tered into or renewed for any calendar year beginning, after end of 9-month period beginning Nov. 14, 1988, and with respect to any qualifying event occurring on or after first day of first calendar year beginning after end of such 9-month period, see section 203 of Pub. L. 100–654, set out as a note under section 8902 of this title.

EFFECTIVE DATE OF 1984 AMENDMENT

Amendment by Pub. L. 98–615 effective May 7, 1985, with enumerated exceptions, and applicable to any individual who is married to an employee or annuitant on or after that date, see section 4(a)(2) of Pub. L. 98–615, as amended, set out as a note under section 8341 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–454 effective 90 days after Oct. 13, 1978, see section 907 of Pub. L. 95–454, set out as a note under section 1101 of this title.

§ 8903a. Additional health benefits plans

(a) In addition to any plan under section 8903 of this title, the Office of Personnel Management may contract for or approve one or more health benefits plans under this section.

(b) A plan under this section may not be contracted for or approved unless it—

(1) is sponsored or underwritten, and administered, in whole or substantial part, by an employee organization described in section 8901(8)(B) of this title;

(2) offers benefits of the types named by paragraph (1) or (2) of section 8904 of this title or both;

(3) provides for benefits only by paying for, or providing reimbursement for, the cost of such benefits (as provided for under paragraph (1) or (2) of section 8903 of this title) or a combination thereof; and

(4) is available only to individuals who, at the time of enrollment, are full members of the organization and to members of their families.

(c) A contract for a plan approved under this section shall require the carrier—

(1) to enter into an agreement approved by the Office with an underwriting subcontractor licensed to issue group health insurance in all the States and the District of Columbia; or

(2) to demonstrate ability to meet reasonable minimum financial standards prescribed by the Office.

(d) For the purpose of this section, an individual shall be considered a full member of an organization if such individual is eligible to exercise all rights and privileges incident to full membership in such organization (determined without regard to the right to hold elected office).

(Added Pub. L. 99–53, §1(b)(1), June 17, 1985, 99 Stat. 93.)

§ 8903b. Authority to readmit an employee organization plan

(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plan's eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

(b) A contract for a plan approved under this section shall require the carrier—

(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.

(Added Pub. L. 105–266, §6(a)(1), Oct. 19, 1998, 112 Stat. 2368.)

EFFECTIVE DATE

Pub. L. 105–266, §6(a)(3), Oct. 19, 1998, 112 Stat. 2369, provided that:

''(A) IN GENERAL.—The amendments made by this subsection [enacting this section] shall apply as of the date of the enactment of this Act [Oct. 19, 1998], including with respect to any plan which has been discontinued as of such date.

''(B) TRANSITION RULE.—For purposes of applying section 8903b(a) of title 5, United States Code (as amended by this subsection) with respect to any plan seeking to be readmitted for purposes of any contract year beginning before January 1, 2000, such section shall be applied by substituting 'second contract year' for 'third contract year'.''

§ 8904. Types of benefits

(a) The benefits to be provided under plans described by section 8903 of this title may be of the following types:

(1) SERVICE BENEFIT PLAN.—

(A) Hospital benefits.
(B) Surgical benefits.
(C) In-hospital medical benefits.
(D) Ambulatory patient benefits.
(E) Supplemental benefits.
(F) Obstetrical benefits.

(2) INDEMNITY BENEFIT PLAN.—

(A) Hospital care.
(B) Surgical care and treatment.
(C) Medical care and treatment.
(D) Obstetrical benefits.
(E) Prescribed drugs, medicines, and prosthetic devices.
(F) Other medical supplies and services.

(3) EMPLOYEE ORGANIZATION PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both.

(4) COMPREHENSIVE MEDICAL PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both.

All plans contracted for under paragraphs (1) and (2) of this subsection shall include benefits both for costs associated with care in a general hospital and for other health services of a catastrophic nature.

(b)(1)(A) A plan, other than a prepayment plan described in section 8903(4) of this title, may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not covered to receive Medicare hospital and insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), to pay a charge imposed by any health care provider, for inpatient hospital services which are

covered for purposes of benefit payments under this chapter and part A of title XVIII of the Social Security Act, to the extent that such charge exceeds applicable limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Hospital providers who have in force participation agreements with the Secretary of Health and Human Services consistent with sections 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), whereby the participating provider accepts Medicare benefits as full payment for covered items and services after applicable patient copayments under section 1813 of such Act (42 U.S.C. 1395e) have been satisfied, shall accept equivalent benefit payments and enrollee copayments under this chapter as full payment for services described in the preceding sentence. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a hospital is found to knowingly and willfully violate this subsection on a repeated basis and the Secretary may invoke appropriate sanctions in accordance with section 1866(b)(2) of the Social Security Act (42 U.S.C. 1395cc(b)(2)) and applicable regulations.

(B)(i) A plan, other than a prepayment plan described in section 8903(4), may not provide benefits, in the case of any retired enrolled individual who is age 65 or older and is not entitled to Medicare supplementary medical insurance benefits under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), to pay a charge imposed for physicians' services (as defined in section 1848(j) of such Act, 42 U.S.C. 1395w–4(j)) which are covered for purposes of benefit payments under this chapter and under such part, to the extent that such charge exceeds the fee schedule amount under section 1848(a) of such Act (42 U.S.C. 1395w–4(a)).

(ii) Physicians and suppliers who have in force participation agreements with the Secretary of Health and Human Services consistent with section 1842(h)(1) of such Act (42 U.S.C. 1395u(h)(1)), whereby the participating provider accepts Medicare benefits (including allowable deductible and coinsurance amounts) as full payment for covered items and services shall accept equivalent benefit and enrollee cost-sharing under this chapter as full payment for services described in clause (i). Physicians and suppliers who are nonparticipating physicians and suppliers for purposes of part B of title XVIII of such Act shall not impose charges that exceed the limiting charge under section 1848(g) of such Act (42 U.S.C. 1395w–4(g)) with respect to services described in clause (i) provided to enrollees described in such clause. The Office of Personnel Management shall notify a physician or supplier who is found to have violated this clause and inform them of the requirements of this clause and sanctions for such a violation. The Office of Personnel Management shall notify the Secretary of Health and Human Services if a physician or supplier is found to knowingly and willfully violate this clause on a repeated basis and the Secretary of Health and Human Services may invoke appropriate sanctions in accordance with sections 1128A(a) and 1848(g)(1) of such Act (42 U.S.C. 1320a–7a(a), 1395w–4(g)(1)) and applicable regulations.

(C) If the Secretary of Health and Human Services determines that a violation of this subsection warrants excluding a provider from participation for a specified period under title XVIII of the Social Security Act, the Office shall enforce a corresponding exclusion of such provider for purposes of this chapter.

(2) Notwithstanding any other provision of law, the Secretary of Health and Human Services and the Director of the Office of Personnel Management, and their agents, shall exchange any information necessary to implement this subsection.

(3)(A) Not later than December 1, 1991, and periodically thereafter, the Secretary of Health and Human Services (in consultation with the Director of the Office of Personnel Management) shall supply to carriers of plans described in paragraphs (1) through (3) of section 8903 the Medicare program information necessary for them to comply with paragraph (1).

(B) For purposes of this paragraph, the term ''Medicare program information'' includes (i) the limitations on hospital charges established for Medicare purposes under section 1886 of the Social Security Act (42 U.S.C. 1395ww) and the identity of hospitals which have in force agreements with the Secretary of Health and Human Services consistent with section 1814(a) and 1866 of the Social Security Act (42 U.S.C. 1395f(a) and 1395cc), and (ii) the fee schedule amounts and limiting charges for physicians' services established under section 1848 of such Act (42 U.S.C. 1395w–4) and the identity of participating physicians and suppliers who have in force agreements with such Secretary under section 1842(h) of such Act (42 U.S.C. 1395u(h)).

(4) The Director of the Office of Personnel Management shall enter into an arrangement with the Secretary of Health and Human Services, to be effective before the first day of the fifth month that begins before each contract year, under which—

(A) physicians and suppliers (whether or not participating) under the Medicare program will be notified of the requirements of paragraph (1)(B);

(B) enforcement procedures will be in place to carry out such paragraph (including enforcement of protections against overcharging of beneficiaries); and

(C) Medicare program information described in paragraph (3)(B)(ii) will be supplied to carriers under paragraph (3)(A).

(Pub. L. 89–554, Sept. 6, 1966, 80 Stat. 603; Pub. L. 101–508, title VII, §7002(f)(1), Nov. 5, 1990, 104 Stat. 1388–330; Pub. L. 102–378, §2(76), Oct. 2, 1992, 106 Stat. 1355; Pub. L. 103–66, title XI, §11003(a), Aug. 10, 1993, 107 Stat. 409.)

HISTORICAL AND REVISION NOTES

Derivation	*U.S. Code*	*Revised Statutes and Statutes at Large*
.....	5 U.S.C. 3004.	Sept. 28, 1959, Pub. L. 86–382, §5, 73 Stat. 712.

Standard changes are made to conform with the definitions applicable and the style of this title as outlined in the preface to the report.

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (b)(1), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended. Title XVIII of the Act is classified generally to subchapter XVIII (§1395 et seq.) of chapter 7 of Title 42, The Public Health and Welfare. Parts A and B of title XVIII of the Act are classified generally to part A (§1395c et seq.) and part B (§1395j et seq.), respectively, of subchapter XVIII of chapter 7 of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

AMENDMENTS

1993—Subsec. (b)(1). Pub. L. 103–66, §11003(a)(1), designated existing provisions as subpar. (A) and added subpars. (B) and (C).

Subsec. (b)(3)(B). Pub. L. 103–66, §11003(a)(2), inserted cl. (i) designation and added cl. (ii).

Subsec. (b)(4). Pub. L. 103–66, §11003(a)(3), added par. (4).

1992—Subsec. (a). Pub. L. 102–378 substituted ''this subsection'' for ''this section'' in pars. (3) and (4) and in last sentence.

1990—Pub. L. 101–508 designated existing provisions as subsec. (a) and added subsec. (b).

EFFECTIVE DATE OF 1993 AMENDMENT

Pub. L. 103–66, title XI, §11003(b), Aug. 10, 1993, 107 Stat. 410, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to contract years beginning on or after January 1, 1995.''

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–508, title VII, §7002(f)(2), Nov. 5, 1990, 104 Stat. 1388–331, provided that: ''The amendments made by this subsection [amending this section] shall apply with respect to contract years beginning on or after January 1, 1992.''

MENTAL HEALTH, ALCOHOLISM, AND DRUG ADDICTION BENEFITS; CONGRESSIONAL FINDINGS; SENSE OF CONGRESS

Pub. L. 99–251, title I, §107, Feb. 27, 1986, 100 Stat. 16, provided that:

''(a) FINDINGS.—The Congress finds that—

''(1) the treatment of mental illness, alcoholism, and drug addiction are basic health care services which are needed by approximately 40,000,000 Americans each year;

''(2) treatment of mental illness, alcoholism, and drug addiction is increasingly successful;

''(3) timely and appropriate treatment of mental illness, alcoholism, and drug addiction is cost effective in terms of restored productivity, reduced utilization of other health services, and reduced social dependence; and

''(4) mental illness is a problem of grave concern to the people of the United States and is widely but unnecessarily feared and misunderstood.

''(b) SENSE OF THE CONGRESS.—It is the sense of the Congress—

''(1) that participants in the Federal employees health benefits program should receive adequate benefits coverage for treatment of mental illness, alcoholism, and drug addiction; and

''(2) that the Office of Personnel Management should encourage participating health benefits plans to provide adequate benefits relating to treatment of mental illness, alcoholism, and drug addiction (including benefits relating to coverage for inpatient and outpatient treatment and catastrophic protection benefits).''

§ 8905. Election of coverage

(a) An employee may enroll in an approved health benefits plan described in section 8903 or 8903a—

(1) as an individual;

(2) for self plus one; or

(3) for self and family.

(b) An annuitant who at the time he becomes an annuitant was enrolled in a health benefits plan under this chapter—

(1) as an employee for a period of not less than—

(A) the 5 years of service immediately before retirement;

(B) the full period or periods of service between the last day of the first period, as prescribed by regulations of the Office of Personnel Management, in which he is eligible to enroll in the plan and the date on which he becomes an annuitant; or

(C) the full period or periods of service beginning with the enrollment which became effective before January 1, 1965, and ending with the date on which he becomes an annuitant;

whichever is shortest; or

(2) as a member of the family of an employee or annuitant;

may continue his enrollment under the conditions of eligibility prescribed by regulations of the Office. The Office may, in its sole discretion, waive the requirements of this subsection in the case of an individual who fails to satisfy such requirements if the Office determines that, due to exceptional circumstances, it would be against equity and good conscience not to allow such individual to be enrolled as an annuitant in a health benefits plan under this chapter[1]

(c)(1) A former spouse may—

(A) within 60 days after the dissolution of the marriage, or

(B) in the case of a former spouse of a former employee whose marriage was dissolved after the employee's retirement, within 60 days after the dissolution of the marriage or, if later, within 60 days after an election is made under section 8339(j)(3) or 8417(b) of this title for such former spouse by the retired employee,

enroll in an approved health benefits plan described by section 8903 or 8903a of this title as an individual or for[2] for self plus one or self and family as provided in paragraph (2) of this subsection, subject to agreement to pay the full subscription charge of the enrollment, including the amounts determined by the Office to be necessary for administration and reserves pursuant to section 8909(b) of this title. The former spouse shall submit an enrollment application and make premium payments to the agency which, at the time of divorce or annulment, employed the employee to whom the former spouse was married or, in the case of a former spouse who is receiving annuity payments under section 8341(h), 8345(j), 8445, or 8467 of this title, to the Office of Personnel Management.

(2) Coverage for self plus one or for self and family under this subsection shall be limited to—

[1] So in original. Probably should be followed by a period.

[2] So in original. The word ''for'' probably should precede ''self and family''.