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(2) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(3) Will be limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits.

[61 FR 15179, Apr. 5, 1996]

§ 890.108 Waiver of requirements for continued coverage during retirement.

(a) OPM may waive the eligibility requirements under 5 U.S.C. 8905(b) for health benefits coverage as an annuitant in the case of an individual who fails to satisfy such requirements if OPM, in its sole discretion, determines that, because of 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 part.

(b) OPM may grant a waiver as described in paragraph (a) of this section to an annuitant in rare and unusual circumstances if the annuitant shows by the preponderance of the evidence that—

(1) There is evidence demonstrating that the individual intended to be covered as an annuitant;

(2) The circumstance(s) that prevented the completion of the requirements of 5 U.S.C. 8905(b) was (were) essentially outside the individual's control; and

(3) The individual exercised due diligence in protecting the right to coverage as an annuitant.

(c) OPM will not grant a waiver solely because—

(1) An individual's retirement is based on disability or an involuntary separation; or

(2) An individual was misadvised (or not advised) by his or her employing office regarding the requirements for continuation of health benefits coverage into retirement.

[52 FR 3, Jan. 2, 1987]

§ 890.109 Exclusion of certain periods of eligibility when determining continued coverage during retirement.

(a) Except as provided in paragraph (b) of this section, periods during which temporary employees are eligible under 5 U.S.C. 8906a to receive health benefits by enrolling and paying the full subscription charge, but are not eligible to participate in a retirement system, are not considered when determining eligibility for continued coverage during retirement. For the purpose of continuing coverage during retirement, an employee is considered to have enrolled at his or her first opportunity if the employee registered to be enrolled when he or she received a permanent appointment entitling him or her to participate in a retirement system and to receive the Government contribution toward the health benefits premium payments.

(b) A temporary employee eligible under 5 U.S.C. 8906a may continue enrollment as a compensationer if he or she has been enrolled or covered as a family member under another enrollment under this part for:

(1) The 5 years of service immediately preceding the commencement of his or her monthly compensation; or

(2) During all periods of service since his or her first opportunity to enroll, if less than 5 years. For the purpose of this paragraph, an employee is considered to have enrolled at his or her first opportunity if the employee registered to be enrolled when he or she first became eligible under 5 U.S.C. 8906a.

[58 FR 47824, Sept. 13, 1993]

Subpart B—Health Benefits Plans

§ 890.201 Minimum standards for health benefits plans.

(a) To qualify for approval by OPM, a health benefits plan shall meet the following standards. Once approved, a health benefits plan shall continue to meet the minimum standards. Failure on the part of the carrier's plan to meet the standards is cause for OPM's withdrawal of approval of the plan in accordance with 5 CFR 890.204. A health benefits plan shall:

(1) Comply with chapter 89 of title 5, United States Code, and this part, as amended from time to time.

(2) Accept the enrollment, in accordance with this part, and without regard to age, race, sex, health status, or hazardous nature of employment, of each eligible employee, annuitant, former spouse, former employee, or child, except that a plan that is sponsored or underwritten by an employee organization may not accept the enrollment of a person who is not a member of the organization, but it may not limit membership in the organization on account of the prohibited factors (age, race, sex, health status, or hazardous nature of employment). The carrier may terminate the enrollment of an enrollee other than a survivor annuitant, a former spouse continuing coverage under §890.803, or person continuing coverage under §890.1103(a) (2) or (3), in a health benefits plan sponsored or underwritten by an employee organization on account of termination of membership in the organization. A carrier that wants to terminate the enrollment of an enrollee under this paragraph may do so by notifying the employing office in writing, with a copy of the notice to the enrollee. The termination is effective at the end of the pay period in which the employing office receives the notice. A comprehensive medical plan need not enroll an employee, annuitant, former employee, former spouse, or child residing outside the geographic areas specified by the plan.

(3) Provide health benefits for each enrollee and covered family member wherever they may be.

(4) Provide for conversion to a contract for health benefits regularly offered by the carrier, or an appropriate affiliate, for group conversion purposes, which must be guaranteed renewable, subject to such amendments as apply to all contracts of this class, except that it may be canceled for fraud, overinsurance, or nonpayment of periodic charges. A carrier must permit conversion within the time allowed by the temporary extension of coverage provided under §890.401 for each enrollee and covered family member entitled to convert. When an employing office gives an enrollee written notice of his or her privilege of conversion, the carrier must permit conversion at any time before 31 days after the date of notice or 91 days after the enrollment is terminated, whichever is earlier. Belated conversion opportunities as provided in §890.401(c) must also be permitted by the carrier. When OPM requests an extension of time for conversion because of delayed determination of ineligibility for immediate annuity, the carrier must permit conversion until the date specified by OPM in its request for extension. On conversion, the contract becomes effective as of the day following the last day of the temporary extension, and the enrollee or covered family member, as the case may be, must pay the entire cost thereof directly to the carrier. The nongroup contract may not deny or delay any benefit covered by the contract for a person converting from a plan approved under this part except to the extent that benefits are continued under the health benefits plan from which he or she converts.

(5) Provide that each enrollee receive an identification card or cards or other evidence of enrollment.

(6) Provide a standard rate structure which contains, for each option, one standard individual rate, and one standard family rate.

(7) Maintain statistical records regarding the plan, separately from those of any other activities conducted or benefits offered by the carrier sponsoring or underwriting the plan.

(8) Provide for a special reserve for the plan. The carrier shall account for amounts retained by it as reserves for the plan separately from reserves maintained by it for other plans. The carrier shall invest the special reserve and income derived from the investment of the special reserve shall be credited to the special reserve. If the contract is terminated or approval of the plan is withdrawn, the carrier shall return the special reserve to the Employees Health Benefits Fund. However, in the case of a comprehensive medical plan, the carrier, without regard to the foregoing provisions of this paragraph, shall follow such financial procedures as are mutually agreed on by the carrier and OPM.

(9) Provide for continued enrollment to the end of the current pay period, or termination date, if earlier, of each enrollee enrolled at the effective date of termination of a contract. The carrier is entitled to subscription charges for this continued enrollment.

(10) Provide that any covered expenses incurred from January 1 to the effective date of an open season change count toward the losing carrier's prior year deductible. If the prior year deductible or family limit on deductibles of the losing carrier had previously been met, the enrolled individual (and eligible family members) shall be eligible for reimbursement by the losing carrier for covered expenses incurred during the current year. Reimbursement of covered expenses shall apply only to covered expenses incurred from January 1 to the effective date of the open season change. This section shall not apply to any other permissible changes made during a contract year.

(11) Except where OPM determines otherwise, have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan at some time during the preceding two contract terms.

(b) To be qualified to be approved by OPM and, once approved, to continue to be approved, a health benefits plan shall not:

(1) Deny a covered person a benefit provided by the plan for a service performed on or after the effective date of coverage solely because of a preexisting physical or mental condition.

(2) Require a waiting period for any covered person for benefits which it provides.

(3) Have more than two options.

(4) Have an initiation, service, enrollment, or other fee or charge in addition to the rate charged for the plan, except that a comprehensive medical plan may impose an additional charge to be paid directly by the enrollee for certain medical supplies and services, if the supplies and services on which additional charges are imposed are clearly set forth in advance and are applicable to all enrollees. This subparagraph does not apply to charges for membership in employee organizations sponsoring or underwriting plans.

(5) Paragraphs (b)(1) and (2) of this section do not preclude a plan offering benefits for dentistry or cosmetic surgery, or both, limited to conditions arising after the effective date of coverage.

(c) The Director or his or her designee will determine whether to propose withdrawal of approval of the plan and hold a hearing based on the seriousness of the carrier's actions and its proposed method to effect corrective action.

[33 FR 12510, Sept. 4, 1968, as amended at 43 FR 52460, Nov. 13, 1978; 47 FR 14871, Apr. 6, 1982; 49 FR 48905, Dec. 17, 1984; 52 FR 10217, Mar. 31, 1987; 54 FR 52336, Dec. 21, 1989; 55 FR 9108, Mar. 12, 1990; 55 FR 22891, June 5, 1990]

§ 890.202 Minimum standards for health benefits carriers.

The minimum standards for health benefits carriers for the FEHB Program shall be those contained in 48 CFR subpart 1609.70.

[57 FR 14324, Apr. 20, 1992]

§ 890.203 Application for approval of, and proposal of amendments to, health benefit plans.

(a) *New plan applications.* (1) The Director of OPM shall consider applications to participate in the FEHB Program from comprehensive medical plans (CMP's) at his or her discretion. CMP's are automatically invited to submit applications annually to participate in the FEHB Program unless otherwise notified by OPM. If the Director should determine that it is not beneficial to the enrollees and the Program to consider applications for a specific contract year, OPM will publish a notice with a 60 day comment period in the FEDERAL REGISTER no less than 7 months prior to the date applications would be due for the specific contract year for which applications will not be accepted.

(2) When applications are considered, CMP's should apply for approval by writing to the Office of Personnel Management, Washington, DC 20415. Application letters must be accompanied by any descriptive material, financial data, or other documentation required by OPM. Plans must submit the letter and attachments in the OPM-specified format by January 31, or another date

specified by OPM, of the year preceding the contract year for which applications are being accepted. Plans must submit evidence demonstrating they meet all requirements for approval by March 31 of the year preceding the contract year for which applications are being accepted. Plans that miss either deadline cannot be considered for participation in the next contract year. All newly approved plans must submit benefit and rate proposals to OPM by May 31 of the year preceding the contract year for which applications are being accepted in order to be considered for participation in that contract year. OPM may make counter-proposals at any time.

(3) OPM may approve such comprehensive medical plans as, in the judgment of OPM, may be in the best interest of enrollees in the Program. In addition to specific requirements set forth in 5 U.S.C. chapter 89, in chapter 1 and other relevant portions of title 48 of the Code of Federal Regulations, and in other sections of this part, to be approved, an applicant plan must actually be delivering medical care at the time of application; must be in compliance with applicable State licensing and operating requirements; must not be a Federal, State, local, or territorial governmental entity; and must not be debarred, suspended, or ineligible to participate in Government contracting or subcontracting for any reason, including fraudulent health care practices in other Federal health care programs.

(4) Applications must identify those individuals who have the legal authority and responsibility to enter into and guarantee contracts. The applications will be reviewed for evidence of substantial compliance with the following standards:

(i) *Health plan management:* Stable management with experience pertinent to the prepaid health care provider industry; sufficient operating experience to enable OPM to realistically evaluate the plan's past and expected future performance;

(ii) *Marketing:* A rate of enrollment that ensures equalization of income and expenses within projected timeframes and sufficient subscriber income to operate within budget thereafter; enrollment dispersed among groups such that there is not a concentration of enrollment with one or a few groups so that the loss of one or more contracts by the carrier would not jeopardize its financial viability; feasible projections of future enrollment and employer distribution, as well as the potential enrollment area for maketing purposes;

(iii) *Health care delivery system:* A health care delivery system providing reasonable access to and choice of quality primary and specialty medical care throughout the service area; specifically, in the individual practice setting, contractual arrangements for the services of a significant number of primary care and speciality physicians in the service area; and in the group practice setting, compliance with 5 U.S.C. 8903(4)(A) preferably demonstrated by full-time providers specializing in internal medicine, family practice, pediatrics, and obstetrics/gynecology; and

(iv) *Financial condition:* Establishment of firm budget projections and demonstrated success in meeting or exceeding those projections on a regular basis; evidence of the ability to sustain operation in the future and to meet obligations under the contract OPM might enter into with the plan; clearly specified committed funding to see the plan to an expected break-even point including a sufficient amount for unexpected contingencies; adequate current and projected funding, such as estimated premium income or commitment from a financially sound and acceptable parent organization or a mature stable entity outside the plan; insolvency protection, such as stop-loss reinsurance services and agreements with all plan providers that they will hold members harmless if, for any reason, the plan is unable to pay its providers.

(5) A comprehensive medical plan that has been certified either as a qualified Health Maintenance Organization (HMO) or as a qualified Competitive Medical Plan by the Department of Health and Human Services (HHS) at the time of application to OPM, and whose qualification status is not under investigation by HHS, will need to submit only an abbreviated application to OPM. The extent of the

data and documentation to be submitted by a plan so qualified by HHS, as well as by a non-qualified plan, for a particular review cycle may be obtained by writing directly to the Office of Insurance Programs, Retirement and Insurance Service, Office of Personnel Management, Washington, DC 20415.

(b) *Participating plans.* Changes in rates and benefits for approved health benefits plans shall be considered at the discretion of the Director of OPM. If the Director of OPM determines that it is beneficial to enrollees and the Federal Employees Health Benefits Program to invite health plan benefit and/or rate changes for a given contract period, a ''call letter'' shall be issued to the carrier approximately 9 months prior to the expiration of the current contract period. Any proposal for change shall be in writing, specifically describe the change proposed, and be signed by an authorized official of the carrier. OPM will review any requested proposal for change and will notify the carrier of its decision to accept or reject the change. OPM may make a counter proposal or at any time propose changes on its own motion. Benefits changes and rate proposals, when requested by OPM, shall be submitted not less than 7 months before the expiration of the then current contract period, unless the Director of OPM determines that a later date is acceptable. The negotiation period shall begin approximately 7 months before the expiration of the current contract period, and OPM shall seek to complete all benefit and rate negotiations no later than 4 months preceding the contract period to which they will apply. If OPM and the carrier do not reach agreement by this date, either party may give written notice of nonrenewal in accordance with § 890.205 of this part.

[37 FR 20668, Oct. 3, 1972, as amended at 41 FR 40090, Sept. 17, 1976; 43 FR 52461, Nov. 13, 1978; 48 FR 16232, Apr. 15, 1983; 50 FR 8315, Feb. 28, 1985; 52 FR 23934, June 26, 1987; 54 FR 52337, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 57 FR 19374, May 6, 1992; 59 FR 62284, Dec. 5, 1994; 60 FR 62988, Dec. 8, 1995]

§ 890.204 Withdrawal of approval of health benefits plans or carriers.

(a) The Director may withdraw approval of a health benefits plan or carrier if the standards at § 890.201 of this part and 48 CFR subpart 1609.70 are not met. Such action carries with it the right to a hearing as provided in paragraph (a)(2) of this section.

(1) Before withdrawing approval, the Director or his or her representative shall notify the carrier of the plan, by certified mail, that OPM intends to withdraw approval of the health benefits plan and/or carrier. The notice shall set forth the reasons why approval is to be withdrawn. The carrier is entitled to reply in writing within 15 calendar days after its receipt of the notice, stating the reasons why approval should not be withdrawn.

(2) On receipt of the reply, or in the absence of a timely reply, the Director or representative shall set a date, time, and place for a hearing. The carrier shall be notified by certified mail at least 15 calendar days in advance of the hearing. The hearing officer shall be the Director, or a representative designated by the Director, who shall not otherwise have been a party to the initial administrative decision to issue a letter of intent to withdraw the plan's or carrier's approval. The hearing officer shall conduct the hearing unless it is waived in writing by the carrier. The carrier is entitled to appear by representative and present oral or documentary evidence, including rebuttal evidence, in opposition to the proposed action.

(i) A transcribed record shall be kept of the hearing and shall be the exclusive record of the proceeding.

(ii) After the hearing is held, or after OPM's receipt of the carrier's written waiver of the hearing, the Director shall make a decision on the record, taking into consideration any recommendation submitted by the hearing officer, and send it to the carrier by certified mail. A decision of the Director shall be considered a final decision for the purposes of this section. The Director, or his or her representative, may set a future effective date for withdrawal of approval.

(3) The Director, or his or her representative, may give written notice of non-renewal of the contract of a carrier whose plan does not meet the minimum enrollee requirement in § 890.201(a)(11). However, the Director

may defer withdrawing approval of a plan not meeting the requirement in § 890.201(a)(11) of this part when, in the judgment of OPM, the carrier shows good cause. The Director or representative may authorize a plan with fewer than 300 employees or annuitants to remain in the FEHB Program when he or she determines, in his or her discretion, that it is in the best interest of the Program (e.g., when the plan is the only plan available to enrollees in a rural area).

(b) During a current contract term, the Director, in his or her discretion, may reinstate approval of a plan or carrier under this section on a finding that the reasons for withdrawing approval no longer exist.

[55 FR 9109, Mar. 12, 1990, as amended at 57 FR 14324, Apr. 20, 1992]

§ 890.205 Nonrenewal of contracts of health benefits plans.

(a) Either OPM or the carrier may terminate a contract by giving a written notice of nonrenewal which includes an indication of the reason for the intended action.

(b) Where termination by notice of intent not to renew is made by OPM, the carrier contesting that notice may request that OPM review the proposed decision. Such review shall be conducted by the Director or a representative designated by the Director, who shall not otherwise have been a party to the initial decision to issue a notice of intent not to renew. A request for such review, which may include a request that a representative of the carrier appear personally before OPM, shall be in writing. That request must be received within 10 calendar days of the carrier's receipt of the notice of intent not to renew. Such request shall include a detailed statement as to why the carrier disagrees with OPM's notice of nonrenewal and shall be accompanied by appropriate supporting documentation. Where a carrier has requested review under this section, the final decision by OPM not to renew a health benefits contract shall be communicated to the carrier in writing not more than 30 days after OPM's receipt of the carrier's request for review, unless a later date is mutually agreed upon.

(c) In the absence of a timely request for review as set forth in paragraph (b) of this section, OPM's notice of intent not to renew will become final without further notification.

[57 FR 19374, May 6, 1992]

Subpart C—Registration and Enrollment

§ 890.301 Opportunities to register to enroll and change enrollment.

(a) *Initial registration.* Except as otherwise provided in this part, each employee who becomes eligible shall register within 31 days after becoming eligible.

(b) *Belated registration.* When an employing office determines that (1) an employee was unable, for cause beyond his or her control, to register to be enrolled or (2) an enrollee was unable, for cause beyond his or her control, to change enrollment within the time limits prescribed by this section, that office must accept his or her registration within 31 days after it advises him or her of that determination.

(c) *Reregistration.* An employee whose enrollment was terminated under § 890.304(a)(1)(v), or because he/she had a break in service of more than 3 days, shall register within 31 days after his/her return to pay status.

(d) *Open season.* (1) An open season will be held from the Monday of the second full workweek in November through the Monday of the second full workweek in December in any year—

(i) That precedes a year during which the rates or benefits of any health benefits plan in the Program will change; or

(ii) That precedes a year during which a newly-approved plan will begin participation in the Program; or

(iii) At the end of which an existing health benefits plan will cease to participate in the Program.

(2) The Director of the Office of Personnel Management may modify the dates specified in this paragraph or announce additional open seasons. Announcements of open seasons will be made by OPM in Federal Personnel Manual (FPM) Bulletins.

(3) During open season—