



U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
Office of Federal Operations
P.O. Box 77960
Washington, DC 20013

[REDACTED]
Shondra S.,¹
Complainant,

v.

Rob Shriver,
Acting Director,
Office of Personnel Management,
Agency.

Appeal No. 0120133174

Agency No. 2012021

DECISION

On August 20, 2013, Complainant filed an appeal with the Equal Employment Opportunity Commission (EEOC or Commission), pursuant to 29 C.F.R. § 1614.403(a), from the Agency's July 29, 2013, final decision concerning her equal employment opportunity (EEO) complaint alleging employment discrimination in violation of Title VII of the Civil Rights Act of 1964 (Title VII), as amended, 42 U.S.C. § 2000e et seq. For the following reasons, the Commission AFFIRMS the Agency's final decision.

ISSUE PRESENTED

The issue presented is whether Complainant has established by the preponderance of the evidence in the record that the Agency subjected her to disparate treatment on the basis of sex (gender identity/transgender status) when, for the 2012 plan year, it contracted with Blue Cross Blue Shield (BCBS) for a health insurance plan in the Federal Employees Health Benefits (FEHB) Program that contained a general exclusion of coverage for "[s]ervices, drugs,

¹ This case has been randomly assigned a pseudonym which will replace Complainant's name when the decision is published to non-parties and the Commission's website.

or supplies related to sex transformations . . . ,” resulting in denial of coverage for certain medical treatment.

BACKGROUND

Complainant became a federal employee effective May 11, 2009. Report of Investigation (ROI) Exs. G at 1, G-17 at 1. For the 2012 plan year, Complainant was enrolled in the BCBS Service Benefit Plan in the FEHB Program. ROI Exs. G at 2, G-4 at 1.

According to Complainant, on April 23, 2012, she called BCBS to request precertification for vocal cord and Adams apple reduction surgery, which was critical to her therapeutic treatment plan for gender identity disorder (GID).² ROI Exs. G at 2, G-16 at 1. Complainant alleged that, during the call, a BCBS representative told her, “We do not cover services, drugs, or supplies related to sexual transformation as we state on page 113 of our Service Benefit Plan.” ROI Ex. G at 2. Complainant did not provide the name of the BCBS representative or describe what time the call occurred. In an email to the EEO investigator, Complainant stated that she did not receive a denial letter from BCBS regarding this surgery. ROI Ex. G-16 at 1. Complainant averred that not receiving a letter was consistent with her past experience, noting that she had called BCBS several times over the past three years to request coverage for therapeutic treatment, her request was denied every time, and she never received a letter from BCBS. ROI Ex. G-16 at 1.

The Agency administers the FEHB Program, which provides health insurance to millions of federal employees and their family members by entering into annual contracts for services with health insurance carriers. Each spring, the Agency issues a call letter inviting carriers to submit benefits packages and pricing for the following plan year. Lawrence v. Office of Pers. Mgmt., EEOC Appeal No. 0120162065 (May 30, 2024). The call letter informs carriers of important benefit issues they must consider in formulating their benefits packages and pricing structures. Id. After receiving the benefits proposals, the Agency begins negotiating with carriers for health benefit plans that will be acceptable to both parties. For the 2012 plan year, the Agency contracted with BCBS to provide the BCBS Service Benefit Plan.

² Complainant stated that she had been diagnosed with both GID and gender dysphoria.

Beginning no later than the 1985 plan year, the Agency required FEHB plan brochures³ to contain a general exclusion of coverage for “[s]ervices, drugs, or supplies related to sex transformations . . .” (hereinafter, “Exclusion”). *Id.* For the 2012 plan year, page 113 of the BCBS Service Benefit Plan brochure contained the Exclusion. ROI Exs. G-5 at 1, K at 1. Complainant alleged that, as a result of the Exclusion, she was denied coverage for medical care. Complainant stated that she was seeking coverage for the full range of services described in the World Professional Association for Transgender Health (WPATH) Standards of Care.⁴ ROI Ex. G at 8.

The investigative record contains an October 15, 2009, court order directing that the sex on Complainant’s original birth certificate be changed to female and that the name be changed to Complainant’s name. ROI Ex. G-3. The record also contains a February 16, 2010, certified copy of Complainant’s birth certificate reflecting the ordered changes. ROI Ex. G-2. The investigative record does not contain any medical documentation or any documentary evidence showing that BCBS denied Complainant benefits based on the Exclusion.

During the EEO investigation, Complainant was asked to describe in detail any injury or condition for which she was claiming compensation and to provide medical documentation. ROI Ex. H at 1. Complainant responded that she had already submitted medical documentation to the Agency and added, “I became aware of my gender dysphoria in 1964 and began therapeutic treatment in 1995. With this length of time, most medical records are not available.” ROI Ex. H at 2. Complainant stated that she was requesting \$1,200,000 in compensatory damages for completion of therapeutic care based on the WPATH Standards of Care, loss of productivity at work, excessive sick leave, indemnification of health benefits paid by BCBS that may be reversed due to the Exclusion, and for unnecessary and continuing pain and suffering. ROI Ex. H at 2. Complainant was asked to provide copies of all medical reports, including all records relative to the claimed injuries and conditions, to identify any health care provider who had examined or treated

³ The plan brochure is a document that establishes the benefits that are covered for individuals participating in the plan.

⁴ Complainant provided a copy of the WPATH Standards of Care for the record. According to the document, WPATH is an international, multidisciplinary professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health, and the Standards of Care are based on “the best available science and expert professional consensus.” ROI Ex. G-14 at 3.

her for any claimed injury or condition, to provide copies of all payment records for expenses relating to any health care that was provided to treat any claimed injury or condition, and to list all non-medical items for which she was claiming compensation, the amount she claimed the Agency owed her as a result of each such loss, and the date upon which she incurred such loss. ROI Ex. H at 2-4. Complainant again stated that she had already provided documentation to the Agency, adding, "Otherwise, I object to this request as an undue burden and expense. I became aware of my gender dysphoria in 1964 and began therapeutic treatment in 1995. With this length of time, all records are not available." ROI Ex. H at 2-4.

Supplementation of the Record

On July 9, 2013, an Agency representative (Representative-1) contacted Complainant about supplementing the record. Appeal Ex. 2 at 3-4. On July 10, 2013, Complainant emailed Representative-1 "schedules of [her] transition costs to date and what [she had] left to complete therapeutic treatment for [her] gender dysphoria under WPATH standards" as well as a statement from her psychiatrist (Psychiatrist-1) and a copy of the court order legally changing her sex. Appeal Ex. 2 at 3. In an October 2, 2012, statement, Psychiatrist-1 stated that Complainant was suffering from untreated GID and required additional therapeutic treatment for GID, including the therapeutic treatments prescribed under the WPATH Standards of Care. Appeal Ex. 5 at 1. According to Psychiatrist-1, the effects of untreated GID included intense psychological distress, which manifested itself in Complainant's case in the form of severe depression and panic disorder. Appeal Ex. 5 at 1. Psychiatrist-1 suggested that, because the majority of Complainant's distress originated in the workplace, she be allowed to telework as a reasonable accommodation. Appeal Ex. 5 at 1.

The schedule of costs was a document created by Complainant showing her out-of-pocket costs through July 10, 2013, for WPATH-compliant treatment for GID, including psychotherapy, voice therapy, electrolysis/laser hair removal, and four surgical procedures, and estimating her future costs for voice therapy, hair removal, and two surgical procedures. Appeal Ex. 2 at 6-7. The schedule of costs did not list any dates for medical treatment and only included the names of some of the medical providers. Appeal Ex. 2 at 6. According to the schedule of costs, Complainant's out-of-pocket medical expenses through July 10, 2013, were \$94,737.00, and the estimate for future costs was \$28,900.00. Appeal Ex. 2 at 6-7.

On July 10, 2013, Representative-1 responded, stating that she needed "something official from a hospital or doctor validating each of the charges you provided in the document you created." Appeal Ex. 2 at 3. Representative-1 also stated that the doctor's statement concerned a request for reasonable accommodation and that Complainant needed to provide medical documentation specifically stating that Complainant was medically approved to undergo gender reassignment surgery (GRS). Appeal Ex. 2 at 3. On July 10, 2013, Complainant replied, stating that she was not sure what medical documentation Representative-1 was asking for and asking Representative-1 to point her to a specific authority in that regard. Appeal Ex. 2 at 2. Complainant continued,

Are you requesting my psychological surgery clearance letters required under WPATH standards? If so, why? All these transition documents such as the psychological clearance letters build on one another under WPATH protocols and culminate in the court order legally changing my sex on my original birth certificate, after a thorough document review and my personal appearance in front of a district court judge in my home state of Arkansas. ALL of these documents were in my original OPM formal complaint filing including my original and corrected birth certificates. Please specify exactly what documents you are requesting for this purpose.

Appeal Ex. 2 at 2. Representative-1 indicated that she had verified with the EEO office that they did not have any additional information that was not in the report of investigation. Appeal Ex. 2 at 2. Representative-1 stated:

In order to conduct the legal review of your claim and request for damages I need, among other things, to be able to see if you have documentation to establish that you have been diagnosed with GID, have been medically approved for GRS, and what the official costs related to the GRS procedures at issue are. The documents you have provided thus far do not fully establish the medical approval for GRS nor the official costs related to the GRS procedures. The purpose of my call and emails is to give you an opportunity to provide the missing documentation for consideration.

Appeal Ex. 2 at 2. On July 11, 2013, Complainant emailed Representative-1, "Your comments remain vague and reflect a lack of the WPATH protocols for gender dysphoria. What EXACT evidence do you want? Want pictures?" Appeal

Ex. 2 at 1. Representative-1 responded that it was up to Complainant to provide the necessary documents to support her claim of standing (that she had the claimed medical condition and medical approvals for surgery) and the alleged amount of damages. Appeal Ex. 2 at 1. Representative-1 stated that, if Complainant was unable to provide such documentation, that would be taken into consideration during the legal review of her case. Appeal Ex. 2 at 1. At 9:34 a.m. on July 11, 2013, Complainant emailed Representative-1, "WHAT are the specific 'necessary' documents, please." Appeal Ex. 2 at 1. There is a handwritten note reflecting that Representative-1 did not respond to Complainant's 9:34 a.m. email. Appeal Ex. 2 at 1. At 9:37 a.m. on July 11, 2013, Complainant emailed Representative-1 again, asking her to provide the name and contact details for her supervisor, and there is a handwritten note on the email reflecting that Representative-1 did not respond. Appeal Ex. 2 at 5.

Complainant's EEO Complaint

Complainant initiated contact with an EEO counselor on April 27, 2012. ROI Ex. A at 1. On April 30, 2012, Complainant filed an EEO complaint alleging that the Agency subjected her to disparate treatment on the basis of sex (gender identity/transgender status)⁵ when, for the 2012 plan year, it contracted with BCBS for a health insurance plan that contained a general exclusion of coverage for "[s]ervices, drugs, or supplies related to sex transformations" As a result of the Exclusion, Complainant alleged that

⁵ In Bostock v. Clayton Cty., the Supreme Court held that discrimination based on sexual orientation or transgender status is prohibited under Title VII. 590 U.S. 644 (2020); see also Macy v. Dep't of Justice, EEOC Appeal No. 0120120821 (Apr. 20, 2012) (an allegation of discrimination based on gender identity, change of sex, and/or transgender status states a claim of sex discrimination under Title VII because discrimination on this basis is inherently sex-based).

"When [the Supreme Court] applies a rule of federal law to the parties before it, that rule is the controlling interpretation of federal law and must be given full retroactive effect in all cases still open on direct review and as to all events, regardless of whether such events predate or postdate our announcement of the rule." Harper v. Virginia Dep't of Tax'n, 509 U.S. 86, 97 (1993); see also Rivers v. Roadway Exp., Inc., 511 U.S. 298, 312-13 (1994) ("A judicial construction of a statute is an authoritative statement of what the statute meant before as well as after the decision of the case giving rise to that construction.").

she was denied coverage for medical care related to GID and gender dysphoria.

At the conclusion of the investigation, the Agency provided Complainant with a copy of the report of investigation and notice of her right to request a hearing before an Equal Employment Opportunity Commission Administrative Judge (AJ). On October 15, 2012, Complainant requested a final Agency decision. In accordance with Complainant's request, on July 26, 2013, the Agency issued a final decision pursuant to 29 C.F.R. § 1614.110(b).

In its final decision, the Agency found that Complainant failed to establish a prima facie case of disparate treatment based on sex. The Agency determined that, other than her assertion, Complainant provided no evidence that she was eligible for, and subsequently denied, a benefit for medically necessary care. According to the Agency, there was no documentation from a licensed medical practitioner showing that Complainant needed the care. Complainant also submitted no proof that she requested and subsequently was denied a benefit. The Agency noted that Complainant objected to a request for medical documentation as an undue burden and expense. The decision concluded that Complainant failed to prove that the Agency subjected her to discrimination as alleged.

The instant appeal followed.

CONTENTIONS ON APPEAL

On appeal, Complainant contends that the Agency did not consider all her evidence and did not respond to her written requests for clarification of the additional evidence requested prior to issuing the final decision. Complainant argues that she discovered her transgender identity in or around 1964 and that medical records from that time are not available. Noting that she provided a schedule of out-of-pocket costs for WPATH compliant treatment for GID, Complainant asserts that she paid out of pocket for treatment, including for two surgeries after she filed her EEO complaint. Complainant states that BCBS repeatedly rejected the claim for one surgery, demanding information that does not exist or was already provided. According to Complainant, the claim for the second surgery was submitted directly by her physician's office and had not been acknowledged by BCBS to date.

Complainant included five exhibits with her appeal, including July 2013 emails with Representative-1 requesting clarification about the additional evidence sought. Appeal Ex. 2 at 1-5. Complainant provides a copy of a December 16,

2008, notarized document signed by Physician-1, which states that Complainant underwent surgical correction for GID on December 3, 2008, after meeting all criteria set forth by WPATH and that, as a result, Complainant had fully transitioned to a female identity. Appeal Ex. 2 at 8. Complainant also provides documents related to a November 19, 2012, facial feminization surgery performed by Physician-2 in Beverly Hills, California. Appeal Ex. 3. Complainant also submits a March 8, 2013, surgery proposal from Bay Area Aesthetic Surgery in San Mateo, California for Smart Liposuction in the upper abdomen, lower abdomen, and flanks. Appeal Ex. 4.

In response to Complainant's appeal, the Agency contends that Complainant's allegations are unsupported by evidence, as she failed to provide evidence other than her own personal assertion that she was denied a benefit for medically necessary care. According to the Agency, when the EEO investigator requested medical documentation, Complainant objected to the request and refused to produce the documentation, arguing the request was an undue burden and expense. The Agency states that it contacted Complainant before issuing the final decision to give her another opportunity to supplement the record with necessary information, yet she only provided three documents: (1) a self-created list of procedures Complainant claimed she required; (2) the October 2012 statement from Psychiatrist-1; and (3) the court order changing the sex and name on her birth certificate.

The Agency argues that the Commission should not consider the documents provided by Complainant for the first time on appeal because Complainant cannot establish that the documents were not reasonably available prior to or during the investigation. The Agency asserts that, even if this evidence were considered, Complainant could not establish that she was subjected to discrimination.

STANDARD OF REVIEW

As this is an appeal from a decision issued without a hearing, pursuant to 29 C.F.R. § 1614.110(b), the Agency's decision is subject to de novo review by the Commission. 29 C.F.R. § 1614.405(a). See Equal Employment Opportunity Management Directive for 29 C.F.R. Part 1614 (EEO MD-110), at Chapter 9, § VI.A. (Aug. 5, 2015) (explaining that the de novo standard of review "requires that the Commission examine the record without regard to the factual and legal determinations of the previous decision maker," and that EEOC "review the documents, statements, and testimony of record, including any timely and relevant submissions of the parties, and . . . issue its decision

based on the Commission's own assessment of the record and its interpretation of the law").

ANALYSIS

As a preliminary matter, we address the parties' contentions on appeal concerning the evidence in the record. Complainant contends that the Agency failed to respond to her requests for clarification regarding the evidence sought by the Agency and failed to consider all the evidence she provided. According to the Agency, it provided Complainant the opportunity to provide evidence during the EEO investigation and again before the issuance of the final decision, yet she failed to do so. The Agency argues that the Commission should not consider the new evidence Complainant provides for the first time on appeal.

On appeal, Complainant does not specifically identify the evidence that was not considered by the Agency in its final decision. Upon a thorough review of the investigative record and the evidence Complainant submitted to Representative-1 in July 2013, there is no indication that the Agency failed to consider evidence provided by Complainant during the investigation or in July 2013. Regarding Complainant's assertion that the Agency failed to respond to Complainant's written requests for clarification of what additional evidence the Agency was requesting prior to issuing the final decision, we find this contention to be without merit. Handwritten notes do reflect that Complainant did not receive a response to the emails she sent to Representative-1 at 9:34 a.m. and 9:37 a.m. on July 11, 2013. Appeal Ex. 2 at 1, 5. However, on July 10 and 11, 2013, Representative-1 sent Complainant multiple emails explaining what kind of evidence she was asking for. Appeal Ex. 2 at 1-5. At 9:09 a.m. on July 11, 2013, Representative-1 had explained that it was up to Complainant to provide evidence to support her claim as well as the alleged amount of damages. Appeal Ex. 2 at 1. Complainant has not shown that the Agency did not respond to her requests for clarification. Moreover, we note that the record reflects that the EEO investigator had already requested this evidence during the investigation, but Complainant either stated that the requested evidence did not exist or objected to the question or request for documentation. ROI Exs. G-16, H.

As a general rule, no new evidence will be considered on appeal absent an affirmative showing that the evidence was not reasonably available prior to or during the investigation or during the hearing process. See EEO MD-110 at Ch. 9, § VI.A.3.

The Agency argues that the Commission should not consider the evidence provided by Complainant for the first time on appeal because she has not shown that it was not reasonably available prior to or during the investigation. According to the record, the investigation was conducted from May 7, 2012, to July 16, 2012.

We find that Appeal Ex. 2 at 1-5, the July 2013 emails between Complainant and Representative-1, Appeal Ex. 2 at 6-7, Complainant's schedule of costs, and Appeal Ex. 5, the October 2, 2012, statement from Psychiatrist-1, should properly be considered part of the record. After reviewing the record, Representative-1 provided Complainant the opportunity to supplement the record before the Agency issued a final decision. Complainant provided documents supplementing the record, which should have been considered by the Agency in its final decision⁶ and are now part of the appellate record.

However, Complainant has not explained why she did not provide the December 16, 2008, document signed by Physician-1 during the investigation or when she supplemented the record in July 2013. While Complainant could not have provided the documents related to the November 19, 2012, facial feminization surgery or the surgery proposal dated March 8, 2013, during the EEO investigation because they did not exist during the investigation, she has not explained why she did not provide these documents to Representative-1 in July 2013. Representative-1 specifically requested documents validating each of the charges included on Complainant's schedule of costs as well as medical documentation that Complainant was diagnosed with GID and medically approved for the surgical procedures in question. Appeal Ex. 2 at 1-5. We find that Complainant has not shown that these documents submitted for the first time were not reasonably available when she supplemented the record prior to the issuance of the final decision. Accordingly, we decline to consider these documents provided for the first time on appeal.

Discrimination on the Basis of Sex

In Lawrence, EEOC Appeal No. 0120162065, the Commission determined that the Exclusion, which specifically targeted gender-affirming care for disfavorable treatment, plainly discriminated against transgender employees. See Kadel v. Folwell, 100 F.4th 122, 149 (4th Cir. 2024) (en banc); Glenn v.

⁶ It is not clear if these documents were considered in the issuance of the final decision, as the documents only appear in the appellate record as exhibits to Complainant's appeal and in the copy of Complainant's appeal and exhibits included in the Agency's complaint file.

Brumby, 663 F.3d 1312, 1316 (11th Cir. 2011) The Commission also found that withholding benefits because an employee needed it in connection with a gender transition constituted discrimination on the basis of transgender status and, therefore, sex. See Macy, EEOC Appeal No. 0120120821; see also EEOC v. R.G. & G.R. Harris Funeral Homes, 884 F.3d 560, 577 (6th Cir. 2018); Glenn, 663 F.3d at 1321. Finally, the Commission found that the Exclusion was discriminatory because it was an impermissible, sex-based rule for allocating employment benefits. See Bostock, 590 U.S. at 652, 660-61, 667-69. For these reasons, the Commission found that the Exclusion was direct evidence of disparate treatment based on sex. The Commission rejected the Agency's arguments that it was not liable because it acted reasonably and without animus against transgender individuals in establishing and maintaining the Exclusion and in later removing it, effective with the 2016 plan year and that the Exclusion could not be evidence of discriminatory intent to violate Title VII because it was first adopted in or prior to 1985.

Accordingly, the Commission found in Lawrence that the Agency subjected employees to disparate treatment on the basis of sex (gender identity/transgender status) when, for the 2013 and 2014 plan year, it contracted with a carrier for a health insurance plan in the FEHB Program that contained a general exclusion of coverage for "[s]ervices, drugs, or supplies related to sex transformations . . . ," resulting in the denial of coverage for medical treatment in 2014. Lawrence, EEOC Appeal No. 0120162065. The Commission held, "it is sex discrimination under Title VII for an employee health benefits plan to deny coverage for medical care simply because it was needed by transgender individuals." Id. The Commission also held, "as a corollary, in an employee health benefit plan, the mere fact that medical care is needed to treat gender dysphoria or provide other gender-affirming care may not, under Title VII, be a motivating factor in any decision to deny coverage for such care." Id. While Title VII does not require coverage of all gender-affirming care in an employee health benefits plan, the Commission found that Title VII requires that coverage decisions for such care be made using standards and criteria that are nondiscriminatory. Id.

Here, applying the standard set forth in Lawrence, we find that the preponderance of the evidence establishes that, for the 2012 plan year, the Agency contracted with BCBS to provide the BCBS Service Benefit Plan and that the BCBS Service Benefit Plan contained a general exclusion of coverage for "[s]ervices, drugs, or supplies related to sex transformations" However, Complainant has not established by preponderant evidence in the record that, as a result of the Exclusion, she was denied coverage for medical care related to her GID or gender dysphoria by BCBS for the 2012 plan year.

Complainant did not provide any documentary evidence showing that BCBS had denied her a benefit for treatment of GID or gender dysphoria because of the Exclusion. The only medical documentation in the record at the time the Agency issued the final decision was the October 2, 2012, statement from Psychiatrist-1, which stated that Complainant had GID, was in compliance with all criteria for therapeutic treatment of GID as set forth by WPATH and required additional therapeutic treatment for GID. Appeal Ex. 5. The statement primarily addressed Complainant's severe depression and panic disorder, and Psychiatrist-1 recommended that Complainant be allowed to telework as a reasonable accommodation for these conditions. Psychiatrist-1 did not discuss any medical treatment Complainant had received for GID or the additional medical treatment she needed.

We note that Complainant objected to providing medical documentation, identifying health care providers, and providing payment records as an undue burden and expense. Complainant stated that she became aware of her gender dysphoria in 1964 and began therapeutic treatment in 1995 and that, as a result, not all records were available. ROI Ex. H at 2-3. We agree that asking Complainant to provide all of her medical records dating back to 1964 or 1995 would not be reasonable. However, the Agency asked Complainant to provide information and medical documentation regarding any injury or condition for which she was claiming the Agency was liable. Complainant's EEO complaint alleges that she was denied a benefit during the 2012 plan year. Complainant has not shown that it would be an undue burden or expense to provide information and medical documentation for the benefit(s) allegedly denied by BCBS because of the Exclusion during the 2012 plan year or to provide medical documentation showing that the benefit(s) allegedly denied during the 2012 plan year were medically necessary to treat her GID or gender dysphoria.

Without providing such evidence, Complainant has not shown that she was denied coverage for medical treatment in 2012. Accordingly, we find that Complainant has not established by the preponderance of the evidence in the record that she was subjected to discrimination on the basis of sex by the Agency.

CONCLUSION

Based on a thorough review of the record and the contentions on appeal, including those not specifically addressed herein, we AFFIRM the Agency's final decision finding no discrimination.

STATEMENT OF RIGHTS - ON APPEAL
RECONSIDERATION (M0124.1)

The Commission may, in its discretion, reconsider this appellate decision if Complainant or the Agency submits a written request that contains arguments or evidence that tend to establish that:

1. The appellate decision involved a clearly erroneous interpretation of material fact or law; or
2. The appellate decision will have a substantial impact on the policies, practices, or operations of the agency.

Requests for reconsideration must be filed with EEOC's Office of Federal Operations (OFO) **within thirty (30) calendar days** of receipt of this decision. If the party requesting reconsideration elects to file a statement or brief in support of the request, **that statement or brief must be filed together with the request for reconsideration**. A party shall have **twenty (20) calendar days** from receipt of another party's request for reconsideration within which to submit a brief or statement in opposition. See 29 C.F.R. § 1614.405; Equal Employment Opportunity Management Directive for 29 C.F.R. Part 1614 (EEO MD-110), at Chap. 9 § VII.B (Aug. 5, 2015).

Complainant should submit their request for reconsideration, and any statement or brief in support of their request, via the EEOC Public Portal, which can be found at <https://publicportal.eeoc.gov/Portal/Login.aspx>

Alternatively, Complainant can submit their request and arguments to the Director, Office of Federal Operations, Equal Employment Opportunity Commission, via regular mail addressed to P.O. Box 77960, Washington, DC 20013, or by certified mail addressed to 131 M Street, NE, Washington, DC 20507. In the absence of a legible postmark, a complainant's request to reconsider shall be deemed timely filed if OFO receives it by mail within five days of the expiration of the applicable filing period. See 29 C.F.R. § 1614.604.

An agency's request for reconsideration must be submitted in digital format via the EEOC's Federal Sector EEO Portal (FedSEP). See 29 C.F.R. § 1614.403(g). Either party's request and/or statement or brief in opposition must also include proof of service on the other party, unless Complainant files their request via the EEOC Public Portal, in which case no proof of service is required.

Failure to file within the 30-day time period will result in dismissal of the party's request for reconsideration as untimely, unless extenuating circumstances prevented the timely filing of the request. **Any supporting documentation must be submitted together with the request for reconsideration.** The Commission will consider requests for reconsideration filed after the deadline only in very limited circumstances. See 29 C.F.R. § 1614.604(f).

COMPLAINANT'S RIGHT TO FILE A CIVIL ACTION (S0124)

You have the right to file a civil action in an appropriate United States District Court **within ninety (90) calendar days** from the date that you receive this decision. If you file a civil action, you must name as the defendant in the complaint the person who is the official Agency head or department head, identifying that person by their full name and official title. Failure to do so may result in the dismissal of your case in court. "Agency" or "department" means the national organization, and not the local office, facility or department in which you work. If you file a request to reconsider and also file a civil action, **filing a civil action will terminate the administrative processing of your complaint.**

RIGHT TO REQUEST COUNSEL (Z0815)

If you want to file a civil action but cannot pay the fees, costs, or security to do so, you may request permission from the court to proceed with the civil action without paying these fees or costs. Similarly, if you cannot afford an attorney to represent you in the civil action, you may request the court to appoint an attorney for you. **You must submit the requests for waiver of court costs or appointment of an attorney directly to the court, not the Commission.** The court has the sole discretion to grant or deny these types of requests.

Such requests do not alter the time limits for filing a civil action (please read the paragraph titled Complainant's Right to File a Civil Action for the specific time limits).

FOR THE COMMISSION:



Carlton M. Hadden, Director
Office of Federal Operations

December 4, 2024
Date