FEHB Federal Employees Health Benefits

INFORMATION for RETIREES and SURVIVOR ANNUITANTS

This pamphlet contains information about the Federal Employees Health Benefits Program. Refer to it when you or your family have questions about this Program.

United States Office of Personnel Management Retirement and Insurance Service

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Previous editions are not usable

We provide retirement information and assistance on the Internet. You will find retirement brochures, forms, and other information at:

http://www.opm.gov

You will find health benefits plan brochures at:

http://www.opm.gov/insure

You may also contact us for assistance using email at:

retire@opm.gov

We will respond to your email address.

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Contacting Us at the U.S. Office of Personnel Management (OPM)

You can call us about your health benefits enrollment. Our toll-free telephone number is 1-888-767-6738. With the exception of Federal holidays and weekends, you can stay on the line and speak to one of our customer service specialists between the hours of 7:30 a.m. and 7:45 p.m. (Eastern time). Customers within local calling distance to Washington, DC, must call us on 202-606-0500. Persons with hearing impairments who have TDD equipment should call 1-800-878-5707.

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 health maintenance organization.
- Change to a less expensive plan or option 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 at:

U.S. Office of Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017-0045.

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

Health Benefits Coverage

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), 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. We will change your enrollment to the 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 already established a child's eligibility for continued coverage 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, contact us. We will send you a form which you and the child's doctor must complete.

Foster Children
A foster child for health benefits purposes is a child under age 22 who:

- is financially dependent on you,
- lives with you in a regular parent-child relationship, and
- 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. Please notify your health insurance carrier about your new family member so they can update their records. Your carrier may ask for proof of your relationship (such as proof of marriage or birth) and for the new family member's name, date of birth, and Social Security Number. 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 end. However, if your survivor annuity continues because you were married to the deceased for 30 years or more, your coverage will continue.

If you remarry on or after age 55, your coverage will continue, but it will not cover your new spouse and his or her dependents. If you also receive an annuity as a retiree based on your own Federal career, you may be eligible to transfer the enrollment to your retirement annuity to cover your new spouse and his or her eligible children. If you wish to do so, contact us. Be sure to provide your retirement and survivor annuity claim numbers. We will determine if you are eligible to transfer your enrollment after we receive your request.

If You Are a Former Spouse Survivor Annuitant

If you have health benefits 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 natural child or adopted child under age 22 from your marriage to the employee or retiree. A disabled child over age 22 may also be covered. You cannot cover any foster child or grandchild. 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 end, unless your survivor annuity continues because you were married to the deceased for 30 years or more.

Deferred Annuitants

If you separated from Federal service before you could retire and are now receiving a deferred annuity that 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 not based on your deferred annuity.

Federal Employees Retirement System (FERS) Postponed Retirement

If you are covered by FERS and eligible for an immediate retirement at separation from government service, you may postpone receiving your annuity to avoid the age reduction. You are eligible to reenroll for health benefits and life insurance coverage when you begin to receive your postponed annuity, if you were eligible to continue the coverage in retirement.

When a Family Member Loses Eligibility for Coverage

- You will not be informed by us or by your health insurance carrier when a family member loses eligibility for coverage.
- Your spouse loses eligibility for coverage under your Self and Family enrollment on the effective date of divorce or annulment of the marriage.
- A child loses eligibility for coverage upon 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 upon marriage or recovery of ability for self support. If the marriage ends, the child would

again be eligible for coverage provided the child is still not capable of self support.

If your family member loses eligibility for coverage for any of the above reasons, you may wish to ask us for information about temporary continuation of coverage; this is discussed on page 18. Meanwhile, the family member's 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.

Changing Your Plan

Factors to Consider When Changing Your Enrollment

Because health insurance needs vary with each person, we cannot provide specific advice on which plan or enrollment is best for you. In deciding which plan to choose, you should consider your family's medical needs, the type of health care delivery system you prefer, and the cost of each plan. You should compare the benefits offered by the plans available to you. Your eligibility for Medicare is another factor in your decision.

We prepare a Federal Employees Health Benefits (FEHB) Guide each year to give you general information about the major features of each plan participating in the health benefits program. Each plan has a brochure that describes its benefits in detail. We mail each enrollee a Guide every year before open season. However, you may ask us for the Guide at any time; it provides information about how to obtain individual plan brochures. You can obtain an Federal Employees Health Benefits (FEHB) Guide by calling 1-888-767-6738 or by writing to:

U.S. Office of Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017-0045

Brochures and the Guide are on the Internet at http://www.opm.gov/insure.

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, prescription drugs, etc., not covered or only partially covered by the plan.

The Federal Employees Health Benefits (FEHB) Program offers a variety of health plans so you will have choices and opportunities to make your health-care dollar go further.

Medicare-sponsored Coordinated Care Plans (MCCP)

Medicare-sponsored coordinated care plans are an option for anyone who is age 65 or older and enrolled in Medicare, Parts A and B. These plans are sometimes called Medicare Health Maintenance Organization's (HMO's). If you join an MCCP, 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 MCCP's 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. Before you make any changes in your health insurance, you should carefully examine the benefits of

the Medicare-sponsored Coordinated Care Plans (MCCP) and compare them to what you now have.

If You Want to Suspend Your Enrollment

You may suspend your Federal Employees Health Benefits (FEHB) enrollment because you have joined an MCCP. Send us a copy of the document that shows your enrollment date and ask us to suspend your FEHB enrollment.

If You Want to Reactivate Suspended Coverage

If you move out of the service area of the MCCP, you may reenroll in FEHB the beginning of the month in which you move. However, if you decide to cancel your MCCP, 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 MCCP coverage until the FEHB open season enrollment effective date, which is January first of the next year. Contact us for instructions on how to reenroll in the FEHB Program.

Medicaid and Your FEHB Enrollment

You may suspend your FEHB enrollment if you furnish proof of eligibility for coverage under the Medicaid program or a similar State-sponsored program of medical assistance for the needy. If you involuntarily lose the Medicaid or similar State-sponsored coverage, you may reenroll in any available FEHB plan at any time beginning 31 days before and ending 60 days after the loss of that coverage. The reenrollment would take effect on the date following the date of loss of Medicaid or similar State-sponsored coverage.

If you suspend your enrollment because you furnished proof of eligibility for coverage under the Medicaid program or a similar State-sponsored program of medical assistance for the needy, and you wish to reenroll in an FEHB plan for reasons other than an involuntary loss of the Medicaid or similar state-sponsored coverage, you may do so during the next available open season.

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. Generally, voluntary cancellation of enrollment ***permanently bars*** reenrollment in the Federal Employees Health Benefits (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 FEHB.

If you cancel your FEHB enrollment to be enrolled as a family member under another person's FEHB enrollment, you are eligible to reenroll if you lose coverage under the other person's enrollment. To reenroll, you must contact us within the period beginning 31 days before and ending 60 days after the loss of coverage.

Families Where Both Spouses Are Eligible to Enroll in the FEHB Program in Their Own Right
If you are eligible to continue FEHB enrollment in retirement and your spouse is a Federal employee eligible for FEHB enrollment (or if both of you are retired and each is eligible for enrollment as a retiree), you 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.

You may change to two Self Only coverages at any time during the year as explained below.

Direct Payment of Premiums by Annuitants
Sometimes the annuity payable is less than the amount of the health benefits premiums. If this occurs, to prevent the loss of this important benefit, we give you the choice of changing to a lower cost plan or making premium payments directly to us. Once you choose direct payment of premiums, they cannot be deducted from the monthly annuity even if it increases to an amount that is higher than the health benefits premiums.

The cost of your coverage is the same as it would be if we could withhold premiums from your monthly annuity. You will pay only the enrollee share to us. We will send you a letter providing payment instructions and a set of health benefit premium coupons 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 us, contact us as described on page 1.

How to Change Your Enrollment

To change your enrollment, contact us. Be sure to give your retirement claim number or your survivor annuity claim number. 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 Federal Employees Health Benefits (FEHB) Program at a later date. However, if you suspend your enrollment to join a Medicare-sponsored coordinated care plan (MCCP) or Medicaid or a similar State-sponsored program or you cancel your enrollment to be covered by a spouse's FEHB Self and Family coverage, you may be eligible to reenroll.

Effective Dates for Enrollment Changes

The effective date for enrollment changes depends on the date our office receives your request. 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.)

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. For example, if you change from Family to Self Only coverage effective June 1, the lower Self Only premium will be deducted from your July 1 annuity payment.

Events Which Permit Change	From Self Only to Family
Change from Self and Family to Self Only.	N/A
Open season.*	Yes
Your family status changes (marriage, divorce, legal separation, death of a family member, birth or adoption of a child).	Yes
You are enrolled in a Health Maintenance Organization (HMO) and you move or a covered family member moves from the area it serves.*	Yes
Your plan stops participating in the Federal Employees Health Benefit Program (FEHB).*	Yes
You become eligible for Medicare.* *(You may make this change only once in your lifetime.)*	No
You or an eligible family member lose coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another Federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or a similar state-sponsored program; • Loss of coverage under a non-Federal health plan.	Yes
*We can make this change for you based on your telephone call.	

These are some of the most common events which allow you to make an enrollment change. To request an enrollment change, call us at 1-888-767-6738.

From One Plan or Option to Another	Time Limit In Which Election to Change Must Be Filed With the Office of Personnel Management (OPM)
No	At any time.
Yes	As announced by OPM.
Yes	From 31 days before through 60 days after the event.
Yes	When you or a family member present OPM with notification of a change of address outside the plan's service area.
Yes	As announced by OPM at that time.
Yes	30 days before you become eligible for Medicare or any time thereafter.
Yes	From 31 days before through 60 days after loss of coverage.

Continuation of Coverage for Survivors After Enrollee's Death

After your death, your eligible family members will continue to be covered if 1) you were enrolled for Self and Family and 2) a family member receives a survivor annuity. The coverage ends if the survivor annuity terminates. The survivor's share of the cost of the plan is the same amount you are paying and will be deducted from the survivor 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 Self Only coverage.

Some Federal Employees Retirement System (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 us, 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 us to cancel your survivor annuitant enrollment. (You cannot be enrolled in two plans at the same time.) If you are a Federal employee and choose to have your Federal Employees Health Benefits (FEHB) enrollment transferred from your retirement system to your employing agency, you can have your health benefits premiums withheld from your salary before taxes. We call this "premium conversion." Premium conversion allows you to reduce your taxable income by the amount of your contribution to your FEHB premium and save on Federal income tax, Medicare, and Social Security — and, in most instances, State and local taxes. You must

be a survivor annuitant who is also a Federal employee in a position that conveys eligibility for Federal Employees Health Benefits (FEHB) coverage in order to participate in premium conversion. For additional information on premium conversion, visit the Office of Personnel Management's (OPM's) web site at www.opm.gov/insure and click on the link for premium conversion. If your enrollment as a Federal employee stops for any reason, it may be reinstated as a survivor annuitant enrollment if you are still receiving a survivor annuity. To request such reinstatement, write to the address shown on page 1. 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 with your request for reinstatement. If we receive your letter within 60 days after the event that 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.

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 keep 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 need to notify us immediately. 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 after age 55, your survivor annuity and health benefits coverage will continue.

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 discussed on page 18). However, if you were married for 30 years or more to the deceased employee or annuitant, your survivor annuity and your health benefits enrollment will continue. If you are enrolled in Self and Family coverage when your annuity ends, 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 notify us immediately. 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, your new spouse and his or her children cannot receive health benefits coverage under your survivor annuitant enrollment. (How-

ever, 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.)

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 ended because you remarried 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 ended because you remarried before age 55, your survivor annuity and health benefits coverage ***cannot*** be reinstated if your marriage ends.

If You Are a Child Survivor Annuitant
If you have Federal Employees Health Benefits 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 health benefits coverage ends at the end of the month before the one in which you remarry. (This does not apply if you were married for 30 years or more as discussed on page 4.) 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 can reenroll in a Federal Employees Health Benefits (FEHB) plan when your survivor annuity is reinstated. If your remarriage ends, you need to notify us immediately. 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

Temporary Continuation of Federal Employees Health Benefits (FEHB) Coverage

Beginning with the enactment of Public Law 100-654 on 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, ***we 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 or marries. For a former spouse, ***you or the former spouse*** must contact us within 60 days after the former spouse loses coverage because of divorce, annulment, or remarriage 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.

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 when you voluntarily cancel your 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 Federal Employees Health Benefits (FEHB) Program in your own name,

and your enrollment ends 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 ends, we will send you a notice of termination and your right to convert. (Note: We do not

notify family members who lose eligibility for coverage under a Self and Family enrollment.) 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 you do not receive the notice of termination 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 6 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 (1) that 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 us to review that decision by writing:

U.S. Office of Personnel Management
Retirement and Insurance Service
Office of Insurance Programs
P.O. 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 18. ***You will not be noti-***

fied by us when a family member loses eligibility. The affected family member will not be notified by us 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 the plan.

How Medicare Affects Your Health Benefits Coverage

Because many people covered by the Federal Employees Health Benefits (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:

- are age 65 or over and
- are not employed in the Federal service,

Medicare is the primary payer of your health benefits expenses. Your Federal Employees Health Benefits (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.

Please refer to our publication RI 75-12 listed on page 28 for more detailed information about the relationship between Medicare and FEHB.

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 insurance carrier cannot process a claim until after Medicare has paid any expenses they cover. Most Federal Employees Health Benefit (FEHB) carriers have arranged with Medicare to transfer your claim to them after Medicare has paid its share. If your carrier does not have such an arrangement, you must always submit the Explanation of Benefits you receive from Medicare to your carrier 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.

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 or at any time thereafter.

Medicare Premiums

We 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 the U.S. Office of Personnel Management) if you want Medicare premiums withheld from your annuity. Social Security will need your retirement claim number (CSA number) or survivor annuity number (CSF number). If you are eligible, your local Social Security office will notify the Social Security Administration head-

quarters in Baltimore, Maryland, which will notify us 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 insurance carrier for payment consideration. Do not send your claim form to us. Contact your carrier to ask for claim forms.

If Your Claim for Medical Expenses Is Denied

If your carrier denies a claim for payment or for service, it will reconsider its denial on receipt of a written request within six months after the date of the denial. This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit. In your written request state why you believe your carrier should pay the claim or provide the service. Your reasons must be based on the specific provisions in your plan's brochure.

Within 30 days after receipt of your request for reconsideration, the carrier 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 carrier will base its decision on the information it has on hand.

If the carrier affirms its denial, you have a right to a review by us to determine whether the carrier has acted in accordance with its contract. You must request our review within 90 days after the date of the carrier's letter affirming its decision to deny your claim. We will not review your claim unless you demonstrate that you gave the carrier the opportunity to reconsider its initial denial.

Before seeking our review of a claim, these are some things you should keep in mind:

- Submit bills from providers for payment to the carrier along with the appropriate claim form; do not send bills to the address below or any other office within our agency 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 carrier 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 your letter to the carrier requesting reconsideration;
    - a copy of the carrier's reconsideration decision;
    - copies of documents that support your claim (such as operation reports, bills, medical records, explanation of benefit forms);
    - your daytime telephone number.

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

To request our review write to:

U.S. Office of Personnel Management
Retirement and Insurance Service
Office of Insurance Programs
P.O. Box 436
Washington, DC 20044-0436.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies, or drugs covered by your plan until you have exhausted our procedure established at section 890.105, title 5, Code of Federal Regulations.

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. 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 this agency. These actions are limited to the record that was before us and that was the basis of our decision to disallow the benefit, thus affirming the carrier's decision.

Privacy Act Statement. If you request us to review a denial of a claim for payment or service, we or our contractors are authorized by Chapter 89 of title 5, United States Code, to use the information collected from you and the carrier to determine if the carrier has acted properly in denying you the payment or service, and the information so

collected may be disclosed to you and/or the carrier in support of the U.S. Office of Personnel Management's decision on the disputed claim.

How to Obtain a Health Benefits Identification Card

If you have lost your identification card, you must contact your insurance carrier for a replacement. If you change your enrollment or change plans, we will send you a notice confirming the change, and your carrier will send you a new identification card. This generally takes 30 days from the date we notify you that we have processed your change.

If you should need health services before you receive your new ID card, you may show the notice from us 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 carrier. 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, we will be responsible for your health benefits enrollment and will withhold premiums from your reinstated annuity.

Related Information and Publications

We hope this pamphlet has helped you. If you have other questions about retirement and survivor benefits, you may call us at 1-888-767-6738, email retire@opm.gov, or write us at the following address:

U.S. Office of Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017-0045.

If you do write, please be sure to provide your civil service retirement claim number and date of birth to allow us to identify your records promptly.
If you wish to request one or more of the booklets, listed below, they are available from our automated system at any time seven days a week. You may send an email request or write to the above address. You may also find many of these on our web sites at http://www.opm.gov/asd/htm/pub.htm and http://www.opm.gov/retire.

Title	Publication Number
Information for Annuitants (CSRS)	RI 20-59
Information for Survivor Annuitants (CSRS)	RI 25-26
Information for Disability Annuitants (CSRS)	RI 30-13
The Federal Employees Health Benefits Program and Medicare	RI 75-12
Information for Retirees About the Federal Employees' Group Life Insurance Program	RI 76-12
Information for Federal Employees Retirement System (FERS) Annuitants	RI 90-8
Information for FERS Survivor Annuitants	RI 90-12
Information for FERS Disability Annuitants	RI 98-2

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