For more information on dual enrollments, contact your human resources office or see the FEHB Handbook at www.opm.gov/insure/handbook/FEHB10.htm.

When Can I Enroll in Federal Employees Health Benefits (FEHB) or Change My FEHB Enrollment?

<i>I am ...</i>	<i>When Can I Enroll?</i>
A new employee.	Within 60 days after your appointment date.
Moving to a position that offers FEHB coverage. My previous position was excluded from coverage.	Within 60 days after your appointment date.
An eligible employee, but I am not enrolled in FEHB.	Open season, or when another event permitting enrollment occurs (such as a change in family status or employment status).
Enrolled in FEHB, and I want to change my enrollment.	Open season, or when another event permitting enrollment occurs (such as a change in family status or employment status).

If you are an eligible temporary employee, all of the enrollment and enrollment change information applies to you with one exception. A decision not to enroll will not affect your future eligibility to continue FEHB enrollment after retirement.

To enroll or change your enrollment, you must file an enrollment request with your human resources office within the time limit shown in the Table of Permissible Changes in Enrollment (see pages 29-36).

Important: You will not be eligible for FEHB coverage after retirement unless you are enrolled before you retire and meet all the requirements for continuing enrollment after retirement (see page 16).

What Are the Major Events That Permit Enrollment or Change in Enrollment?

- A change in family status:
 - ✓ marriage
 - ✓ birth or adoption of a child
 - ✓ acquisition of a foster child
 - ✓ legal separation
 - ✓ divorce
- A change in employment status:
 - ✓ you are reemployed after a break in service of more than 3 days
 - ✓ you return to pay status after your coverage terminated during leave without pay status or because you were in leave without pay status for more than 365 days
 - ✓ your pay increases enough for premiums to be withheld
 - ✓ you are restored to a civilian position after serving in the uniformed services
 - ✓ you change from a temporary appointment to an appointment that entitles you to a Government contribution
 - ✓ you change to or from part-time career employment.
- You or a family member lose Federal Employees Health Benefits (FEHB) or other coverage:
 - ✓ under another FEHB enrollment because the covering enrollment was terminated, canceled, or changed to self only
 - ✓ under another Federally-sponsored health benefits program
 - ✓ under Medicaid or similar state-sponsored program for the needy
 - ✓ because your membership terminates in the employee organization sponsoring the FEHB plan
 - ✓ under a non-Federal health plan.
- When one of these events occur, you may:
 - ✓ enroll
 - ✓ change your enrollment from self only to self and family
 - ✓ change your enrollment to another FEHB plan or option.

What Are the Major Events That Permit Enrollment or Change in Enrollment? *(continued)*

You also may waive or cancel your waiver of premium conversion at the same time (see “What Is Premium Conversion?”).

You must give your enrollment change to your human resources office from 31 days before to 60 days after the event.

See the Table of Permissible Changes in Enrollment for other enrollment and enrollment change opportunities.

When Does My Enrollment Become Effective?

Generally, the effective date of your enrollment or enrollment change is the first day of the pay period that follows:

- the day your human resources office receives your completed enrollment request; and
- a pay period during any part of which you were in pay status. (This pay status requirement doesn’t apply to a change from self only to self and family.)

However, some events, such as open season, have different effective dates. You can find complete information about effective dates in the Federal Employees Health Benefits (FEHB) Handbook at www.opm.gov/insure/handbook/FEHB10.htm.

What Is an Enrollment Request?

You may use the Health Benefits Election form (SF 2809) to request a new enrollment or change in enrollment. The SF 2809 may be in either paper or electronic format. In addition, your human resources office may also allow you to make open season changes through “Employee Express” or another electronic method, which doesn’t involve a SF 2809.

Can I Change My Enrollment if My Physician Stops Participating With My Plan?

No, this is not a qualifying event for changing your enrollment. However, if you have a chronic or disabling condition and your health plan terminates your provider's contract (unless the termination is for cause), you may be able to continue seeing your provider for up to 90 days after the notice of termination. If you are in the second or third trimester of pregnancy, you may continue seeing your obstetrician until the end of postpartum care.

When Will I Get an Identification Card?

Your plan will send you an identification card once it processes your enrollment. If you need services before you get your identification card, use your copy of the Health Benefits Election form (SF 2809) or your Employee Express enrollment verification letter as proof of enrollment.

What Happens When I Have Federal Employees Health Benefits (FEHB) Coverage and Medicare?

Generally, your FEHB plan and Medicare provide protection against the same kind of medical expenses. Your FEHB plan also provides prescription drug coverage, routine physicals and a wider range of preventive services that Medicare does not. Some FEHB plans also provide coverage for dental and vision care. Medicare covers orthopedic and prosthetic devices, durable medical equipment, home health care, limited chiropractic services, and medical supplies, which some FEHB plans may not cover or only partially cover (check your plan brochure for details).

Whether your FEHB plan or Medicare is primary depends on your current employment or health status. Your FEHB plan brochure provides specific information on how its benefits are coordinated with Medicare.

You can get more information about Medicare at www.medicare.gov or from the publication *Medicare and You* (also available on the web site). You can get more information on FEHB plans and Medicare in the booklet entitled "*The Federal Employees Health Benefits Program and Medicare*," at www.opm.gov/insure/MCare/MHB01.htm.

Can I Continue My Federal Employees Health Benefits (FEHB) Coverage After I Retire?

You may continue your FEHB enrollment after you retire if:

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

An immediate annuity is one that begins within 30 days of separation for retirement. An annuity you receive under the Minimum Retirement Age (MRA)+10 provision of the Federal Employees Retirement System (FERS) also qualifies as an immediate annuity, even though you postponed receipt of your annuity after separating from service.

“Service” means time in a position in which you were eligible to be enrolled and receive a Government contribution towards the cost of your enrollment. You do not need to have been enrolled in the same FEHB plan. Coverage under a non-FEHB plan doesn’t count toward the five-year or first-opportunity requirement, except that time covered under TRICARE counts as long as you are covered under an FEHB enrollment when you retire.

Your first opportunity to enroll is within 60 days after you first become eligible to enroll and receive a Government contribution towards the cost of your enrollment.

The Office of Personnel Management (OPM) may waive the five-year requirement for continuation of enrollment after retirement only under exceptional circumstances. For more information on OPM’s waiver authority, see the FEHB Handbook at www.opm.gov/insure/handbook/FEHB22.htm.

When Does My Enrollment Continue Automatically?

Transfer

Your Federal Employees Health Benefits (FEHB) enrollment will continue when you transfer from one agency to another, as long as you:

- don't have a break in service of more than three calendar days; and
- are eligible for FEHB coverage in your new position.

Leave Without Pay

Your FEHB enrollment will continue for up to one year while you are in leave without pay status, unless you cancel it. You must pay your share of the premiums. Your human resources office will tell you how to make the premium payments.

Military Service

Your FEHB enrollment will continue without change if you enter on active duty in the military service for 30 days or less.

If you enter on active duty for more than 30 days, you may continue your FEHB enrollment for up to 18 months. You may have to pay your share of the premiums for the first 12 months, and you may have to pay an additional amount to continue coverage during the last 6 months of the 18-month period. Your human resources office will tell you whether you will have to pay premiums, how much the premiums will be, and how to make the premium payments.

You may also choose to terminate your enrollment. You will get it back when you exercise your reemployment rights and return to civilian service. Your decision to terminate your enrollment will not affect your future eligibility to continue FEHB enrollment after retirement as long as you enroll within 60 days after you return to civilian service.

When Does My Enrollment Continue Automatically? *(continued)*

What Happens to My Family's Coverage When I Die?

Can I Cancel My Enrollment?

Workers' Compensation

Your enrollment continues while you are receiving compensation from the Office of Workers' Compensation Programs (OWCP) if:

- OWCP determines you are unable to return to duty; and
- you meet the same requirements for continuing coverage as for retirement.

Your surviving eligible family members may continue your health benefits enrollment after you die if:

- you had a self and family enrollment; and
- one family member is entitled to a survivor annuity.

Your retirement system will take appropriate action with your survivors.

If you participate in premium conversion, you may cancel your enrollment only during an open season or upon a qualifying life event. The cancellation of coverage must be consistent with and correspond to your qualifying life event. For example, if you get married and your spouse is employed by a company that provides health insurance for you, then canceling Federal Employees Health Benefits (FEHB) coverage would be consistent with that qualifying life event. If you are divorcing and have children to cover, canceling coverage would not be consistent with that qualifying life event.

If you have waived participation in premium conversion, you may cancel your enrollment at any time.

Your cancellation takes effect on the last day of the pay period in which your human resources office receives your request. You and your family members are not eligible for the 31-day extension of coverage, Temporary Continuation of Coverage, or conversion to an individual policy.

Can I Cancel My Enrollment? (continued)

When you cancel your enrollment, you may not enroll again until an event occurs (such as an open season or a change in family status) that permits enrollment.

You will not be eligible for health benefits coverage after your retirement unless you reenroll before you retire and meet all of the requirements for continuing enrollment into retirement. If you plan to reenroll in time to qualify for coverage as a retiree, keep in mind you may have to retire earlier than expected. You then might not meet the five-year requirement for continuing coverage into retirement. **When you cancel your enrollment you are accepting this risk.** You may want to consider changing your enrollment to a lower cost plan instead of cancellation.

If you are going to be covered by someone else's enrollment and do not want a gap in coverage, you can coordinate the effective dates of your cancellation and your new coverage.

When Will My Enrollment End?

Your enrollment will end, subject to a 31-day extension of coverage, when you:

- separate from service (unless you can retire and continue your enrollment);
- separate under the Federal Employees Retirement System (FERS) MRA+10 provision and you postpone receiving your annuity (you will get Federal Employees Health Benefits [FEHB] coverage back when your annuity starts);
- change to a position that is excluded from coverage;
- die (your family may be eligible to continue coverage);
- have been on leave without pay for 365 consecutive days, or when your leave under the Family and Medical Leave Act expires, whichever is later;
- return to leave without pay status, if you haven't been in pay status for 4 consecutive months after 365 days of continued coverage while in leave without pay status;
- enter on active duty in the military service for more than 30 days, if you decide to terminate your enrollment;
- have completed 18 months of active duty in the military service, or your entitlement to continued coverage ends, whichever is earlier; or

When Will My Enrollment End? *(continued)*

- are a temporary employee whose pay is not enough to cover the premiums and you do not choose a lower-cost plan.

See the Federal Employees Health Benefits (FEHB) Handbook at www.opm.gov/insure/handbook/FEHB15.htm for the effective dates of termination actions.

Do I Get an Extension of Coverage After My Enrollment Ends?

Your coverage will continue without cost to you for 31 days after your enrollment ends for any reason except when you cancel it. During that time you can elect Temporary Continuation of Coverage (TCC) or convert to an individual health benefits contract with your FEHB plan. **Important:** you must exhaust TCC eligibility as one condition for guaranteed access to individual health coverage under the Health Insurance Portability and Accountability Act of 1996.

Your family members are eligible for the extension of coverage when they lose coverage for any reason except when you cancel your enrollment.

If you are hospitalized on the 31st day of extended coverage, your FEHB plan will continue to provide benefits for up to 60 more days of continuous hospitalization unless you converted to an individual contract.

Can I Continue FEHB Coverage After I Separate From Service?

You are eligible to temporarily continue your FEHB coverage for up to 18 months when you:

- separate from service, voluntarily or involuntarily, unless your separation is for gross misconduct; and
- are not otherwise eligible for continued coverage under the Program (not counting the 31-day extension of coverage).

You can get more details on Temporary Continuation of Coverage (TCC) from the FEHB Handbook at www.opm.gov/insure/handbook/FEHB15.htm or from the booklet *Temporary Continuation of Coverage under the Federal Employees Health Benefits Program* (RI 79-27).

How Do I Elect Temporary Continuation of Coverage?

Your human resources office will give you notice of your Temporary Continuation of Coverage (TCC) rights within 61 days after you separate from service. If you want TCC, you must elect it within 60 days from the later of:

- your separation; or
- the date of your human resources office's notice.

You may choose self only or self and family coverage in any plan or option you are eligible to join. You are not limited to the plan, option, or type of enrollment under which you had been covered.

Can My Family Members Continue Federal Employees Health Benefits (FEHB) Coverage?

Your family members are eligible to continue FEHB coverage for up to 36 months under their own Temporary Continuation of Coverage (TCC) enrollments when they:

- lose their eligibility under your coverage; and
- are not otherwise eligible for FEHB coverage.

This includes when your child reaches age 22 or marries, or when you divorce and your former spouse does not qualify under Spouse Equity provisions. ***Neither your human resources office nor your plan will notify you or your family member when he/she loses coverage.***

Your family members are not eligible for TCC when you cancel your enrollment or change to a self only enrollment.

How Do My Family Members Elect Temporary Continuation of Coverage?

You must notify your human resources office or retirement system within 60 days from the date your family member loses eligibility under your enrollment. (If you are divorcing, your former spouse may notify your human resources office on his/her own behalf.) Within 14 days, your human resources office will send your family member notice of his/her own Temporary Continuation of Coverage (TCC) rights.

If your family member wants TCC, he/she must elect it within 60 days from the later of:

How Do Family Members Elect Temporary Continuation of Coverage? *(continued)*

- the date he/she loses eligibility under your enrollment; or
- the date of your human resources office's notice.

If your former spouse loses Spouse Equity eligibility within 36 months after your marriage ends, he/she must notify your human resources office within 60 days of losing this eligibility to apply for the remaining months of TCC.

What About Premiums for Temporary Continuation of Coverage?

Generally, you or your family member must pay both the Government and employee shares of the premium, plus a 2% administrative charge. When Temporary Continuation of Coverage (TCC) ends, you will get another 31-day extension of coverage and conversion rights (unless you canceled your coverage or did not pay premiums).

When Does My Temporary Continuation of Coverage Become Effective?

The first 31 days of the Temporary Continuation of Coverage (TCC) eligibility period overlap with the free 31-day extension of coverage. You must begin to pay premiums for TCC after the 31-day extension of coverage ends. You must pay retroactive premiums to this date even if your enrollment is not finalized by then.

If you:

- elect a different plan or option when you enroll under TCC, and
- you or a covered family member are in a hospital on the 31st day of the extension of coverage,

your old plan or option will continue coverage for the hospitalized person as long as he/she is hospitalized, 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.

Can I Convert to an Individual Policy?

You may convert to an individual policy with the carrier of your plan when your Federal Employees Health Benefits (FEHB) coverage ends, except when you cancel your enrollment.

The plan is not allowed to:

- ask for evidence of good health;
- impose waiting periods; or
- limit coverage for pre-existing conditions.

Your benefits and rates will be different from those under the FEHB Program. The Government does not contribute to the cost of the individual conversion contract.

How Do I Apply for an Individual Policy?

Your human resources office must give you a notice of your right to convert to an individual policy no later than 60 days from the termination date.

Complete the back of your copy of the notice and send it to the carrier of your plan within 31 days from the date of the notice, but no later than 91 days from the date your enrollment terminates.

What Happens if I Miss the Deadline?

You lose your opportunity to convert to an individual policy unless there are reasons beyond your control (including when you do not get the required conversion notice within 60 days). In those cases, you can ask the carrier of your plan to accept a late conversion. You must send your written request within 6 months after the date your enrollment terminated. You must include some documentation that your enrollment has terminated (for example, a *Notification of Personnel Action*, SF 50 showing separation from service).

Can My Family Members Convert to an Individual Policy?

Your family members also may convert to individual coverage when they lose eligibility under your enrollment, or when their Spouse Equity or Temporary Continuation of Coverage (TCC) ends. *Neither your human resources office nor your plan will notify you or your family member when he/she loses coverage.*

You or your family member should write to the carrier of your plan within 31 days after your family member's Federal Employees Health Benefits (FEHB) coverage ends to request conversion to an individual contract.

When Does the Individual Policy Become Effective?

Your or your family member's conversion contract becomes effective at the end of the 31-day extension of coverage, even when you or your family member are hospitalized on the 31st day of extended coverage.

I'm Leaving Federal Employment. Can I Get a Certificate of My FEHB Coverage?

When your FEHB coverage ends, your plan will automatically send you a Certificate of Group Health Plan Coverage. You need to show this certificate to a new non-FEHB insurer to reduce or eliminate any pre-existing condition limitations that it may otherwise be able to apply to your coverage. If you do not get a certificate automatically, the plan must send you one at your request. If needed, you also may get certificates from other FEHB plans you have been enrolled in to document continued group health plan coverage.

Where Can I Get Information on How My Plan Processes Claims?

You can get this information by reading your plan brochure carefully. It will help you become familiar with your plan's benefits and claims procedures. You may also ask your plan directly about benefits, claims payment and claims processing.

Will the Office of Personnel Management (OPM) Process or Pay My Claim?

What Can I Do if My Plan Won't Pay a Claim?

What Are My Rights and Responsibilities as a Federal Employees Health Benefits (FEHB) Enrollee?

No, OPM does not pay or process claims.

Your plan brochure has detailed information on how to file a reconsideration request with your plan and a disputed claim request with OPM. Before you request reconsideration from the plan or ask OPM for a disputed claim review, please read this information in your plan brochure.

A mainstay of the FEHB Program is the Patients' Bill of Rights and Responsibilities, as recommended by the President's Advisory Commission of Consumer Protection and Quality in the Health Care Industry. The following are consumer protections and quality initiatives you can count on from your FEHB plan.

- Transitional care:
 - ✓ If you have a chronic or disabling condition and your health plan terminates your provider's contract (unless the termination is for cause), you may be able to continue seeing your current specialist for up to 90 days after the notice of termination. If you are in the second or third trimester of pregnancy, you may continue seeing your obstetrician until the end of your postpartum care.
 - ✓ If you have a chronic or disabling condition or are in your second or third trimester of pregnancy and your health plan drops out of the FEHB Program, you may be able to continue seeing your provider if you enroll in a new FEHB plan. You may continue to see your current specialist after your old enrollment ends, even if he or she is not associated with your new plan, for up to 90 days after you receive the termination notice or through the end of postpartum care, and pay no more than if your old enrollment had not ended.
- You have the right to review and obtain copies of your medical records on request. You may ask a physician amend a record that is not accurate, relevant, or complete. If the physician does not amend your record, you may add a brief statement to the record.

What Are My Rights and Responsibilities as a Federal Employees Health Benefits (FEHB) Enrollee? *(continued)*

- Direct access to women’s health care providers for routine and preventive health care services.
- Coverage of emergency department services for screening and stabilization without authorization if you have reason to believe serious injury or disability would otherwise result.
- Direct access to a qualified specialist within your network of providers if you have complex or serious medical conditions that need frequent specialty care. Authorizations, when required by the plan, will be for an adequate number of direct access visits under an approved treatment plan.
- Assurance there will be no “gag rules” in provider contracts that could limit communication about medically necessary treatment.
- Extensive information about plan characteristics and performance, provider network characteristics, physician and health care facility characteristics, and care management.

Check our web site at

www.opm.gov/insure/health/billrights.htm for listings of the specific types of information your health plan must make available to you. You may also contact your health plan directly for this information.

The health care system works best when you take the time to become informed. As a responsible consumer, you should:

- Read and understand your health benefits coverage, limitations, and exclusions, health plan processes, and procedures to follow when seeking care.
- Work with your physician in developing and carrying out a treatment plan.
- Practice healthy habits.

What Are the Five Steps to Safer Health Care?

Medical error and patient safety aren't well understood by most Americans. When we need vital or risky health care services, we want to believe someone else has made sure that we'll get safe care. Sadly, every hour, 10 Americans die in a hospital due to avoidable errors; another 50 are disabled. Too many patients get the wrong medicines, the wrong tests and the wrong diagnosis. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Speak up if you have questions or concerns. Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It's okay to ask questions and to expect answers you can understand.

2. Keep a list of all the medicines you take. Tell your doctor and pharmacist about the medicines you take, including over-the-counter medicines such as aspirin and ibuprofen, and dietary supplements such as vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.

3. Make sure you get the results of any test or procedure. Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected — in person, on the phone, or in the mail — don't assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.

4. Talk with your doctor and health care team about your options if you need hospital care. If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures. Also, before you leave the hospital, be sure to

What Are the Five Steps to Safer Health Care? *(continued)*

ask about follow-up care, and be sure you understand the instructions.

5. Make sure you understand what will happen if you need surgery. Ask your doctor and surgeon: Who will take charge of my care while I'm in the hospital? Exactly what will you be doing? How long will it take? What will happen after the surgery? How can I expect to feel during recovery? Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

**Table of Permissible Changes in Enrollment
Employees**

Event Code for SF 2809	Events that Permit Enrollment Changes	May Enroll	Self Only to Self and Family	Change Plans or Options	Time Limits
1A	Initial opportunity to enroll	Yes	N/A	N/A	Within 60 days after becoming eligible
1B	Open Season	Yes	Yes	Yes	As announced by OPM
1C	Change in family status	Yes	Yes	Yes	From 31 days before through 60 days after event
1D	Change in employment status	Yes	Yes	Yes	Within 60 days of employment status change
1E	Separation from Federal employment when you or your spouse are pregnant	Yes	Yes	Yes	During final pay period of employment
1F	Transfer from a post of duty within United States to one outside United States, or reverse	Yes	Yes	Yes	From 31 days before leaving old post through 60 days after arriving at new post
1G	You or eligible family member lose coverage under FEHB or another group insurance plan	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage
1H	You or eligible family member lose coverage because FEHB plan is discontinued, in whole or part	N/A	Yes	Yes	During open season, unless OPM sets a different time

Event Code for SF 2809	Events that Permit Enrollment Changes	May Enroll	Self Only to Self and Family	Change Plans or Options	Time Limits
1I	You or eligible family member lose coverage under a non-FEHB group health plan because you move out of the commuting area to accept another position and your non-Federally employed spouse leaves job to join you	Yes	Yes	Yes	From 31 days before you leave commuting area through 180 days after arriving in new commuting area
1J	You or covered family member in an HMO move or take job outside the service area, or if already outside this area, move or take job further from this area	N/A	Yes	Yes	Upon notifying the human resources office of the move or change of place of employment
1K	On becoming eligible for Medicare (You may make this change only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare
1L	You complete one year of continuous service as a temporary employee	Yes	N/A	N/A	Within 60 days after becoming eligible
1M	Your salary as a temporary employee is not enough to pay for plan in which enrolled	N/A	No	Yes	Within 60 days after receiving notice from human resources office

Annuitants

Event Code for SF 2809	Events that permit enrollment changes	May Enroll	Self Only to Self and Family	Change Plans or Options	Time Limits
2A	Open season	No	Yes	Yes	As announced by OPM
2B	Change in family status (Special rules apply for survivor annuitants; refer to the FEHB Handbook)	No	Yes	Yes	From 31 days before through 60 days after the event
2C	Reenrollment when you suspended FEHB enrollment to enroll in a Medicare HMO or Medicaid and later were involuntarily disenrolled from Medicare HMO or Medicaid	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment
2D	Reenrollment when you voluntarily disenroll from a Medicare HMO or Medicaid	May Reenroll	N/A	N/A	During open season
2E	You apply for postponed Minimum Retirement Age (MRA)+10 annuity under the Federal Employees Retirement System (FERS)	Yes	N/A	N/A	Within 60 days after OPM mails you a notice of eligibility
2F	Your annuity or OWCP payments are restored	Yes	N/A	N/A	Within 60 days after OPM or OWCP mails a notice of insurance eligibility
2G	You or eligible family member lose FEHB coverage because the covering enrollment was terminated, canceled, or changed to self only	Yes	Yes	Yes	From 31 days through 60 days after date of loss of coverage

Event Code for SF 2809	Events that permit enrollment changes	May Enroll	Self Only to Self and Family	Change Plans or Options	Time Limits
2H	You or eligible family member lose coverage under FEHB or another group insurance plan	No	Yes	Yes	From 31 days before through 60 days after loss of coverage
2I	You or eligible family member lose coverage because FEHB plan is discontinued in whole or part	N/A	Yes	Yes	During open season, unless OPM sets a different time
2J	You or covered family member move or take job outside the HMO service area, or if already outside this area, move or take job further from this area	N/A	Yes	Yes	Upon notifying the Retirement System of the move or change of place of employment
2K	You are in an overseas post of duty and retire or die	No	Yes	Yes	Within 60 days after retirement or death
2L	You are enrolled and separate from duty after serving 31 days or more in a uniformed service	N/A	Yes	Yes	Within 60 days after separation from the uniformed service
2M	On becoming eligible for Medicare (You may make this change only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare
2N	Your annuity is not enough to make withholdings for plan in which enrolled	N/A	No	Yes	Retirement system will advise you of the options

Former Spouse Under Spouse Equity Provisions

Event Code for SF 2809	Events that Permit Enrollment Changes	May Enroll	Self Only to Self and Family	Change Plans or Options	Time Limits
3A	Initial opportunity to enroll	Yes	N/A	N/A	Generally, must apply within 60 days after marriage ends. If retiring employee elects a former spouse or insurable interest annuity, the former spouse must apply within 60 days after OPM's notice of FEHB eligibility. May enroll any time after eligibility established
3B	Open season	No	Yes	Yes	As announced by OPM
3C	Change in family status based on addition of family members who are also eligible family members of the employee or annuitant	No	Yes	Yes	From 31 days before through 60 days after change in family status
3D	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare-sponsored HMO or Medicaid and who later was involuntarily disenrolled from Medicare HMO or Medicaid	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment

Event Code for SF 2809	Events that Permit Enrollment Changes	May Enroll	Self Only to Self and Family	Change Plans or Options	Time Limits
3E	Reenrollment of former spouse who voluntarily disenrolls from a Medicare-sponsored HMO or Medicaid	May Reenroll	N/A	N/A	During open season
3F	Former spouse or eligible child loses FEHB coverage because covering enrollment is terminated, canceled, or changed to self only	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage
3G	Enrolled former spouse or eligible child loses coverage under another group insurance plan (but see 3D and 3E)	N/A	Yes	Yes	From 31 days before through 60 days after date of loss of coverage
3H	Former spouse or eligible family member loses coverage because FEHB plan is discontinued in whole or part	N/A	Yes	Yes	During open season, unless OPM sets a different time
3I	Former spouse or covered family member move or take job outside the HMO's service area, or if already outside this area, move or take job further from this area	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment
3J	On becoming eligible for Medicare (You may make this change only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare
3K	Former spouse's annuity is not enough to make the FEHB withholdings for plan in which enrolled	No	No	Yes	Retirement System will advise former spouse of options

Temporary Continuation of Coverage Enrollees

Event Code for SF 2809	Events that Permit Enrollment Changes	May Enroll	Self Only to Self and Family	Change Plans or Options	Time Limits
4A	Opportunity to enroll for continued coverage under Temporary Continuation of Coverage (TCC) provisions	Yes	Yes, for former employee. N/A for former spouse and child who ceases to qualify as a family member	Yes, for former employee. N/A for former spouse and child who ceases to qualify as a family member	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open season	No	Yes*	Yes	As announced by the Office of Personnel Management (OPM)
4C	Change in family status (except former spouse)	No	Yes	Yes	From 31 days before through 60 days after event
4D	Change in family status of former spouse based on addition of family members who are also eligible family members of the employee or annuitant	No	Yes	Yes	From 31 days before through 60 days after event
4E	Reenrollment after Temporary Continuation of Coverage (TCC) enrollment terminated because of other Federal Employees Health Benefits (FEHB) coverage; then the other FEHB coverage is lost before the TCC eligibility period (18 or 36 months) expires	May Reenroll	N/A	N/A	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage
4F	Enrollee or eligible family member loses coverage under FEHB or another group insurance plan (but see 4E)	No	Yes	Yes	From 31 days before through 60 days after date of loss of coverage

Event Code for SF 2809	Events that Permit Enrollment Changes	May Enroll	Self Only to Self and Family	Change Plans or Options	Time Limits
4G	Enrollee or eligible family member loses coverage because FEHB plan is discontinued in whole or part	N/A	Yes	Yes	During open season, unless the Office of Personnel Management (OPM) sets a different time
4H	Enrollee or covered family member in a Health Maintenance Organization (HMO) move or take job outside the service area, or if already outside this area, move or take job further from this area	N/A	Yes	Yes	Upon notifying the human resources office of the move or change of place of employment
4I	On becoming eligible for Medicare (You may make this change only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare

* Former spouse may change to self and family only if family members are also eligible family members of the employee or annuitant.



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