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assignees who choose to continue the coverage.

(d) When multiple assignees have been named and, at the time the insured individual becomes eligible for continued coverage as a compensationer under §§ 870.701, 871.501, and/or 872.501 of this chapter, some assignees choose to convert their portions of the insurance and others choose to have their portions continued while the insured individual is receiving compensation, the amount of each type of continued insurance is determined by the total percentage of the shares of the assignees who choose to continue the coverage.

§ 874.702 Reemployed annuitants.

(a) The right of a reemployed annuitant to elect additional optional coverage as an employee rather than as an annuitant under § 872.604 remains with the insured individual and does not transfer to the assignee.

(b) When an annuitant who has assigned his or her insurance is reemployed in a position in which he or she is entitled to life insurance coverage, the coverage he or she acquires as a reemployed annuitant is subject to the existing assignment.

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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AUTHORITY: 5 U.S.C. 8913; § 890.102(f) also issued under sec. 153 of Pub. L. 104–134, 110 Stat. 1321; § 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; subpart L also issued under sec. 599C of Pub. L. 101–513, 104 Stat. 2064, as amended.

SOURCE: 33 FR 12510, Sept. 4, 1968, unless otherwise noted.

Subpart A—Administration and General Provisions

§ 890.101 Definitions; time computations.

(a) In this part, the terms *annuitant, carrier, employee, employee organization, former spouse, health benefits plan, member of family,* and *service,* have the meanings set forth in section 8901 of title 5, United States Code, and supplement the following definitions:

Basic employee death benefit has the meaning set out at § 843.102. Survivors receiving this benefit are deemed to be ''annuitants'' for purposes of this chapter.

Cancellation means the act of filing a health benefits registration form terminating enrollment in a health benefits plan and electing not to be enrolled for the future by an enrollee who is eligible to continue enrollment.

Change of enrollment means the registration of an enrollee to be enrolled for a different plan or option, or for a different type of coverage (self alone or self and family), from that for which then enrolled.

Claim means a request for (i) payment of a health-related bill; or (ii) provision of a health-related service or supply.

Compensation means compensation under subchapter I of chapter 81 of title 5, United States Code, which is payable because of a job-related injury or disease.

Compensationer means an employee or former employee who is entitled to compensation and whom the Department of Labor determines is unable to return to duty. A compensationer is also an annuitant for purposes of chapter 89 of title 5, United States Code.

Covered individual means an enrollee or a covered family member.

Covered family member means a member of the family of an enrollee with a self and family enrollment who meets the requirements of §§ 890.302, 890.804, or 890.1106(a), as appropriate to the type of enrollee.

Eligible means eligible under the law and this part to be enrolled.

Employing office means the office of an agency to which jurisdiction and responsibility for health benefits actions for an employee, an annuitant, a former spouse eligible for continued coverage under subpart H of this part, or an individual eligible for temporary continuation of coverage under subpart K of this part, have been delegated.

(1) For an enrolled annuitant (including survivor annuitant, former spouse annuitant, and surviving spouses receiving a basic employee death benefit under 5 U.S.C. 8442(b)(1)(A)) who is not also an eligible employee, *employing office* is the office which has the authority to approve payment of annuity, basic employee death benefit, or workers' compensation for the annuitant concerned.

(2) For a former spouse of an annuitant whose marriage dissolved after the employee's retirement and who has entitlement to receive future annuity payments under sections 8341(h), 8345(j), 8445, or 8467 of title 5, United States Code, *employing office* is the office that has the authority to approve payment of annuity for the annuitant or former spouse concerned.

(3) For a former spouse of a current employee, and a former spouse of an annuitant or separated employee having title to a deferred annuity or to an immediate annuity under 5 U.S.C. 8412(g), whose marriage dissolved during the employee's Federal service, *employing office* is the agency that employed the employee or annuitant at the time the marriage was dissolved.

(4) For a surviving spouse in receipt of a basic employee death benefit under 5 U.S.C. 8442(b)(1)(A) who is not also an eligible employee, the *employing office* is the retirement system which has authority to approve the basic employee death benefit.

(5) For a former spouse of an employee or former employee of the Central Intelligence Agency (CIA) whose marriage was dissolved before May 7, 1985, and who meets the requirements under § 890.803(a)(3)(iv), the *employing office* is the CIA.

(6) For a former spouse of an employee or former employee of the Foreign Service whose marriage was dissolved before May 7, 1985, and who meets the requirements under § 890.803(a)(3)(v) of this part, the *employing office* is the Department of State.

(7) [Reserved]

(8) For a former spouse of an employee who separated from service after qualifying for an immediate annuity under 5 U.S.C. 8412(g), whose marriage dissolves after the employee separated from service but before the date the separated employee's annuity commences, and who is entitled to continued coverage under subpart H of this part, *employing office* is the office that has the authority to approve payment of annuity for the annuitant or former spouse concerned.

Enrollee means the individual in whose name the enrollment is carried. The term includes employees, annuitants, former employees, former spouses, or children who are enrolled after completing a valid registration form under the provisions of §§ 890.301, 890.601(c), 890.803, or 890.1103 or have continued an enrollment as an annuitant or survivor annuitant under 5 U.S.C. 8905(b) or § 890.303(c).

Foster child means a child who:

(1) Lives with an employee, former employee, or annuitant or with a child enrolled under § 890.1103(a)(2) in a regular parent-child relationship and

(2) Is expected to be raised to adulthood by the enrollee.

Immediate annuity means an annuity which begins to accrue not later than 1 month after the date enrollment under a health benefits plan would cease for an employee or member of family if he were not entitled to continue enrollment as an annuitant. Notwithstanding the foregoing, an annuity which commences on the birth of the posthumous child of an employee or annuitant is an immediate annuity. For an individual who separates from service upon meeting the requirements for an annuity under § 842.204(a)(1) of this chapter, *immediate annuity* includes an annuity for

which the commencing date is postponed under § 842.204(c).

Letter of credit is defined in 48 CFR 1602.170–9.

Option means a level of benefits. It does not include distinctions as to whether the members of the family are covered.

OWCP means the Office of Workers' Compensation Programs, U.S. Department of Labor, which administers subchapter I of chapter 81 of title 5, United States Code.

Pay period means the biweekly pay period established pursuant to section 5504 of title 5, United States Code, for the employees to whom that section applies and the regular pay period for employees not covered by that section. *Pay period,* as it relates to a former spouse or annuitant who is not actively receiving an annuity, including surviving spouses receiving a basic employee death benefit, and enrollees temporarily continuing coverage under subpart K of this part, means any regular pay period for employees of the agency to which jurisdiction and responsibility for health benefits actions for the enrollee have been delegated as provided under the definition of ''employing office'' in this section. *Pay period* for annuitants in active receipt of annuity means the period for which a single installment of annuity is customarily paid.

Reconsideration means the final level of administrative review of an employing office's initial decision to determine if the employing office correctly applied the law and regulations.

Register means to file with the employing office a properly completed health benefits registration form, either electing to be enrolled in a health benefits plan or electing not to be enrolled. Retirement systems may accept alternative methods, such as telephone requests, in substitution of a properly completed health benefits registration form. Alternative methods must transmit to the health benefits plans the information they require before accepting an enrollment. In addition, for enrollments and cancellations to be valid, the signature of the requesting individual must be on the request, or on a form from the retirement system to the requesting individual giving notice of the enrollment or cancellation. For changes of enrollment, the signature of the requesting individual is not required but the retirement system must promptly give to the requesting individual written notice of the change of enrollment. *Register to enroll* means to register an election to be enrolled. *Enrolled* means a valid registration form has been accepted by the employing office, or an alternative method has been accepted by the retirement system, and the enrollment in a health benefits plan approved by OPM under this part has not been terminated or cancelled.

Regular tour of duty means a work schedule, prescribed in advance to continue indefinitely or for at least 6 months, of a certain number of hours or other time units in a day, week, biweekly pay period, month, or year.

Underdeduction means a failure to withhold the required amount of health benefits contributions from an individual's pay, annuity, or compensation. This definition includes both nondeductions (when none of the required amounts was withheld) and partial deductions (when only part of the required amount was withheld). Though FEHB contributions are required to cover a period of nonpay status, the nonpayment of contributions during such period does not result in an underdeduction.

(b) Whenever, in this part, a period of time is stated as a number of days or a number of days from an event, the period is computed in calendar days, excluding the day of the event. Whenever, in this part, a period of time is defined by beginning and ending dates, the period includes the beginning and ending dates.

[33 FR 12510, Sept. 4, 1968]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 890.101, see the List of Sections Affected in the Finding Aids section of this volume.

§ 890.102 Coverage.

(a) Each employee, other than those excluded by paragraph (c) of this section, is eligible to be enrolled in a health benefits plan at the time and under the conditions prescribed in this part.

(b) An employee who serves in cooperation with non-Federal agencies and is paid in whole or in part from non-Federal funds may register to be enrolled within the period prescribed by OPM for the group of which the employee is a member following approval by OPM of arrangements providing that (1) the required withholdings and contributions will be made from Federally-controlled funds and timely deposited into the Employees Health Benefits Fund, or (2) the cooperating non-Federal agency will, by written agreement with the Federal agency, make the required withholdings and contributions from non-Federal funds and transmit them for timely deposit into the Employees Health Benefits Fund.

(c) The following employees are not eligible:

(1) An employee (other than an acting postmaster, a Presidential appointee appointed to fill an unexpired term, and an appointee whose appointment meets the definition of provisional appointment set out in §§ 316.401 and 316.403 of this chapter) who is serving under an appointment limited to 1 year or less and who has not completed 1 year of current continuous employment, excluding any break in service of 5 days or less.

(2) An employee who is expected to work less than 6 months in each year, except for an employee who is employed under an OPM approved career-related work-study program under Schedule B of at least 1 year's duration and who is expected to be in a pay status for at least one-third of the total period of time from the date of the first appointment to the completion of the work-study program.

(3) An intermittent employee—a non-full-time employee without a prearranged regular tour of duty.

(4) An employee whose pay on an annual basis is $350 a year or less.

(5) A beneficiary or patient employee in a Government hospital or home.

(6) An employee paid on a contract or fee basis, except an employee who is a citizen of the United States who is appointed by a contract between the employee and the Federal employing authority which requires his personal service and is paid on the basis of units of time.

(7) An employee paid on a piecework basis, except one whose work schedule provides for full-time service or part-time service with a regular tour of duty.

(8) An individual first employed by the government of the District of Columbia on or after October 1, 1987. However, this exclusion does not apply to employees of St. Elizabeths Hospital who accept offers of employment with the District of Columbia government without a break in service, as provided in section 6 of Pub. L. 98–621.

(d) Paragraph (c) of this section does not deny coverage to:

(1) An employee appointed to perform ''part-time career employment,'' as defined in section 3401(2) of title 5, United States Code, and 5 CFR part 340, subpart B; or

(2) An employee serving under an interim appointment established under § 772.102 of this chapter.

(e) The Office of Personnel Management makes the final determination of the applicability of this section to specific employees or groups of employees.

(f) An employee of the District of Columbia Financial Responsibility and Management Assistance Authority (the Authority) who makes an election under the Technical Corrections to Financial Responsibility and Management Assistance Act (section 153 of Pub. L. 104–134, 110 Stat. 1321) to be considered a Federal employee for health benefits and other benefit purposes is subject to this part. If the employee is eligible to make an election to enroll under § 890.301, such election must be made within 60 days after the later of either the date the employment with the Authority begins or the date the Authority receives his or her election to be considered a Federal employee. Employees of the Authority who are former Federal employees are subject to the provisions of § 890.303(a), except that a former Federal employee employed by the Authority before October 26, 1996, and within 3 days following the termination of the Federal employment may make an election to enroll under § 890.301(c). Annuitants who have continued their coverage under this part as annuitants are not eligible

to enroll under this paragraph. An election to enroll under this part is effective under the provisions of § 890.306(a) unless the employee requests the Authority to make the enrollment effective on the first day of the first pay period following the date the employee entered on duty in a pay status with the Authority.

[33 FR 12510, Sept. 4, 1968, as amended at 33 FR 20002, Dec. 31, 1968; 35 FR 753, Jan. 20, 1970; 44 FR 57382, Oct. 5, 1979; 46 FR 25595, May 8, 1981; 52 FR 38220, Oct. 15, 1987; 54 FR 7755, Feb. 23, 1989; 56 FR 10143, Mar. 11, 1991; 57 FR 3715, Jan. 31, 1992; 61 FR 58460, Nov. 15, 1996]

§ 890.103 Correction of errors.

(a) The employing office may make prospective corrections of administrative errors as to enrollment at any time. The employing office may make retroactive corrections of administrative errors that occur after December 31, 1994.

(b) OPM may order correction of an administrative error upon a showing satisfactory to OPM that it would be against equity and good conscience not to do so.

(c) OPM may order the termination of an enrollment in any comprehensive medical plan described in section 8903(4) of title 5, United States Code, and permit the individual to enroll in another health benefits plan for purposes of this part, upon a showing satisfactory to OPM that the furnishing of adequate medical care is jeopardized by a seriously impaired relationship between a patient and the comprehensive medical plan's affiliated health care providers.

(d) Retroactive corrections are subject to withholdings and contributions under the provisions of § 890.502.

[45 FR 23637, Apr. 8, 1980, as amended at 53 FR 2, Jan. 4, 1988; 54 FR 52336, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 59 FR 66437, Dec. 27, 1994]

§ 890.104 Initial decision and reconsideration on enrollment.

(a) *Who may file.* Except as provided under § 890.1112, an individual may request an agency or retirement system to reconsider an initial decision of its employing office denying coverage or change of enrollment.

(b) *Initial employing office decision.* An employing office's decision is considered an initial decision as used in paragraph (a) of this section when rendered by the employing office in writing and stating the right to an independent level of review (reconsideration) by the agency or retirement system. However, an initial decision rendered at the highest level of review available within OPM is not subject to reconsideration.

(c) *Reconsideration.* (1) A request for reconsideration must be made in writing, must include the claimant's name, address, date of birth, Social Security number, name of carrier, reason(s) for the request, and, if applicable, retirement claim number.

(2) The reconsideration review must be an independent review designated at or above the level at which the initial decision was rendered.

(d) *Time limit.* A request for reconsideration of an initial decision must be filed within 30 calendar days from the date of the written decision stating the right to a reconsideration. The time limit on filing may be extended when the individual shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit. An agency or retirement system decision in response to a request for reconsideration of an employing office's decision is a final decision as described in paragraph (e) of this section.

(e) *Final decision.* After reconsideration, the agency or retirement system must issue a final decision, which must be in writing and must fully set forth the findings and conclusions.

[59 FR 66437, Dec. 27, 1994]

§ 890.105 Filing claims for payment or service.

(a) *General.* (1) Each health benefits carrier resolves claims filed under the plan. All health benefits claims must be submitted initially to the carrier of the covered individual's health benefits plan. If the carrier denies a claim (or a portion of a claim), the covered individual may ask the carrier to reconsider its denial. If the carrier affirms its denial or fails to respond as required by paragraph (c) of this section,

the covered individual may ask OPM to review the claim. A covered individual must exhaust both the carrier and OPM review processes specified in this section before seeking judicial review of the denied claim.

(2) This section applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) *Time limits for reconsidering a claim.* (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the carrier in which to submit a written request for reconsideration to the carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the carrier's notice requesting additional information. The carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this section if the carrier fails to act within the time limit set forth in this paragraph (b)(2)(iii).

(3) The covered individual may write to OPM and request that OPM review the carrier's decision if the carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this section. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this section.

(4) The carrier may extend the time limit for a covered individual's submission of additional information to the carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) *Information required to process requests for reconsideration.* (1) The covered individual must put the request to the carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) *Carrier determinations.* The carrier must provide written notice to the covered individual of its determination. If the carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the carrier's denial notice and include a copy of the denial notice as well as documents to

support the covered individual's position.

(e) *OPM review.* (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the carrier's notice to the covered individual that the denial was affirmed;

(ii) If the carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this section, within 120 days after the date of the covered individual's timely request for reconsideration by the carrier; or

(iii) Within 120 days after the date the carrier requests additional information from the covered individual, or the date the covered individual is notified that the carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the carrier, OPM may:

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the carrier, the carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this section, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the carrier.

(5) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

[61 FR 15178, Apr. 5, 1996]

§890.106 Delegation of authority for resolving certain contract disputes.

For the purpose of making findings of fact and to the extent that conclusions of law may be required under any proceeding conducted in accordance with the provisions of the disputes clause included in health benefits contracts, OPM delegates this function to the Armed Services Board of Contract Appeals.

[40 FR 50023, Oct. 28, 1975; 40 FR 55829, Dec. 2, 1975. Redesignated at 44 FR 37895, June 29, 1979 and 45 FR 23637, Apr. 8, 1980]

§890.107 Court review.

(a) A suit to compel enrollment under §890.102 must be brought against the employing office that made the enrollment decision.

(b) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(c) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (5 U.S.C. chapter 89). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute.

(d) An action under paragraph (c) of this section to recover on a claim for health benefits:

(1) May not be brought prior to exhaustion of the administrative remedies provided in §890.105;

(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—

(i) An eligible unenrolled employee may register to be enrolled.

(ii) An enrollee may change to another plan, another option, or from self alone to self and family, or may make any combination of these changes.

(iii) An annuitant or a former spouse, as defined in 5 U.S.C. 8901(10), who canceled enrollment under this part for the purpose of enrolling in a prepaid health plan under sections 1833 or 1876 of the Social Security Act may register to reenroll.

(e) *Change in family status.* (1) Other than a former spouse who is continuing coverage under subpart H or subpart K of this part or a remarried survivor annuitant, an enrollee may register to change enrollment from self alone to self and family, or from one plan or option to another, or both; and an employee, if not registered to be enrolled, may register to be enrolled at any time during the period beginning 31 days before a change in marital status and ending 60 days after the change in marital status. Other than a former spouse who is continuing coverage under subpart H or subpart K of this part or a remarried survivor annuitant, an enrollee may change enrollment from self alone to self and family within 60 days after any other change in family status.

(2) A former spouse who is continuing coverage under subpart H or subpart K of this part may register to change enrollment from self alone to self and family, or from one plan or option to another, or both, within 60 days after the birth or acquisition of a child who meets the requirements to be a covered family member under §890.804(a) or §890.1106(a)(2) of this part.

(f) *Change to self alone.* (1) An enrollee may register at any time to change enrollment from self and family to self alone.

(2) Other than a former spouse, an employee or annuitant who is covered by the enrollment of another under this part may elect self alone coverage within 31 days after a change in the covering enrollment has been filed under authority of this paragraph.

(3) In order for an employee annuitant to be eligible to elect self only coverage under authority of this paragraph, he or she must meet the statutory requirements of having retired on an immediate annuity and having been covered by a plan under this part (including enrollment in his or her own right) since his or her first opportunity to enroll or for the 5 years immediately preceding his or her retirement, whichever is shorter.

(g) *Loss of coverage under Federal programs.* (1) An employee who is not enrolled, but is covered by another federally-sponsored health benefits program, and whose coverage or enrollment terminates under the other federally-sponsored program, may register to be enrolled:

(i) Within 31 days after termination of coverage for a reason other than death; or

(ii) Within 60 days after termination of coverage because of death of the enrollee.

(2) An employee, or former spouse who has established eligibility for health benefits under §890.803 of this part and who is not enrolled but is covered by the enrollment of another under this part, may register to be enrolled: (i) within 31 days after termination of coverage for a reason other than death of the enrollee or cancellation, and (ii) within 60 days after termination of coverage because of the enrollee's death.

(3) An employee annuitant who was covered by the enrollment of another under this part and had been covered (including enrollment in his own right) under this part since his first opportunity or for the 5 years immediately preceding his retirement, whichever is shorter, may register to enroll within 31 days after the termination of the covering enrollment, other than by cancellation.

(4) An employee, annuitant, or former spouse who has established eligibility for health benefits under §890.803 of this part, who is not enrolled but is covered by the enrollment of another enrollee under this part, may register to be enrolled in the same plan and option within 31 days after cancellation of the other's enrollment. If the individual is not eligible to enroll in the plan from which coverage is lost, he or she may enroll in the same option of any available plan. In order for an employee annuitant to be eligible to

enroll under authority of this paragraph, he or she must meet the statutory requirements of having retired on an immediate annuity and having been covered by a plan under this part (including enrollment in his or her own right) since his or her first opportunity to enroll or for the 5 years immediately preceding his or her retirement, whichever is shorter.

(5) A former employee, former spouse, or a child whose continued coverage under subpart K of this part terminates because of the provisions of § 890.1110(a)(3) of this part (termination due to other coverage under this part) may reenroll in the same plan and option within 31 days after the other coverage under this part ends, but not later than the expiration of the period described in § 890.1107. If the individual is not eligible to enroll in the plan from which coverage was lost under § 890.1110(a)(3), he or she may enroll in the same option of any available plan. Coverage does not extend beyond the expiration of the period described in § 890.1107 of this part.

(6) An employee annuitant who had been covered under this part since his or her first opportunity to enroll or for the 5 years immediately preceding the commencing date of his or her annuity or monthly compensation, whichever is shorter, a survivor annuitant who had been enrolled or was otherwise eligible to enroll for coverage under this part, or a former spouse who had been enrolled for coverage under this part who cancels enrollment for the purpose of enrolling in a prepaid health plan under sections 1833 or 1876 of the Social Security Act and is subsequently disenrolled from the prepaid health plan, may register to reenroll in any available plan or option. Voluntary disenrollment from a prepaid health plan must be made in conjunction with reenrollment during the next available open season to assure continuing, uninterrupted health plan coverage. Involuntary disenrollment provides an opportunity to immediately reenroll under this part at any time beginning 31 days before and ending 31 days after the disenrollment.

(h) *Move from area served by comprehensive medical plan.* An enrollee in a comprehensive plan who moves outside the service area, or, if already living outside the service area, moves further from the service area, may register to change enrollment upon presenting written notification to the employing office of the change of address in connection with pay or annuity functions (including tax withholding forms W–4 and W–4P and the Thrift Saving Plan). Similarly, if an enrollee's family member(s) move(s) out of the service area, or moves further from the service area, the enrollee may register to change enrollment upon presenting satisfactory evidence of the move to the employing office.

(i) *Termination by employee organization plan.* An enrollee in a health benefits plan sponsored or underwritten by an employee organization whose membership in the employee organization is terminated may register to enroll in another plan under the following conditions:

(1) Health benefits enrollment is terminated by the plan; and,

(2) Registration to enroll in another plan is submitted within 31 days after termination of enrollment in the employee organization plan. The enrollee may not change enrollment from self alone to self and family under this paragraph.

(j) *Transfer to or from overseas post of duty.* An employee who is transferred from a post of duty within the several States or the District of Columbia to a post of duty outside the several States and the District of Columbia, or the reverse, may register to be enrolled or to change his enrollment with respect to whether his family is covered, or the health benefits plan or option in which he is enrolled, or both, within the period beginning 31 days before the date he leaves the old post of duty and ending 31 days after he arrives at the new post of duty. An annuitant who is eligible to continue health benefits may register to change enrollment with respect to whether his family is covered, or the health benefits plan or option in which enrolled, or both, within 60 days after retirement or the death of the employee on whose service title to annuity is based, if the employee is stationed at a post of duty outside the

several States and the District of Columbia at the time of his retirement or death, as the case may be.

(k) *Termination of plan in which enrolled.* (1) If a plan is discontinued in whole or in part, each enrollee whose enrollment is thereby terminated may enroll in another plan. If the discontinuance is at the end of a contract period that is immediately preceded by an open season, the time for enrollment is the open season, unless OPM establishes a different time for enrollment. If the discontinuance is at a time other than the end of the contract year, OPM must establish a time and an effective date for enrollment. Except as provided in paragraphs (k)(2) and (k)(3) of this section, enrollees who fail to change enrollment within the time set are considered to have cancelled the plan in which enrolled.

(2) If one option of a plan is discontinued, enrollees who do not change plans are considered to be enrolled in the remaining option of the plan.

(3) Annuitants enrolled in a discontinued plan with a single option who do not change plans are deemed to have elected to be enrolled in the Standard Option of the Service Benefit plan. Annuitants enrolled in a discontinued plan with two options are deemed to have elected the corresponding option of the Service Benefit Plan, unless they are enrolled in a high option and their annuity is insufficient to pay the withholding for the high option of the Service Benefit Plan. If their annuity is insufficient to pay the withholding for the high option, they are deemed to have elected enrollment in the Standard Option of the Service Benefit Plan. The exemptions from debt collection procedures that are provided under 5 CFR 831.1305(d)(2) and 5 CFR 845.205(d)(2) apply to elections under this paragraph.

(l) *Loss of coverage under parent's non-Federal plan.* An employee who is not registered to be enrolled may register to be enrolled within 31 days after he/she loses coverage under his/her parent's non-Federal health plan for a reason other than death and within 60 days after loss of coverage because of the parent's death.

(m) *On return from a uniformed service.* An employee who enters on duty in a uniformed service for a period of time not limited to 30 days or less may register to be enrolled or to change his enrollment within 31 days after he is restored to a civilian position pursuant to part 353 of this chapter or other similar authority; and an annuitant who enters on duty in a uniformed service for a period of time not limited to 30 days or less may register to change his enrollment within 31 days after he is separated from the uniformed service.

(n) *On becoming eligible for coverage under title XVIII of the Social Security Act.* An enrollee may register, at any time beginning on the 30th day before he or she is eligible for coverage under title XVIII of the Social Security Act (Medicare), to change enrollment to any option of any available plan under this part. A change of enrollment under this paragraph may be made only once.

(o) *Change in employment status.* If an employee or annuitant is entitled to provide coverage for another by a self-and-family enrollment, but both are enrolled for self alone, he may change his enrollment to self and family within 31 days after the other enrollment is terminated by a change in employment status which results in loss of eligibility.

(p) *Sole survivor.* When an employee or annuitant enrolled for self and family dies, leaving a survivor annuitant who is entitled to continue the enrollment in a health benefits plan, and it is apparent from available records that the survivor annuitant is the sole survivor entitled to continue enrollment in the health benefits plan, the office of the retirement system which is acting as employing office shall change the enrollment from self and family to self alone, effective on the commencing date of annuity for the survivor annuitant. On request of the survivor annuitant made within 31 days after the first installment of annuity is paid, the office of the retirement system which is acting as employing office shall rescind the action retroactive to the effective date of the action, with corresponding adjustment in withholdings and contributions.

(q) *Annuity insufficient to pay withholdings.* (1) If the annuity of an

annuitant is insufficient to pay the withholdings for the plan in which the annuitant is enrolled, the retirement system will provide information to the annuitant regarding the available plans and notify him or her in writing of the opportunity to either: register to be enrolled in any plan in which the enrollee's share of the premium is not in excess of the annuity; or make payment of the premium directly to the retirement system in accordance with § 890.502(f). If the annuitant is enrolled in the high option of a plan that has two options, and does not elect a plan at a cost to him or her not in excess of the annuity or does not elect to pay premiums directly, he or she is deemed to have selected enrollment in the standard option of the same plan unless the annuity is insufficient to pay the withholdings for the standard option.

(2) An annuitant whose enrollment was terminated on account of such annuitant's annuity being insufficient to cover the enrollee's share of the premium may apply to be reinstated in any available plan or option.

(3) An annuitant who can show evidence that he or she previously changed to a lower cost option, plan, or to a self-only enrollment prior to May 29, 1990, because the annuity was insufficient to cover the withholdings for the plan in which he or she was enrolled, may apply to change his or her enrollment to any available plan or option in which the enrollee's share of the total premium exceeds his or her monthly annuity.

(r) *Registration by proxy.* In the discretion of the employing office, a representative of an enrollee or individual eligible to enroll under this part, having written authorization to do so, may register for the individual.

(s) *Survivor annuity restored.* A surviving spouse who was covered by a health benefits enrollment under this part immediately before his or her survivor annuity was terminated because of remarriage, and whose survivor annuity is later restored, may register to enroll in a health benefits plan under this part within 60 days after the mailing by OPM of a notice of eligibility and registration forms.

(t) *Loss of medicaid coverage.* An employee who is not enrolled, but is covered by medicaid (State program of medical assistance for the needy), may register to be enrolled within 31 days after termination of medicaid; and an employee who is enrolled for self only may change to a self and family enrollment within 31 days after an eligible family member loses coverage under medicaid.

(u) *Child's coverage ends.* An enrollee may register to change enrollment from self alone to self and family within 31 days after an eligible child loses coverage under another enrollment under this part.

(v) *Change to part-time career employment.* An enrolled employee who moves, without a break in service or after a separation of 3 days or less, to ''part-time career employment'' as defined in section 3401(2) of title 5, United States Code, and 5 CFR part 340, subpart B, may change to any other plan or option. This change in enrollment may be made within 31 days after the change to ''part-time career employment.''

(w) *Election between survivor annuities.* A surviving spouse, irrespective of whether his or her survivor annuity continued or was terminated upon remarriage, who was covered by a health benefits enrollment under this part immediately before his or her remarriage, may elect to continue a health benefits enrollment under this part acquired by virtue of the remarriage or to enroll in his or her own right in the plan under which he or she was previously covered under this part within 60 days after the termination of the remarriage and entitlement to a survivor annuity.

(x) *Change to position out of commuting area.* (1) An employee who moves out of the commuting area to accept another position and who loses coverage under a spouse's non-Federal enrollment because the non-Federally employed spouse terminates his or her enrollment to accompany the Federal employee, may register to enroll within the period beginning 31 days before the date the Federal employee leaves employment in the old commuting area and ending 180 days after entry on duty at the place of employment in the new commuting area.

(2) An employee who moves out of the commuting area to accept another position and whose spouse loses non-Federal coverage when he or she terminates non-Federal employment to accompany the Federal employee, may change enrollment from self only to self and family within the period beginning 31 days before the date the Federal employee leaves employment in the old commuting area and ending 180 days after entry on duty at the place of employment in the new commuting area.

(y) *Loss of coverage under spouse's non-Federal plan*—(1) An employee whose spouse involuntarily loses his or her non-Federal health insurance coverage, or coverage for his or her dependents, may register to enroll within the period beginning 31 days before and ending 31 days after the spouse's or dependent's loss of coverage. An employee whose children lose coverage under the other parent's non-Federal health plan because the other parent involuntarily loses coverage for his or her dependents, may register to enroll within the period beginning 31 days before and ending 31 days after the children's loss of coverage.

(2) An employee or annuitant whose spouse involuntarily loses his or her non-Federal health insurance coverage, or coverage for his or her dependents, may change enrollment from self only to self and family within the period beginning 31 days before and ending 31 days after the spouse's or dependent's loss of coverage. An employee or annuitant whose children lose coverage under the other parent's non-Federal health plan because the other parent involuntarily loses coverage for his or her dependents, may change enrollment from self only to self and family within the period beginning 31 days before and ending 31 days after the children's loss of coverage.

(z) *Disability annuity restored.* A disability annuitant who was enrolled in a health benefits plan under this part immediately before his or her disability annuity was terminated because of restoration to earning capacity or recovery from disability, and whose disability annuity is restored under section 8337(e) of title 5, United States Code, after December 31, 1983, may register to enroll in a health benefits plan under this part within 60 days after OPM mails a notice of insurance eligibility and registration form.

(aa) *Termination of remarriage of ''lump sum'' survivors in receipt of basic employee death benefits.* A surviving spouse who received a basic employee death benefit under 5 U.S.C. 8442(b)(1)(A) and who was covered by a health benefits enrollment under this part immediately before remarriage prior to age 55 may register to enroll in a health benefits plan under this part upon termination of the remarriage. The survivor must provide OPM with a certified copy of the notice of death or the court order terminating the marriage. Registration must be made within 60 days after OPM mails the registration form to the surviving spouse.

(bb) *Change from a temporary appointment under 5 U.S.C. 8906a to another type of covered appointment.* A temporary employee who is eligible to enroll according to provisions of 5 U.S.C. 8906a, which require payment of the full premium with no Government contribution, and who subsequently changes to an appointment that entitles the employee to receive the Government contribution toward the premium, may enroll or change to any other plan or option within 31 days after changing to the appointment that allows the Government contribution.

(cc) *Reenrollment upon application for postponed MRA-plus-10 annuity.* A former employee who meets the requirements for an immediate annuity under 5 U.S.C. 8412(g) and for continuation of coverage under 5 U.S.C. 8905(b) at the time of the separation and whose enrollment is terminated under § 890.304(a)(2) may register to enroll in a health benefits plan under this part within 60 days after OPM mails the former employee a notice of eligibility and the appropriate registration form. If such former employee dies before the end of the 60-day election period in the preceding sentence, a survivor who is entitled to a survivor annuity may register to enroll in a health benefits plan under this part within 60 days after OPM mails the survivor a notice of eligibility and the appropriate registration form.

(dd) *Separating employees.* An employee may change enrollment from self only to self and family during the pay period in which the employee's coverage terminates due to separation if the employee or the employee's spouse is pregnant. The employee must supply medical documentation of the pregnancy.

(ee) *Salary of temporary employee insufficient to pay withholdings.* If the salary of a temporary employee eligible under 5 U.S.C. 8906a is not sufficient to pay the withholdings for the plan in which the employee is enrolled, the employing office shall notify the employee of the plans available at a cost not in excess of the employee's salary. The employee may register to be enrolled in another plan whose cost is no greater than his or her salary within 31 days after receiving such notification from the employing office.

[33 FR 12510, Sept. 4, 1968]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 890.301, see the List of Sections Affected in the Finding Aids section of this volume.

§ 890.302 Coverage of family members.

(a)(1) An enrollment for self and family includes all family members who are eligible to be covered by the enrollment. Except as provided in paragraphs (a) (2), (3), and (4) of this section, no employee, former employee, annuitant, child, or former spouse may enroll or be covered as a family member if he or she is covered under another person's self and family enrollment in the FEHB Program.

(2) *Dual enrollment—spouse.* (i) To protect the interests of the children, an employee or annuitant may enroll in his or her own right in a self and family enrollment even though his or her spouse also has a self and family enrollment. Generally, such dual enrollments are permitted only where two employees or annuitants are married, each with children from prior marriages who do not live with them, or are legally separated, with each spouse retaining custody of his or her own children by a prior marriage. To ensure that no person receives benefits under more than one enrollment, each enrollee must tell the insurance carrier which family members are covered under his or her enrollment. These individuals are not covered under the other enrollment.

(ii) To protect the interests of legally separated Federal employees, annuitants and their children, a legally separated employee or annuitant may enroll in his or her own right in a self only or self and family enrollment even though his or her spouse also has a self and family enrollment. To ensure that no person receives benefits under more than one enrollment, each enrollee must tell the insurance carrier which family members are covered under his or her enrollment. These individuals are not covered under the other enrollment.

(3) *Dual enrollment—child.* (i) When natural parents are divorced or legally separated and children are included as family members under the enrollment of both natural parents or of a natural parent and a step-parent, the children are entitled to receive benefits under only one enrollment. Each enrollee must notify his or her insurance carrier of the name(s) of the child(ren) to be covered under his or her enrollment that are not named under the other enrollment.

(ii) When an employee who is under age 22 and covered under a parent's self and family enrollment becomes the parent of a child, the employee may elect to enroll for self and family coverage. Because the employee is entitled to receive benefits under only one enrollment, each enrollee must notify his or her insurance carrier of the names of the persons to be covered under his or her enrollment that are not named under the other enrollment.

(4) *Dual enrollment—spouse and child.* Where a situation such as that in paragraph (a)(2) of this section occurs (that is, two employees or annuitants are married, but each has children from prior marriages who do not live with them) and there are also children who are the issue of the marriage, an employee or annuitant may enroll in his or her own right in a self and family enrollment even though his or her spouse also has a self and family enrollment. Because no person is entitled to receive benefits under more than one enrollment, each enrollee must notify his or her insurance carrier of the

names of the family members to be covered under his or her enrollment that are not covered under the other enrollment.

(b) *Proof of dependency.* (1) A child is considered to be dependent on an enrolled employee or annuitant or a former employee or child enrolled under § 890.1103 of this part if he or she is:

(i) A legitimate child;

(ii) An adopted child;

(iii) A stepchild, foster child, or recognized natural child who lives with the enrollee in a regular parent-child relationship.

(iv) A recognized natural child for whom a judicial determination of support has been obtained; or

(v) A recognized natural child to whose support the enrollee makes regular and substantial contributions.

(2) The following are examples of proof of regular and substantial support. More than one of the following proofs may be required to show support of a recognized natural child who does not live with the enrollee in a regular parent-child relationship and for whom a judicial determination of support has not been obtained.

(i) Evidence of eligibility as a dependent child for benefits under other State or Federal programs;

(ii) Proof of inclusion of the child as a dependent on the enrollee's income tax returns;

(iii) Canceled checks, money orders, or receipts for periodic payments from the enrollee for or on behalf of the child.

(iv) Evidence of goods or services which show regular and substantial contributions of considerable value;

(v) Any other evidence which OPM shall find to be sufficient proof of support or of paternity or maternity.

(c) *Exceptions.* Coverage as a family member may be denied:

(1) If evidence shows that the enrollee did not recognize the child as his or her own, despite a willingness to support the child, or

(2) If evidence calls the child's paternity or maternity into doubt, despite the enrollee's recognition and support of the child.

(d) *Child incapable of self-support.* When an individual enrolls for a family that includes a child who has become 22 years of age and is incapable of self-support, the employing office must require such enrollee to submit a physician's certificate verifying the child's disability. The certificate must—

(1) State that the child is incapable of self-support because of a physical or mental disability that existed before the child became 22 years of age and that can be expected to continue for more than 1 year;

(2) Include a statement of the name of the child, the nature of the disability, the period of time it has existed, and its probable future course and duration; and,

(3) Be signed by the physician and show the physician's office address. The employing office must require the enrollee to submit the certificate on or before the date the child becomes 22 years of age. However, the employing office may accept otherwise satisfactory evidence of incapacity that is not timely filed.

(e) *Renewal of certificates of incapacity.* The employing office must require an enrollee who has submitted a certificate of incapacity to renew that certificate on the expiration of the minimum period of disability certified.

(f) *Determination of incapacity.* The employing office shall make determinations of incapacity.

(g) *Meaning of unmarried.* A child who has never married or whose marriage has been annulled, or a child who is divorced or widowed is considered to be unmarried.

[33 FR 12510, Sept. 4, 1968, as amended at 43 FR 52460, Nov. 13, 1978; 45 FR 76088, Nov. 18, 1980; 46 FR 35082, July 7, 1981; 49 FR 1047, Jan. 9, 1984; 51 FR 15748, Apr. 28, 1986; 53 FR 45070, Nov. 8, 1988; 54 FR 52338, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 59 FR 60296, Nov. 23, 1994]

§ 890.303 Continuation of enrollment.

(a) *On transfer or retirement.* (1) Except as otherwise provided by this part, the registration of an employee or annuitant eligible to continue enrollment continues without change when he or she moves from one employing office to another, without a break in service of more than 3 days, whether the personnel action is designated as a transfer or not.

(2) In order for an employee to continue an enrollment as an annuitant, he or she must meet the participation requirements set forth at 8905(b) of title 5, United States Code, for continuing an enrollment as an annuitant as of the commencing date of his or her annuity or monthly compensation.

(3) For the purpose of this part, an employee is considered to have enrolled at his or her first opportunity if the employee registered to be enrolled during the first of the periods set forth in §890.301 in which he or she was eligible to register or was covered at that time by the enrollment of another employee or annuitant, or registered to be enrolled effective not later than December 31, 1964.

(4) Enrollment or eligibility for enrollment under subparts H or K of this part of an individual who is not an employee eligible for coverage under other provisions of this part is not considered in determining whether a retiring employee has met the participation requirements of §8905(b) of title 5, U.S. Code. Coverage under subparts H or K of this part of an individual who is an employee eligible for coverage under other provisions of this part may be considered in determining whether a retiring employee has met the participation requirements.

(b) *Change of enrolled employees to certain excluded positions.* Employees and annuitants enrolled under this part who move, without a break in service or after a separation of 3 days or less, to an employment in which they are excluded by §890.102(c), continue to be enrolled so long as they are employed, unless excluded by paragraphs (c) (4), (5), (6), (7), or (8) of §890.102.

(c) *On death.* The enrollment of a deceased employee or annuitant who is enrolled for self and family (as opposed to self only) is transferred automatically to his or her eligible survivor annuitants. The enrollment is considered to be that of (1) the survivor annuitant from whose annuity all or the greatest portion of the withholding for health benefits is made or (2) the surviving spouse entitled to a basic employee death benefit. The enrollment covers members of the family of the deceased employee or annuitant. In those instances in which the annuity is split among surviving family members, multiple enrollments are allowed. A remarried spouse is not a member of the family of the deceased employee or annuitant unless annuity under section 8341 or 8442 of title 5, United States Code, continues after remarriage.

(d)(1) *Survivor annuitants.* If an employee who is entitled to health benefits coverage as a survivor annuitant elects to enroll or to continue to be enrolled under his eligibility as an employee, and is thereafter separated without entitlement to continued enrollment based on his own service, he is entitled to reinstatement of his employee-acquired enrollment on application to his retirement office. Reinstatement is effective immediately after termination of his employee-acquired enrollment if the application is received by the retirement office within 60 days of separation; otherwise reinstatement is effective on the first day of the first pay period after receipt of the application. The retirement office shall withhold from the annuity that the former employee receives as a survivor annuitant, the amounts necessary to pay his share of the cost of the enrollment.

(2) *Employee becomes a survivor annuitant.* (i) If an employee who is entitled to health benefits coverage as a survivor annuitant elects to enroll or to continue to be enrolled under his or her eligibility as an employee, and is thereafter separated without entitlement to continued enrollment based on his or her own service, the employee is entitled to reinstatement of the enrollment as a survivor anuitant on application to the retirement office. Reinstatement as a survivor annuitant is effective on the day after the termination date of the employee-acquired enrollment if the application is received by the retirement office within 60 days of separation; otherwise, reinstatement is effective on the first day of the first pay period after receipt of the application. The retirement office shall withhold from the annuity that the former employee receives as a survivor annuitant the amounts necessary to pay the health benefits premium.

(ii) If the surviving spouse of a deceased employee or annuitant is enrolled as an employee with a self and

family enrollment (or, if both the decedent and the surviving spouse were enrolled in a self only enrollment) at the time the surviving spouse becomes a survivor annuitant and the surviving spouse is thereafter separated without entitlement to continued enrollment as a retiree, the surviving spouse is entitled to enroll as a survivor annuitant. The change from coverage as an employee to coverage as a survivor annuitant must be made with 30 days of separation from service.

(iii) Except for an employee who meets the definition of former spouse under 5 U.S.C. 8901(10) based on an individual's deferred annunity under 5 U.S.C. 8341(h) or 8445(f), the employee survivor of an annuitant receiving deferred retirement benefits is not eligible for FEHB Program enrollment as a survivor annuitant and therefore may not enroll as a survivor annuitant based on coverage obtained as an employee.

(3) *Insurance interest survivor annuity.* A current spouse who is an insurable interest beneficiary under § 831.606(b) or § 842.605(b) of this title is eligible to continue health benefits enrollment as an insurable interest survivor annuitant so long as he or she was covered as a family member at the time of the annuitant's death. This entitlement applies even if the spouse is eligible for continued enrollment as a survivor annuitant under another section of 5 CFR parts 831 or 843. To prevent dual coverage, the spouse must be covered under only one health benefits enrollment under this part.

(e) *In nonpay status.* (1) Except as otherwise provided by law, the enrollment of an employee continues while he/she is in nonpay status for up to 365 days. The 365 days' nonpay status may be continuous or broken by periods of less than 4 consecutive months in pay status. If an employee has at least 4 consecutive months in pay status after a period of nonpay status he/she is entitled to begin the 365 days' continuation of enrollment anew. For the purposes of this paragraph, 4 consecutive months in pay status means any 4-month period during which the employee is in pay status for at least part of each pay period.

(2) However, in the case of an employee who is employed under an OPM approved career-related work-study program under Schedule B of at least one year's duration and who is expected to be in a pay status during not less than one-third of the total period of time from the date of the first appointment to the completion of the work-study program, his/her enrollment continues while he/she is in nonpay status so long as he/she is participating in the work-study program.

(f) [Reserved]

(g) *Former spouse entitled to coverage as employee or member of family.* An individual entitled to health benefits as a former spouse who also has or becomes entitled to health benefits coverage as a Federal employee or as a family member under another enrollment under this part may defer or suspend coverage as a former spouse and continue his or her coverage as an employee or family member. The former spouse must have established entitlement to the health benefits coverage under § 890.803 of this part and filed all required documents with the employing office responsible for maintaining the former spouse enrollment within the time limits specified in § 890.805 of this part. The employing office shall note in the former spouse's file that the former spouse health benefits enrollment is being deferred or suspended until coverage as a Federal employee or as a family member ends. Upon loss of coverage as a Federal employee or as a family member, the individual is entitled to enroll or resume the enrollment as a former spouse, provided he or she remains eligible as such. A former spouse who enrolls because he or she lost coverage under another enrollment under this part for a reason other than cancellation must meet the requirements of § 890.301(g)(2). A former spouse who enrolls because he or she lost coverage under another enrollment under this part as a result of cancellation of the covering enrollment must meet the requirements of § 890.301(g)(4).

(h) *Temporary continuation of coverage.* Certain former employees who lose coverage because of a separation from Federal service, certain children who lose coverage because they cease to meet the requirements for coverage

as children, and certain former spouses who lose coverage because their marriage to the enrollee ends and who are not eligible for coverage under subpart H of this part may elect temporary continuation of coverage under the provisions of subpart K of this part.

(i) Service in the uniformed services. The enrollment of an individual who separates to enter the uniformed services under conditions that entitle him or her to benefits under part 353 of this chapter may continue for the 18-month period beginning on the date that the absence to serve in the uniformed services begins, provided that the individual continues to be entitled to benefits under part 353 of this chapter. The enrollment of an employee who enters on military furlough or is placed in nonpay status to serve in the uniformed services may continue for the 18-month period beginning on the date that the absence to serve in the uniformed services begins, provided that the employee continues to be entitled to benefits under part 353 of this chapter. An employee in nonpay status is entitled to continued coverage under paragraph (e) of this section if the employee's entitlement to benefits under part 353 of this chapter ends before the expiration of 365 days in nonpay status. The enrollment of an employee who is on military furlough or in nonpay status in order to serve in the uniformed services on October 13, 1994, may continue for the 18-month period beginning on the date that the absence to serve in the uniformed services began, provided that the employee continues to be entitled to continued coverage under part 353 of this chapter. If the enrollment of such an employee had terminated due to the expiration of 365 days in nonpay status, it may be reinstated for the remainder of the 18-month period beginning on the date that the absence to serve in the uniformed services began, provided that the employee continues to be entitled to continued coverage under part 353 of this chapter.

[33 FR 12510, Sept. 4, 1968, as amended at 47 FR 30962, July 16, 1982; 52 FR 17388, May 8, 1987; 52 FR 39496, Oct. 22, 1987, and 53 FR 32368, Aug. 25, 1988; 53 FR 40716, Oct. 18, 1988; 53 FR 45070, Nov. 8, 1988; 54 FR 52338, Dec. 21, 1989; 55 FR 1782, Jan. 19, 1990; 55 FR 13502, Apr. 11, 1990; 55 FR 22891, June 5, 1990; 57 FR 21191, May 19, 1992; 60 FR 45657, Sept. 1, 1995]

§ 890.304 Termination of enrollment.

(a) *Employees.* (1) An employee's enrollment terminates, subject to the temporary extension of coverage for conversion, at midnight of the earliest of the following dates:

(i) The last day of the pay period in which he/she is separated from the service other than by retirement under conditions entitling him/her to continue his/her enrollment.

(ii) The last day of the pay period in which he or she separates after meeting the requirements for an immediate annuity under §842.204(a)(1) of this chapter, but postpones receipt of annuity as provided by §842.204(c).

(iii) The last day of the pay period in which his employment status changes so that he is excluded from enrollment.

(iv) The last day of the pay period in which he dies, unless he leaves a member of the family entitled to continue enrollment as a survivor annuitant.

(v) The last day of the pay period which includes the day on which the continuation of enrollment under §890.303(e) expires, or, if he/she is not entitled to any further continuation because he/she has not had 4 consecutive months of pay status since exhausting his/her 365 days' continuation of coverage in nonpay status, the last day of his/her last pay period in pay status.

(vi) The day he or she is separated, furloughed, or placed on leave of absence to serve in the uniformed services under conditions entitling him or her to benefits under part 353 of this chapter for the purpose of performing duty not limited to 30 days or less, provided the employee elects, in writing to have the enrollment so terminated.

(vii) For an employee who separates to serve in the uniformed services under conditions entitling him or her to benefits under part 353 of this chapter for the purpose of performing duty not limited to 30 days or less, the date that is 18 months after the date that the absence to serve in the uniformed services began or the date entitlement to benefits under part 353 of this chapter ends, whichever is earlier, unless the enrollment is terminated under paragraph (a)(1)(vi) of this section.

(viii) For an employee who is furloughed or placed on leave of absence

under conditions entitling him or her to benefits under part 353 of this chapter, the date that is 18 months after the date that the absence to serve in the uniformed services began or the date entitlement to benefits under part 353 of this chapter ends, whichever is earlier, but not earlier than the date the enrollment would otherwise terminate under paragraph (a)(1)(v) of this section.

(2) If the pay of a temporary employee eligible under 5 U.S.C. 8906a is insufficient to pay the withholdings for the plan in which the employee is enrolled, and the employee does not, or cannot, elect a plan under §890.301(ee) at a cost to him or her not in excess of the pay, the employing office must terminate the employee's enrollment effective as of the end of the last period for which withholding was made. Each temporary employee whose enrollment is so terminated is entitled to a 31-day extension of coverage for conversion.

(b) *Annuitants.* (1) If the annuity of an annuitant is insufficient to pay the withholdings for the plan in which the annuitant is enrolled, the annuitant may elect one of the two opportunities offered under §890.301(q) of this part (electing a plan with a withholding not in excess of the annuity; or, paying premiums directly to the retirement system in accordance with §890.502(f) of this part). The retirement system will send two notices to the annuitant, including one by certified mail return receipt requested. Continuation of coverage rests upon electing direct payment or new coverage within 15 days (45 days for annuitants residing overseas) after receipt of the final notice. Except as provided in paragraph (b)(3) of this section, the enrollment of an individual who fails to make an election within the specified time frame will be terminated. An annuitant whose enrollment is terminated because of failure to make an election may not reenroll or reinstate coverage, except as provided in paragraph (b)(2) of this section. Each annuitant whose enrollment is so terminated is entitled to a 31-day extension of coverage for conversion.

(2) If the individual was prevented by circumstances beyond his or her control from making an election within the time limit after receipt of the final notice, he or she may request reinstatement of coverage by writing to the retirement system. The retirement system will determine if the individual is eligible for reinstatement of coverage; and, when the determination is affirmative, the individual's coverage may be reinstated retroactively to the date of termination or prospectively. If the determination is negative, the individual may request reconsideration of the decision from OPM.

(3) If the annuitant does not make an election under paragraph (b)(1) of this section and is enrolled in the high option of a plan that has two options, the annuitant is deemed to have elected enrollment in the standard option of the same plan unless the annuity is insufficient to pay the withholdings for the standard option.

(4) An annuitant's enrollment terminates, subject to the temporary extension of coverage for conversion, at midnight of the last day of the pay period in which he dies, unless he leaves a member of the family entitled to continue enrollment as a survivor annuitant, or, if his enrollment is not terminated by death, at midnight of the earliest of the following dates:

(i) The last day of the last pay period for which he is entitled to annuity, unless he is eligible for continued enrollment as an employee in which case his enrollment continues without change.

(ii) The last day of the pay period in which his title to compensation under subchapter I of chapter 81 of title 5, United States Code, terminates, or in which he is held by the Secretary of Labor to be able to return to duty, unless he is eligible for continued enrollment as an employee or as an annuitant under a retirement system for civilian employees in which case his enrollment continues without change.

(iii) The day he enters on active duty in a uniformed service for the purpose of performing duty not limited to 30 days or less, provided the annuitant elects, in writing, to terminate the enrollment.

(iv) The last day of the month preceding the month in which a survivor annuitant in receipt of basic employee death benefits under 5 U.S.C. 8442(b)(1)(A) remarries before attaining age 55.

(c) *Coverage of family members.* The coverage of a family member of an enrollee terminates, subject to the temporary extension of coverage for conversion, at midnight of the earlier of the following dates:

(1) The day on which he or she ceases to be a family member;

(2) The day the enrollee ceases to be enrolled, unless the family member is entitled, as a survivor annuitant, to continued enrollment, or is entitled to continued coverage under the enrollment of another.

(d) *Cancellation.* Except as provided in § 890.807(d) of this part, an enrollee may register to cancel his or her enrollment at any time by filing with the employing office a properly completed health benefits registration form. The cancellation becomes effective on the last day of the pay period in which the health benefits registration form canceling the enrollment is received by the employing office, except that the cancellation of an enrollee having a monthly or 4-weekly pay period becomes effective at the end of the pay period in which the health benefits registration form is received if the form is received not less than 15 days before the end of the pay period. If an annuitant submits documentation that the cancellation is for the purpose of enrolling in a prepaid health plan under sections 1833 or 1876 of the Social Security Act, the cancellation becomes effective on the day before the enrollment under the prepaid health plan takes effect. Such documentation must be submitted to the employing office within the period beginning 31 days before and ending 31 days after the prepaid health plan enrollment takes effect. The enrollee and covered family members are not entitled to the temporary extension of coverage for conversion or to convert to an individual contract for health benefits.

(e) *Temporary continuation of coverage.* Employees and family members are entitled to temporary continuation of coverage only as provided under subpart K of this part.

[33 FR 12510, Sept. 4, 1968, as amended at 47 FR 30962, July 16, 1982; 52 FR 39496, Oct. 22, 1987, and 53 FR 32368, Aug. 25, 1988; 53 FR 32369, Aug. 25, 1988; 54 FR 52338, Dec. 21, 1989; 55 FR 996, Jan. 11, 1990; 55 FR 3564, Feb. 2, 1990; 55 FR 22891, June 5, 1990; 56 FR 25996, June 6, 1991; 57 FR 48162, Oct. 22, 1992; 58 FR 47825, Sept. 13, 1993; 60 FR 45658, Sept. 1, 1995]

§ 890.305 Reinstatement of enrollment after military service.

(a) The enrollment of an employee or annuitant whose enrollment was terminated under § 890.304(a)(1)(vi), (vii) or (viii) or § 890.304(b)(4)(iii) is automatically reinstated on the day the employee is restored to a civilian position under the provisions of part 353 of this chapter or on the day the annuitant is separated from the uniformed services, as the case may be.

(b) An employee whose employing office terminates his or her enrollment because his or her order to enter on duty in a uniformed service is for a period longer than 30 days, and who retires on an immediate annuity from his or her Federal civilian position while on such duty, may reinstate his or her enrollment by asking to do so within 60 days after retirement. In the absence of such a request, the retirement system automatically reinstates the enrollment on the day the person separates from the uniformed service. For the retirement system to reinstate the enrollment, the individual must have been covered under this part since his or her first opportunity or for the 5 years of civilian service (excluding the period of uniformed service) immediately preceding the civilian retirement, whichever is shorter.

[43 FR 52460, Nov. 13, 1978, as amended at 59 FR 60296, Nov. 23, 1994; 60 FR 45658, Sept. 1, 1995]

§ 890.306 Effective dates.

(a) *Generally.* Except as set forth in the following paragraphs, the effective date of an enrollment or change of enrollment is the 1st day of the 1st pay

period that begins after the health benefits registration form is received by the employing office and that follows a pay period during any part of which the employee or annuitant is in pay or annuity status.

(b) *Survivor annuity restored.* The effective date of an enrollment under § 890.301(s) of this part is either (1) the 1st day of the month after the date the retirement system receives the health benefits registration form; or (2) the date of restoration of the survivor annuity or October 1, 1976, whichever is later.

(c) *Change to self alone.* The effective date of a change of enrollment under § 890.301(f) is the first day of the first pay period after the health benefits registration form is received by the employing office, except that at the request of the employee or annuitant and upon a showing satisfactory to the employing office that there was no family member eligible for coverage by the family enrollment, the change may be made effective as of the first day of the pay period following the one in which there were no family members.

(d) *Annuitant required to change enrollment.* The effective date of an annuitant's change to a lower cost enrollment under § 890.301(q) is immediately upon termination of his or her prior enrollment.

(e)(1) The effective date of a change in enrollment under § 890.301(d)(1) is the first day of the first pay period which begins in January of the next following year, except that a change in enrollment for the open season ending May 28, 1982, is effective on the first day of the first pay period which begins on or after July 1, 1982.

(2) The effective date of a new enrollment under § 890.301(d)(1) is the first day of the first pay period which begins in the next following year and which follows a pay period during any part of which the employee is in a pay status, except that the effective date of a new enrollment for the open season ending May 28, 1982, is the first day of the first pay period which begins on or after July 1, 1982, and which follows a pay period during any part of which the employee is in pay status.

(f) *Birth or addition of a child.* The effective date of a change in enrollment under § 890.301(e) made in conjunction with the birth of a child, or the addition of a child as a new family member in some other manner, is the first day of the pay period in which the child is born or becomes an eligible family member.

(g) *Belated open season registrations.* When a belatedly filed open season enrollment registration or enrollment change is accepted by the employing office under § 890.301(b), it takes effect on the date required by § 890.306(e).

(h) *Restoration of disability annuity.* The effective date of an enrollment under § 890.301(z) is the first day of the month after the date OPM receives the registration form.

(i) *Restoration of health benefits for survivors in receipt of basic employee death benefits following termination of remarriage.* The effective date of an enrollment under § 890.301(aa) is the first day of the month after the date of receipt by OPM of the registration form and the notice of death or court order terminating the remarriage.

(j) *Reenrollment upon application for postponed MRA-plus-10 annuity.* The effective date of a reenrollment under § 890.301(bb) is the first day of the month following the month in which OPM receives the registration form or on the commencing date of annuity, whichever is later. The effective date of a survivor's enrollment under § 890.301(bb) is the first day of the month following the month in which OPM receives the registration form.

(k) *Annuitant's enrollment reinstated or changed under § 890.301(q).* (1) The effective date of the reinstatement of enrollment of an annuitant whose enrollment was terminated, or the change of enrollment of an annuitant who changed to a lower cost option, plan, or to a self-only enrollment because his or her annuity was insufficient to cover the enrollee's share of the total premium of his or her plan of choice, and who elects to pay premiums directly to the retirement system in accordance with § 890.502(f) of this part is either: (i) The 1st day of the 1st pay period that begins after the health benefits registration form is received by the retirement system; or, (ii) the later of the date the enrollment was terminated or changed, or May 29, 1990.

(2) Retroactive reinstatement or change of enrollment is contingent upon payment of appropriate contributions retroactive to the effective date of the reinstatement or the change of enrollment. For the purpose of this paragraph, a previous cancellation of enrollment because of insufficient annuity to cover the full amount of the withholdings is deemed to be a termination of enrollment.

(l) *Move from area served by comprehensive medical plan.* The effective date of an enrollment under § 890.301(h) is the first day of the pay period that begins after the health benefits registration form is received by the employing office.

(m) *Separating employees.* The effective date of a change in enrollment under § 890.301(dd) is the first day of the pay period in which the health benefits registration form is received by the employing office.

(n) *Reenrollment of annuitant.* The effective date of an annuitant's reenrollment under § 890.301(g)(6) is, for an involuntary disenrollment from a prepaid health plan under sections 1833 or 1876 of the Social Security Act, the date shown on the documentation from the plan. For a voluntary disenrollment, the effective date of reenrollment is the first day of the first pay period which begins in January of the next following year.

(o) *Temporary employee required to change enrollment.* The effective date of a temporary employee's change to a lower cost enrollment under § 890.301(ee) is immediately upon termination of his or her prior enrollment.

[33 FR 12510, Sept. 4, 1968]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 890.306, see the List of Sections Affected in the Finding Aids section of this volume.

§ 890.307 Waiver or suspension of annuity or compensation.

(a) Except as provided in paragraphs (b) and (f) of this section, when annuity or compensation is entirely waived or suspended, the annuitant's enrollment continues for not more than 3 months (not more than 12 weeks for annuitants whose compensation under subchapter I of chapter 81 of title 5, United States Code, is paid each 4 weeks). If the waiver or suspension continues beyond this period, the employing office will notify the annuitant in writing that the employing office will terminate the enrollment effective at the end of the period, subject to the temporary extension of coverage for conversion, unless the annuitant elects to make payment of the premium directly to the employing office during the period of waiver. If the annuitant elects to have the enrollment terminated, the employing office automatically reinstates the enrollment on a prospective basis when the annuitant again receives payment of annuity or compensation. The employing office will make the withholding for the period of waiver or suspension during which enrollment was continued (i.e., 3 months or less).

(b) If the annuitant elects to pay premiums directly, he or she must send to the employing office his or her share of the subscription charge for the enrollment for every pay period during which the enrollment continues, exclusive of the 31-day temporary extension of coverage for conversion provided in § 890.401. The annuitant must pay after each pay period he or she is covered in accordance with a schedule established by the employing office. If the employing office does not receive payment by the date due, the employing office must notify the annuitant in writing that continuation of coverage depends upon payment being made within 15 days (45 days for annuitants residing overseas) after receipt of the notice. If no further payments are made, the employing office terminates the enrollment 60 days after the date of the notice (90 days for annuitants residing overseas). The employing office automatically reinstates enrollment on a prospective basis when payment of annuity or compensation resumes.

(c) If the annuitant is prevented by circumstances beyond his or her control from paying within 15 days after receipt of the notice, he or she may request reinstatement of coverage by writing to the employing office. The annuitant must file the request within 30 calendar days from the date of termination, and must include supporting documentation. The employing office will determine if the annuitant is eligible for reinstatement of coverage; and,

when the determination is affirmative, reinstate the coverage of the annuitant retroactive to the date of termination. If the determination is negative, the annuitant may request a review of the decision as provided in § 890.104.

(d) Termination of enrollment for failure to pay premiums within the time frame established in accordance with paragraph (b) of this section is retroactive to the end of the last pay period for which the employing office timely received payment.

(e) The employing office will submit all direct premium payments along with its regular health benefits premiums to OPM in accordance with procedures established by OPM.

(f) If suspension of annuity or compensation is because of reemployment, the reemploying office must make the withholding currently and enrollment continues during reemployment.

[59 FR 60296, Nov. 23, 1994, as amended at 59 FR 67607, Dec. 30, 1994]

Subpart D—Temporary Extension of Coverage and Conversion

§ 890.401 Temporary extension of coverage and conversion.

(a) *Thirty-one day extension and conversion.* (1) An enrollee whose enrollment is terminated other than by cancellation of the enrollment or discontinuance of the plan, in whole or part, and a covered family member whose coverage is terminated other than by cancellation of the enrollment or discontinuance of the plan, in whole or in part, is entitled to a 31-day extension of coverage for self alone or self and family, as the case may be, without contributions by the enrollee or the Government, during which period he or she is entitled to exercise the right of conversion provided for by this part. The 31-day extension of coverage and the right of conversion for any person ends on the effective date of a new enrollment under this part covering the person.

(2) Termination of an enrollment under this subpart for failure to pay premiums is considered a cancellation of the enrollment for the purposes of this section.

(b) *Continuation of benefits.* (1) Any person who has been granted a 31-day extension of coverage in accordance with paragraph (a) of this section and who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the plan during the continuance of the confinement but not beyond the 60th day after the end of the temporary extension.

(2) Except when a plan is discontinued in whole or in part or the Associate Director for Retirement and Insurance orders an enrollment change, a person whose enrollment has been changed from one plan to another, or from one option of a plan to the other option of that plan, and who is confined to a hospital or other institution for care or treatment on the last day of enrollment under the prior plan or option, is entitled to continuation of the benefits of the prior plan or option during the continuance of the confinement. Continuation of benefits shall not extend beyond the 91st day after the last day of enrollment in the prior plan or option. The plan or option to which enrollment has been changed shall not pay benefits with respect to that person while he or she is entitled to any inpatient benefits under the prior plan or option. The gaining plan or option shall begin coverage according to the limits of its FEHB Program contract on the day after the day all inpatient benefits have been exhausted under the prior plan or option or the 92nd day after the last day of enrollment in the prior plan or option, whichever is earlier. For the purposes of this paragraph, ''exhausted'' means paid or provided to the maximum benefit available under the contract.

(3) *Exception.* The limit on the number of confinement days allowed to be covered under the continuation of benefits specified by paragraph (b)(2) of this subpart does not apply to confinements in a hospital or other institution when the charges and benefit payments for the services provided are covered by the limit specified in subpart I of this part. In these cases, the benefits continue until the end of the confinement.

(c)(1) The employing agency must notify the enrollee of the termination of the enrollment and of the right to convert to an individual policy within 60

days after the date the enrollment terminates.

(2) The individual whose enrollment terminates must request conversion information from the losing carrier within 31 days of the date of the agency notice of the termination of the enrollment and of the right to convert.

(3) When an agency fails to provide the notification required in paragraph (c)(1) of this section within 60 days of the date the enrollment terminates, or the individual fails for other reasons beyond his or her control to request conversion as required in paragraph (c)(2) of this section, he or she may request conversion to an individual policy by writing directly to the carrier. Such a request must be filed within 6 months after the individual became eligible to convert his or her group coverage and must be accompanied by verification of termination of the enrollment; e.g., an SF 50, showing the individual's separation from the service. In addition, the individual must show that he or she was not notified of the termination of the enrollment and of the right to convert, and was not otherwise aware of it, or that he or she was unable, for cause beyond his or her control, to convert. The carrier will determine if the individual is eligible to convert; and when the determination is affirmative, the individual may convert within 31 days of the determination. If the determination by the carrier is negative, the individual may request a review of the carrier's determination from OPM.

(4) When an individual converts his or her coverage anytime after the group coverage has ended, the individual plan coverage is retroactive to the day following the day the temporary extension of group coverage ended. The individual must pay the premiums due for the retroactive period.

(5) An individual who fails to exercise his or her rights to convert to an individual policy within 31 days after receiving notice of the right to convert from the carrier is deemed to have declined the right to convert unless the carrier, or, upon review, OPM determines the failure was for cause beyond his or her control.

[33 FR 12510, Sept. 4, 1968, as amended at 52 FR 10217, Mar. 31, 1987; 54 FR 52339, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 57 FR 10609, Mar. 27, 1992; 57 FR 21191, May 19, 1992]

Subpart E—Contributions and Withholdings

§ 890.501 Government contributions.

(a) The Government contribution for all plans, except those for which another contribution is set by paragraph (b) of this section, for each enrolled employee who is paid biweekly, is the amount provided in section 8906 of title 5, United States Code, plus 4 percent of that amount.

(b) The biweekly Government contribution for each employee or annuitant enrolled in a plan whose total enrollment charge is less than twice the appropriate contribution listed in paragraph (a) of this section is 50 percent of the enrollment charge.

(c) The Government contribution for annuitants and for employees who are not paid biweekly is a percentage of that fixed by paragraphs (a) and (b) of this section proportionate to the length of the pay period, rounding fractions of a cent to the nearest cent.

(d) The Government contribution for employees whose annual pay is paid during a period shorter than 52 workweeks is determined on an annual basis and prorated over the number of installments of pay regularly paid during the year.

(e) Except as provided in paragraphs (f) and (g) of this section, the employing office must make a contribution for an employee for each pay period during which the enrollment continues.

(f) Temporary employees enrolled under 5 U.S.C. 8906a must pay the full subscription charge including the Government contribution. Employees with provisional appointments under § 316.403 are not considered to be enrolled under 5 U.S.C. 8906a for the purpose of this paragraph.

(g) The Government contribution for an employee who enters the uniformed

services and whose enrollment continues under §890.303(i) ceases after 365 days in nonpay status.

[33 FR 12510, Sept. 4, 1968, as amended at 47 FR 30963, July 16, 1982; 54 FR 7756, Feb. 23, 1989; 56 FR 10143, Mar. 11, 1991; 60 FR 45658, Sept. 1, 1995]

§ 890.502 Employee withholdings and contributions.

(a) *Employee and annuitant withholdings and contributions.* (1) Except as provided in paragraphs (a)(2) and (g) of this section, an employee or annuitant is responsible for payment of the employee or annuitant share of the cost of enrollment for every pay period during which the enrollment continues. An employee or annuitant incurs an indebtedness due the United States in the amount of the proper employee or annuitant withholding required for each pay period that health benefits withholdings or direct premium payments are not made but during which the enrollment continues.

(2) An individual is not required to pay withholdings for the period between the end of the pay period in which he or she separates from service and the commencing date of an immediate annuity, if later.

(3) Temporary employees who are eligible to enroll under 5 U.S.C. 8906a must pay the full subscription charges including both the employee share and the Government contribution. Employees with provisional appointments under §316.403 are not considered eligible for coverage under 5 U.S.C. 8906a for the purpose of this paragraph (a)(3).

(4) The employing office must determine the withholding for employees whose annual pay is paid during a period shorter than 52 workweeks on an annual basis and prorate the withholding over the number of installments of pay regularly paid during the year.

(5) The employing office must make the withholding required from enrolled survivor annuitants in the following order. First, withhold from the annuity of a surviving spouse, if any. If that annuity is less than the withholding required, the employing office must make the withholding to the extent necessary from the annuity of the children, if any, in the following order. First, withhold from the annuity of the youngest child, and if necessary, then from the annuity of the next older child, in succession, until the withholding is satisfied.

(6) Surviving spouses in receipt of a basic employee death benefit under 5 U.S.C. 8442(b)(1)(A) and annuitants whose health benefits premiums exceed the amount of their annuities may pay their portion of the health benefits premium directly to the retirement system acting as their employing office in accordance with procedures set out in paragraph (d) of this section.

(b) *Procedures when employee enters LWOP status or pay is insufficient to cover premium.* As soon as the employing office is aware of an employee whose premium payments cannot be made because the employee will be entering or has entered leave without pay status, (or any other type of nonpay status, except periods of nonpay resulting from a lapse of appropriations), or the employee's pay is insufficient to cover the premiums, the employing office must inform the employee of the available health benefits options.

(1) The employing office must provide the employee written notice of the options and consequences as described in paragraphs (b)(2) (i) and (ii) of this section. If the employing office cannot give the notice required by this paragraph (b)(1) to the employee directly, it must send the notice by first class mail. A notice that is mailed is deemed to be received 5 days after the date of the notice.

(2) The employee must elect in writing either to continue health benefits coverage or terminate it. The employee may continue his or her health benefits coverage by choosing one of the options listed in this paragraph (b)(2) and returning the signed form to the employing office within 31 days from the day he or she receives the notice (45 days for an employee residing overseas). When an employee mails the signed form, the date of the postmark is deemed to be the date the notice is returned to the employing office. If an employee elects to continue coverage, he or she must elect in writing either to—

(i) Agree to pay the premium directly to the agency on a current basis. The employee must agree that if he or she

does not pay the premiums, upon returning to employment or upon pay becoming sufficient to cover the premiums, the employing office will deduct, in addition to the current pay period's premiums, an amount equal to the premiums for a pay period during which the employee was in LWOP status. The employing office will continue using this method to deduct the accrued unpaid premiums from salary until the debt is recovered in full. The employee must also agree that if he or she does not return to work or the employing office cannot recover the debt in full from salary, the employing office may recover the debt from whatever other sources it normally has available for recovery of a debt to the United States, or

(ii) Agree upon returning to employment or upon pay becoming sufficient to cover the premiums, the employing office will deduct, in addition to the current pay period's premiums, an amount equal to the premiums for a pay period during which the employee was in LWOP status. The employing office will continue using this method to deduct the accrued unpaid premiums from salary until the debt is recovered in full. The employee must also agree that if he or she does not return to work or the employing office cannot recover the debt in full from salary, the employing office may recover the debt from whatever other sources it normally has available for recovery of a debt to the United States.

(3) Except as provided under paragraph (b)(4) of this section, if the employee does not return the signed form within 31 days after the day he or she receives the notice (45 days for employees residing overseas) the employing office terminates the enrollment according to paragraph (b)(5) of this section. The employing office must give the employee written notification of the termination.

(4) If the employee is prevented by circumstances beyond his or her control from returning a signed form to the employing office within the time frame under paragraph (b)(2) of this section, he or she may request reinstatement of coverage by writing to the employing office. The employee must describe the circumstances that prevented timely notice and file the request within 30 calendar days from the date the employing office gives the employee notification of the termination. The employing office determines if the employee is eligible for reinstatement of coverage. If the determination is affirmative, the employing office reinstates the coverage of the employee retroactive to the date of termination. If the determination is negative, the employee may request a review of the decision from the employing agency as provided under § 890.104.

(5) Terminations of enrollment under paragraphs (b)(2) and (3) of this section are retroactive to the end of the last pay period in which the premium was withheld from pay. The employee and covered family members, if any, are entitled to the temporary extension of coverage for conversion and may convert to an individual contract for health benefits. An employee whose coverage is terminated may enroll upon his or her return to duty in a pay status in a position in which the employee is eligible for coverage under this part.

(c) *Procedures when an agency underwithholds.* (1) An agency that withholds less than the proper health benefits contributions from an individual's pay, annuity, or compensation must submit an amount equal to the sum of the uncollected contributions and any applicable agency contributions required under section 8906 of title 5, United States Code, to OPM for deposit in the Employees Health Benefits Fund.

(2) The agency must make the deposit to OPM described in paragraph (c)(1) of this section as soon as possible, but no later than 60 calendar days after the date the employing office determines the amount of the underdeduction that has occurred, regardless of whether or when the agency recovers the underdeduction. A subsequent agency determination whether to waive collection of the overpayment of pay caused by failure to properly withhold employee health benefits contributions shall be made in accordance with 5 U.S.C. 5584 as implemented by 4 CFR chapter I, subchapter G, unless the agency involved is excluded from application of 5 U.S.C. 5584, in which

case any applicable authority to waive the collection may be used.

(d) *Direct premium payments for annuitants.* (1) If an annuity, excluding an annuity under Subchapter III of Chapter 84 (Thrift Savings Plan), is too low to cover the health benefits premium due or if a surviving spouse receives a basic employee death benefit, the retirement system must provide information to the annuitant or surviving spouse regarding the available plans and notify him or her in writing of the opportunity to either: enroll in any plan in which the enrollee's share of the premium is not in excess of the annuity; or make payment of the premium directly to the retirement system.

(2) The retirement system must establish a method for accepting direct payment for health benefits premiums from surviving spouses who have received or are currently receiving basic employee death benefits as well as from annuitants whose annuities are too low to cover their health premiums. The annuitant or surviving spouse must continue to make direct payment of the health benefits premium even if the annuity increases to the extent that it covers the premium.

(3) The annuitant or surviving spouse must pay to the retirement system his or her share of the premium for the enrollment for every pay period during which the enrollment continues, exclusive of the 31-day temporary extension of coverage for conversion provided in § 890.401. The annuitant or surviving spouse must pay after each pay period in which he or she is covered in accordance with a schedule established by the retirement system. If the retirement system does not receive payment by the date due, the retirement system must notify the annuitant or surviving spouse in writing that continuation of coverage depends upon payment being made within 15 days (45 days for annuitants or surviving spouses residing overseas) after receipt of the notice. If no subsequent payments are made, the retirement system terminates the enrollment 60 days (90 days for annuitants or surviving spouses residing overseas) after the date of the notice. An annuitant or surviving spouse whose enrollment terminates because of nonpayment of premium may not reenroll or reinstate coverage, except as provided in paragraph (d)(4) of this section.

(4) If the annuitant or surviving spouse is prevented by circumstances beyond his or her control from paying within 15 days after receipt of the notice, he or she may request reinstatement of coverage by writing to the retirement system. The annuitant or surviving spouse must describe the circumstances that prevented timely notice and file the request within 30 calendar days from the date of termination. The retirement system determines whether the surviving spouse or annuitant is eligible for reinstatement of coverage. If the determination is affirmative, the retirement system reinstates the coverage of the surviving spouse or annuitant retroactive to the date of termination. If the determination is negative, the surviving spouse or annuitant may request a review of the decision from the retirement system as provided under § 890.104.

(5) Termination of enrollment for failure to pay premiums within the time frame established in accordance with paragraph (d)(3) of this section is retroactive to the end of the last pay period for which payment has been timely received.

(6) The retirement system will submit all direct premium payments along with its regular health benefits premiums to OPM in accordance with procedures established by that office.

(e) *Direct payment of premiums during periods of LWOP status in excess of 365 days.*

(1) An employee who is granted leave without pay under subpart L of part 630 of this chapter which exceeds the 365 of continued coverage under section 890.303(e) must pay the employee contributions directly to the employing office on a current basis.

(2) Payment must be made after the pay period in which the employee is covered in accordance with a schedule established by the employing office. If the employing office does not receive the payment by the date due, the employing office must notify the employee in writing that continuation of coverage depends upon payment being

made within 15 days (45 days for employees residing overseas) after receipt of the notice. If no subsequent payments are made, the employing office terminates the enrollment 60 days (90 days for enrollees residing overseas) after the date of the notice.

(3) If the enrollee was prevented by circumstances beyond his or her control from making payment within the timeframe specified in paragraph (e)(2) of this section he or she may request reinstatement of the coverage by writing to the employing office. The employee must file the request within 30 calendar days from the date of termination and must include supporting documentation.

(4) The employing office determines whether the employee is eligible for reinstatement of coverage. If the determination is affirmative, the employing office reinstates the coverage of the employee retroactive to the date of termination. If the determination is negative, the employee may request a review of the decision from the employing agency as provided under § 890.104.

(5) An employee whose coverage is terminated under paragraph (e)(2) of this section may register to enroll upon his or her return to duty in a pay status in a position in which the employee is eligible for coverage under this part.

(f) *Uniformed services.* (1) except as provided in paragraph (g)(2) of this section, an employee whose coverage continues under section 890.303(i) is responsible for payment of the employee share of the cost of enrollment for every pay period for which the enrollment continues for the first 365 days of continued coverage as set forth under paragraph (b) of this section. For coverage that continues after 365 days in nonpay status, the employee must pay, on a current basis, the full subscription charge, including both the employee and Government shares, plus an additional 2 percent of the full subscription charge.

(2) Payment of the employee's share of the cost of enrollment is waived for the first 365 days of continued coverage in the case of an employee whose coverage continues under § 890.303(e) following furlough or placement on leave of absence under the provisions of part 353 of this chapter or under § 890.303(i) if the employee was ordered to active duty before September 1, 1995 under section 672, 673b, 674, 675, or 688 of title 10, United States Code, in support of Operation Desert Storm.

[33 FR 12510, Sept. 4, 1968, as amended at 47 FR 30963, July 16, 1982; 49 FR 1047, Jan. 9, 1984; 52 FR 3399, Feb. 4, 1987; 52 FR 39497, Oct. 22, 1987, and 53 FR 32368, Aug. 25, 1988; 54 FR 7756, Feb. 23, 1989; 55 FR 39131, Sept. 25, 1990; 56 FR 10143, Mar. 11, 1991; 56 FR 25997, June 6, 1991; 57 FR 10611, Mar. 27, 1992; 58 FR 39607, July 23, 1993; 60 FR 45658, Sept. 1, 1995; 61 FR 37808, July 22, 1996; 61 FR 64454, Dec. 5, 1996]

EFFECTIVE DATE NOTE: At 61 FR 54454, Dec. 5, 1996, § 890.502 was amended by revising paragraph (e), effective Jan. 6, 1997. For the convenience of the user, the superseded text is set forth as follows:

§ 890.502 Employee witholdings and contributions.

* * * * *

(e) *Direct payment of premiums during periods of LWOP status in excess of 365 days.* (1) An employee who is granted leave without pay under subpart L of part 630 of this chapter which exceeds the 365 days of continued coverage under § 890.303(e) must pay the employee contributions directly to the employing office on a current basis.

(2) Payment must be made after the pay period in which the employee is covered in accordance with a schedule established by the employing office. If the employing office does not receive the payment by the date due, the employing office must notify the employee in writing that continuation of coverage depends upon payment being made within 15 days (45 days for employees residing overseas) after receipt of the notice. If no subsequent payments are made, the employing office terminates the enrollment 60 days (90 days for enrollees residing overseas) after the date of the notice.

(3) If the employee was prevented by circumstances beyond his or her control from making payment within the time frame specified in paragraph (e)(2) of this section, he or she may request reinstatement of the coverage by writing to the employing office. The employee must describe the circumstances that prevented timely notice and file the request within 30 calendar days from the date of termination.

(4) The employing office determines whether the employee is eligible for reinstatement of coverage. If the determination is affirmative, the employing office reinstates the coverage of the employee retroactive to the date

of termination. If the determination is negative, the employee may request a review of the decision from the employing agency as provided under § 890.104.

(5) An employee whose coverage is terminated under paragraph (e)(2) of this section may enroll upon his or her return to duty in a pay status in a position in which the employee is eligible for coverage under this part.

* * * * *

§ 890.503 Reserves.

(a) The enrollment charge consists of the rate approved by OPM for payment to the plan for each enrollee, plus 4 percent, of which one part is for an administrative reserve and 3 parts are for a contingency reserve for the plan.

(b) The administrative reserve is credited with the one one-hundred-and-fourth of the enrollment charge set aside for the administrative reserve. The administrative reserve is available for payment of administrative expenses of OPM incurred under this part, and for such other purposes as may be authorized by law.

(c)(1) *Contingency reserve.* The contingency reserve for each plan is credited with—

(i) The three one-hundred-and-fourths of the enrollment charge set aside for the contingency reserve from the enrollment charges for employees and annuitants enrolled for that plan;

(ii) Amounts transferred in accordance with law from other contingency reserves and the administrative reserve;

(iii) Income from investment of the reserve;

(iv) Its proportionate share of the income from investment of the administrative reserve; and

(v) Any return of reserves of the plan.

(2) *Contingency reserve minimum balance.* The preferred minimum balance for the contingency reserve for community-rated plans is 1 month's subscription charges at the average recurring monthly rate paid from the Employees Health Benefits Fund for the plan during the most recent contract period. The preferred minimum balance for the contingency reserve for experience-rated plans is 1½ times an amount equal to the sum of an average month's paid claims plus an average month's administrative expenses and retentions, as determined under paragraph (c)(3) of this section. Amounts in excess of the preferred minimum balance for a contingency reserve account may be used with respect to the plan from which the reserve derives: To defray increases in future rates; to increase plan benefits, or to reduce contributions of eligible subscribers and the Government under the program through devices such as temporary suspension of, or reduction in, required contributions or a refund of contributions to eligible subscribers and the Government.

(3) *OPM/carrier reserve transfers.* The target level for total reserves of an experience-rated plan is 3½ times an amount equal to the sum of an average month's paid claims plus an average month's administrative expenses and retentions. Reserves include funds set aside for incurred-but-unpaid benefit claims and the ''special'' reserve representing the cumulative difference between income to the plan (subscription income plus interest on investments) and plan expenses (benefit costs plus administrative expenses and retentions). Included as carrier reserves is the balance in the letter of credit (LOC) account maintained by OPM for the plan. For the purposes of this section, an average month's paid claims is one-sixth of the total claims paid during the last 6 months of the most recent contract period, and an average month's administrative expenses and retentions is one-twelfth of the administrative expenses and retentions for the most recent contract period.

(i) When, as of the end of a contract period, the total of all the reserves for an experience-rated plan is less than the target level described in the first four sentences of paragraph (c)(3) of this section, the carrier is entitled to payment from the contingency reserve. Such contingency reserve payment shall equal the lesser of: An amount equal to the difference between the target level for the plan's reserves and the total of the reserves for the plan, or an amount equal to the excess, if any, of the contingency reserve over the preferred minimum balance. OMP must authorize this payment promptly after accepting the accounting statement for the contract period. The contingency

reserve payment so authorized will be made available to the carrier's LOC account.

(ii) When, as of the end of a contract period, the total of all reserves of an experience-rated plan amounts to more than the plan's target level, the excess over the plan's target level must be credited to the contingency reserve maintained by OPM for the plan. OPM will withdraw the excess amount from the plan's LOC account, based on reporting in the annual accounting statement for the year, no sooner than May 1, of the following year. If the accounting statement is not filed by the time limit specified in the plan's contract with OPM, OPM will estimate the amount of the excess reserves and may withdraw that amount from the plan's LOC account, or begin the process of offsetting that amount from subscription payments, no sooner than May 1. The amount withdrawn from the plan's LOC account, or offset from subscription payments, will be credited to that plan's contingency reserve.

(4) OPM may, by agreement with the carrier, approve community rating for a comprehensive plan. If the contingency reserve of the carrier of a community-rated plan exceeds the preferred minimum balance, as described in paragraph (c)(2) of this section, the carrier may request OPM to pay to the plan a portion of the reserve not greater than the excess of the contingency reserve over the preferred minimum balance. The carrier shall state the reason for the request. OPM will decide whether to allow the request in whole or in part and will advise the plan of its decision.

(5) *Special contingency reserve transfers.* In addition to those amounts, if any, paid under paragraphs (c)(2) through (c)(4) of this section, OPM may authorize such other payments from the contingency reserve as in the judgment of OPM may be in the best interest of employees and annuitants enrolled in the program. A carrier for a plan may apply to OPM at any time for a payment from the contingency reserve when the carrier has good cause, such as unexpected claims experience and variations from expected community rates. In the administration of this part, OPM will accord a high priority to deciding whether to allow requests under this paragraph in whole or in part and will promptly advise the carrier of its decision. Amounts paid from the contingency reserve under paragraphs (c)(2) through (5) of this section shall be reported as subscription income in the year in which paid. By agreement with the carrier and where good cause exists, OPM may accept payment from carrier reserves for credit to the contingency reserve in an amount and under conditions other than those specified in paragraph (c) of this section. For carriers funded by LOC, the returned amount will be withdrawn from the plan's LOC account.

[33 FR 12510, Sept. 4, 1968, as amended at 37 FR 20668, Oct. 3, 1972; 43 FR 52460, Nov. 13, 1978; 51 FR 7430, Mar. 4, 1985; 52 FR 3212, Feb. 3, 1987; 54 FR 52339, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 57 FR 14324, Apr. 20, 1992]

§ 890.504 Disposition of contingency reserves upon reorganization or merger of plans.

Upon reorganization or merger of a plan, OPM must credit to the surviving plan the reserves of the reorganized or merged plan. If more than one plan survives, the reserves must be divided among the surviving plans in proportion to the number of enrollees continuing to subscribe to the surviving plans.

[54 FR 52339, Dec. 21, 1989, and 55 FR 22891, June 5, 1990.]

§ 890.505 Recurring premium payments to carriers.

The procedures for payment of premiums, contingency reserve, and interest distribution to FEHB Program carriers shall be those contained in 48 CFR subpart 1632.170.

[57 FR 14324, Apr. 20, 1992]

Subpart F—Transfers From Retired Federal Employees Health Benefits Program

§ 890.601 Coverage.

An annuitant (a retired employee or survivor under part 891 of this chapter) who is enrolled, or is eligible to enroll, under the Retired Federal Employees Health Benefits Program (part 891 of this chapter) is eligible to enroll under

the Federal Employees Health Benefits Program under this part.

[39 FR 20055, June 6, 1974]

§ 890.602 Opportunity to change enrollment.

An annuitant eligible to enroll under § 890.601 may register on and after August 8, 1978.

[43 FR 35018, Aug. 8, 1978]

§ 890.603 Effective date.

The effective date of an enrollment under § 890.602 is the first day of the first pay period after the election is received by the retirement system, but not earlier than January 1, 1979.

[43 FR 35018, Aug. 8, 1978; 43 FR 38569, Aug. 29, 1978]

§ 890.604 [Reserved]

§ 890.605 Persons confined on effective date.

Benefits may not be limited for persons who, on the effective date of an enrollment under § 890.602, are confined in a hospital or institution.

[43 FR 35018, Aug. 8, 1978]

Subpart G—Benefits in Medically Underserved Areas

§ 890.701 Definitions.

For purposes of this subpart—

Health benefits plan means the Government-wide Service Benefit Plan, the Government-wide Indemnity Benefit Plan, or an employee organization plan, as described under 5 U.S.C. 8903(1), (2), and (3), respectively.

Medically underserved area includes any of the 50 States of the United States where the Office of Personnel Management determines that 25 percent or more of the residents are located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (42 U.S.C. 254e).

OPM makes its annual determination by comparing the latest Department of Health and Human Services state-by-state population counts on primary medical care manpower shortage areas with U.S. Census figures on state resident population. The determination will be made prior to the annual FEHB open season and will be for the next calendar year. OPM will announce the results of this determination before each open season in a public notice in the FEDERAL REGISTER.

[45 FR 48099, July 18, 1980, as amended at 45 FR 81728, Dec. 12, 1980; 47 FR 17465, Apr. 23, 1982; 48 FR 14563, Apr. 5, 1983; 51 FR 28800, Aug. 12, 1986; 52 FR 2666, Jan. 26, 1987; 53 FR 860, Jan. 14, 1988; 53 FR 28366, July 28, 1988; 53 FR 28997, Aug. 2, 1988; 59 FR 60297, Nov. 23, 1994]

§ 890.702 Payment to any licensed practitioner.

(a) Except as provided in paragraph (b) of this section, if a contract between the Office of Personnel Management and a group health insurance carrier offering a health benefits plan subject to this subpart provides for payment or reimbursement of the cost of health services for the care and treatment of a particular health condition only if such service is rendered by a certain category of practitioner, the plan must also provide benefits, up to the limits of it contract, for the same service when rendered and billed for by any other individual who is licensed under applicable State law to provide such service, if the service is provided to an enrollee of the plan in a medically underserved area as defined by this subpart.

(b) Paragraph (a) of this section applies only to health services provided under contracts which became effective after December 31, 1979.

[45 FR 48099, July 18, 1980, as amended at 52 FR 2666, Jan. 26, 1987]

Subpart H—Benefits for Former Spouses

SOURCE: 51 FR 15748, Apr. 28, 1986, unless otherwise noted.

§ 890.801 Introduction.

This subpart sets forth policies and procedures for obtaining health benefits coverage that are unique to former spouses of Federal employees and retirees.

§ 890.802 Definition.

In this subpart, a *Qualifying court order* means a court order acceptable

for processing as defined in § 838.103 of this chapter or qualifying court order as defined in § 838.1003 of this chapter.

[57 FR 33599, July 29, 1992]

§ 890.803 Who may enroll.

(a) Except as specified in paragraph (b) of this section, a former spouse is eligible to enroll in a health benefits plan under this part provided that—

(1) The former spouse whose marriage to an employee, employee annuitant, or a former Central Intelligence Agency (CIA) or Foreign Service employee is dissolved has not remarried before age 55; and

(2) The former spouse was enrolled in a health benefits plan under this part as a family member at any time during the 18 months preceding the date of the dissolution of marriage; and

(3)(i) The former spouse currently receives, or has future title to receive (A) a portion of annuity payable to the employee upon retirement based on a qualifying court order for purposes of 5 U.S.C. 8345(j) or 5 U.S.C. 8467; (B) survivor annuity benefits based on a qualifying court order for purposes of 5 U.S.C. 8341(h) or 5 U.S.C. 8445; or (C) a survivor annuity elected by the employee under 5 U.S.C. 8339(j)(3) or 5 U.S.C. 8417(b), including a former spouse who is designated as an insurable interest pursuant to 5 CFR 831.606(a) and (b) and 842.605(a) and (b) (or benefits similar to those under this paragraph under another retirement system for Government employees); *or*

(ii) The former spouse was married to an employee who retired before May 7, 1985, and (A) the employee annuitant elects to provide a survivor annuity to the former spouse under procedures prescribed in § 831.682 of this title; or (B) the former spouse satisfies all of the conditions for a survivor annuity in § 831.683 of this title; *or*

(iii) The former spouse was married to an employee who died before May 7, 1985, and the employee was eligible for an immediate annuity on or before the date of death, *and* the former spouse satisfies all of the conditions for a survivor annuity in § 831.683 of this title, or

(iv) The former spouse was married to an employee or former employee of the Central Intelligence Agency (CIA) for at least 10 years during the employee's CIA service, at least 5 years of which both the employee and the former spouse spent outside the United States, and the marriage was dissolved before May 7, 1985; *or*,

(v) The former spouse was married to an employee or former employee of the Foreign Service for at least 10 years during the employee's government service, and the marriage was dissolved before May 7, 1985.

(b) Except as contained in paragraphs (a)(3) (iv) and (v) of this section, a former spouse of an employee who separates from Federal service before becoming eligible for immediate annuity is eligible to enroll only if the former spouse's marriage to the employee was dissolved before the employee left Federal service.

(c) If a former spouse cannot apply for benefits on his or her own behalf because of a mental or physical disability, application may be filed by a court-appointed guardian.

[51 FR 15748, Apr. 28, 1986, as amended at 52 FR 39497, Oct. 22, 1987, and 53 FR 32368, Aug. 25, 1988; 53 FR 45070, Nov. 8, 1988; 57 FR 21192, May 19, 1992; 58 FR 52882, Oct. 13, 1993]

§ 890.804 Coverage.

(a) *Type of enrollment.* A former spouse who meets the requirements of § 890.803 may elect coverage for self alone or for self and family. A family enrollment covers only the former spouse and any unmarried dependent natural or adopted child of both the former spouse and the employee, former employee or employee annuitant, provided such child is not otherwise covered by a health plan under this part. An unmarried dependent child must be under age 22 or incapable of self-support because of a mental or physical disability existing before age 22. No person may be covered by two enrollments.

(b) *Proof of dependency.* (1) A child is considered to be dependent on the former spouse or the employee, former employee, or employee annuitant if he or she is—

(i) A legitimate child;

(ii) An adopted child;

(iii) A recognized natural child who lives with the former spouse or the employee, former employee, or employee

annuitant in a regular parent-child relationship.

(iv) A recognized natural child for whom a judicial determination of support has been obtained; or

(v) A recognized natural child to whose support the former spouse, or the employee, former employee, or employee annuitant makes regular and substantial contributions in accordance with § 890.302(b)(2).

(c) *Exclusions from coverage.* Coverage as a family member may be denied—

(1) If evidence shows that the former spouse, employee, former employee, or annuitant did not recognize the child as his or her own, despite a willingness to support the child; or

(2) If evidence calls the child's paternity or maternity into doubt, despite the former spouse's employee's, former employee's, or employee annuitant's recognition and support of the child.

(d) *Child incapable of self-support.* When a former spouse enrolls for a family enrollment which includes a child who has become 22 years of age and is incapable of self-support, the employing office shall determine such child's eligibility in accordance with § 890.302(d), (e), and (f).

(e) *Meaning of unmarried child.* A child, under age 22 or incapable of self-support, who has never married or whose marriage has been annulled, or a child who is divorced or widowed is considered to be unmarried.

§ 890.805 Application time limitations.

(a) Except for former spouses meeting the requirements in § 890.803(a)(3)(iv) and (v) of this part, former spouses must apply for health benefits coverage—

(1) Within 60 days after dissolution of the marriage to the Federal employee; or

(2) Within 60 days after the date of OPM's notice of eligibility to enroll based on entitlement to one of the following:

(i) A former spouse annuity elected under 5 U.S.C. 8339(j)(3), 5 U.S.C. 8417(b), or 5 CFR 831.682;

(ii) A former spouse annuity under § 831.683;

(iii) A former spouse insurable interest annuity under 5 U.S.C. 8339(k)(1) or 8420(a);

(iv) A former spouse annuity under 5 U.S.C. 8341(h) or 8445(f);

(v) An appointment under 5 U.S.C. 8345(j) or 8467; or

(3) Within 60 days after the date of the notice of eligibility to enroll based on entitlement to a former spouse annuity under another retirement system for Government employees.

(b) Former spouses who meet the requirements in § 890.803(a)(3)(iv) of this part must apply for health benefits coverage by April 1, 1987. Where circumstances warrant, the former spouse may request that the filing date be waived. The authority of the Director of Central Intelligence to direct OPM to waive the filing date has been delegated to CIA's Office of Personnel. Requests for waiver should be addressed to the Office of Personnel, Retirement Division, Central Intelligence Agency, Washington, DC 20505. OPM will waive the April 1, 1987, filing date upon notification to do so from the Director of Central Intelligence.

(c) Former spouses who meet the requirements in § 890.803(a)(3)(v) of this part must apply for health benefits coverage by October 7, 1988. Where circumstances warrant, the former spouse may request the Secretary of State to waive the filing date. The authority of the Secretary of State to waive the filing date has been delegated to the Department of State's Retirement Division. Requests for waiver should be addressed to the Department of State, Retirement Division, Washington, DC 20520. OPM will accept the waiver upon notification to do so from the Department of State.

[51 FR 15748, Apr. 28, 1986, as amended at 53 FR 45071, Nov. 8, 1988; 57 FR 21192, May 19, 1992; 58 FR 52882, Oct. 13, 1993]

§ 890.806 Effective dates of coverage

(a) *Generally.* The effective date of enrollment or change of enrollment is the first day of the first pay period after the date the employing office receives the properly completed Standard Form 2809 or an appropriate substitute (i.e., a signed statement with sufficient information to execute enrollment) and satisfactory proof of eligibility.

(b) *Reenrollment.* The effective date of a reenrollment under § 890.301(g)(6) is,

for an involuntary disenrollment from a prepaid health plan under sections 1833 or 1876 of the Social Security Act, the date shown on the documentation from the plan. For a voluntary disenrollment, the effective date of reenrollment is the first day of the first pay period which begins in January of the next following year.

(c) *Change required because of insufficient annuity.* When a former spouse changes to a lower cost enrollment as provided by § 890.301(q), the change is effective immediately upon loss of coverage under the prior enrollment.

[51 FR 15748, Apr. 28, 1986, as amended at 52 FR 39497, Oct. 22, 1987; 53 FR 32368, Aug. 25, 1988; 56 FR 25997, June 6, 1991; 57 FR 21192, May 19, 1992; 57 FR 48162, Oct. 22, 1992]

§ 890.807 Termination of enrollment.

(a)(1) Except for former spouses meeting the requirements in § 890.803(a)(3) (iv) and (v) of this part, a former spouse's enrollment terminates, subject to the temporary extension of coverage for conversion, at midnight of the last day of the pay period in which the earliest of the following events occurs:

(i) Court order ceases to provide entitlement to survivor annuity or portion of retirement annuity under a retirement system for Government employees.

(ii) Former spouse remarries before age 55.

(iii) Former spouse dies.

(iv) Employee or annuitant on whose service the benefits are based dies and no survivor annuity is payable.

(v) Separated employee on whose service the benefits are based dies before the requirements for deferred annuity have been met.

(vi) Employee on whose service benefits are based leaves Federal service before establishing title to an immediate annuity or a deferred annuity.

(vii) Refund of retirement money is paid to the separated employee on whose service the health benefits are based.

(2) OPM may authorize a longer time frame for the temporary extension of coverage for conversion than the 31 days provided in § 890.401(a) if in OPM's judgment the former spouse could not have known that (1) the employee on whose service benefits are based left Federal service before establishing title to an immediate or deferred annuity; or (2) the separated employee on whose service the benefits are based died before the requirements for deferred annuity had been met. In such cases, the right of conversion may be exercised up to 31 days after the employing office's notice of termination. The former spouse must pay the full premium (employee's and Government's share) during the extended period, exclusive of the 31–day period following the notice.

(3) Termination of enrollment for failure to pay premiums within the time frame established in accordance with § 890.808(d)(1) is retroactive to the end of the last pay period for which payment has been timely received.

(4) A former spouse whose enrollment is terminated under this paragraph may not reenroll.

(b) The enrollment of a former spouse who meets the requirements in § 890.803(a)(3) (iv) or (v) of this part terminates, subject to the temporary extension of coverage for conversion, at midnight of the last day of the pay period in which the earliest of the following events occurs:

(1) Former spouse remarries before age 55.

(2) Former spouse dies.

(c) *Failure to make an election under § 890.808(e).* (1) If the annuity of a former spouse is insufficient to pay the full health benefits premium due for the plan in which the former spouse is enrolled, the former spouse may elect one of the two opportunities offered under § 890.808(e) of this part (electing a plan with a full premium not in excess of the annuity; or, paying premiums directly to the retirement system in accordance with § 890.808(d) of this part). The retirement system will send two notices to the former spouse, including one by certified mail return receipt requested. Continuation of coverage rests upon electing direct payment or new coverage within 15 days (45 days for former spouses residing overseas) after receipt of the final notice. Except as provided in paragraph (c)(3) of this section, the enrollment of an individual who fails to make an election within

the specified time frame will be terminated. A former spouse whose enrollment is terminated because of failure to make an election may not reenroll or reinstate coverage, except as provided in paragraph (c)(2) of this section. Each former spouse whose enrollment is so terminated is entitled to a 31-day extension of coverage for conversion.

(2) If the individual was prevented by circumstances beyond his or her control from making an election within the time limit after receipt of the final notice, he or she may request reinstatement of coverage by writing to the retirement system. The retirement system will determine if the individual is eligible for reinstatement of coverage; and, when the determination is affirmative, the individual's coverage may be reinstated retroactively to the date of termination or prospectively. If the determination is negative, the individual may request reconsideration of the decision from OPM.

(3) If the former spouse does not make an election under paragraph (c)(1) of this section and is enrolled in the high option of a plan that has two options, the former spouse is deemed to have elected enrollment in the standard option of the same plan unless the annuity is insufficent to pay the full withholdings for the standard option.

(d) *Coverage of members of the family.* The coverage of a member of the family of a former spouse terminates, subject to the temporary extension of coverage for conversion, at midnight of the earlier of the following dates:

(1) The day on which the individual ceases to be an eligible family member.

(2) The day the former spouse ceases to be enrolled, unless the family member is entitled as a survivor annuitant to contined enrollment or is entitled to continued coverage under the enrollment of another.

(e) *Cancellation.* A former spouse may cancel enrollment at any time by filing with the employing office a properly completed health benefits form. If a former spouse cancels enrollment, the cancellation becames effective on the last day of the pay period after the pay period in which the health benefits form cancelling the enrollment is received by the employing office. If a former spouse submits documentation that the cancellation is for the purpose of enrolling in a prepaid health plan under sections 1833 or 1876 of the Social Security Act, the cancellation becomes effective on the day before the coverage under the prepaid health plan takes effect. Such documentation must be submitted to the employing office within the period beginning 31 days before and ending 31 days after the prepaid health plan enrollment takes effect. The former spouse and family members, if any, are not entitled to the temporary extension of coverage for conversion or to convert to an individual contract for health benefits. Except for former spouses who provide documentation that they are canceling for the purpose of enrolling in a prepaid health plan under sections 1833 or 1876 of the Social Security Act, a former spouse who cancels his or her enrollment may not later reenroll. The former spouse and family members, if any, are not entitled to the temporary extension of coverage for conversion or to convert to an individual contract for health benefits. A former spouse who cancels his or her enrollment may not later reenroll.

[51 FR 15748, Apr. 28, 1986, as amended at 52 FR 39497, Oct. 22, 1987, and 53 FR 32368, Aug. 25, 1988; 53 FR 45071, Nov. 8, 1988; 56 FR 25997, June 6, 1991; 57 FR 48162, Oct. 22, 1992]

§ 890.808 Employing office responsibilities.

(a) *Application for benefits.* The former spouse's application for health benefits may be in the form of a Standard Form 2809, letter, or written statement to the employing office. Former spouses applying for benefits under § 890.803(a)(3)(iv) of this part must also include with their application a request for waiver of the application time limitation in accordance with § 890.805(b) of this part. Former spouses applying for benefits under § 890.803(a)(3)(v) of this part must also include with their application a request for waiver of the application time limitation in accordance with § 890.805(c) of this part.

(b) *Administration of the enrollment process.* (1) The employing office will set up a method for accepting applications for enrollment informing the

former spouse what documents to submit and where to submit them for an eligibility determination, and collecting premium payments. The method will include procedures for verifying the eligibility requirements under § 890.803(a) (1) and (2) of this part. The employing office must obtain OPM, Foreign Service Retirement and Disability System (FSRDS), or CIA Retirement and Disability System (CIARDS) documentation that the former spouse meets the additional requirement under § 890.803(a)(3) (i), (ii), (iii), (iv), or (v) of this part. A request for the retirement system's determination whether a court order is a qualifying court order for health benefits enrollment under this subpart must be accompanied by the documentation specified in § 838.221, § 838.721, or § 838.1005 of this chapter.

(2) The employing office will send the former spouse notice, in writing, of its decision. When an employing office informs a former spouse of his or her eligibility to enroll, it will identify the documents on which it based its decision and will include a premium payment schedule and statement of the requirements for continued enrollment under § 890.803. If the former spouse does not qualify for health benefits coverage, the employing office must give the former spouse a reconsideration right under § 890.104. Reconsideration requests from former spouses applying for benefits under § 890.803(a)(3)(iv) of this part must be directed to the Office of Personnel, Retirement Division, Central Intelligence Agency, Washington, DC 20505. Reconsideration requests from former spouses applying for benefits under § 890.803(a)(3)(v) of this part must be directed to the Department of State, Retirement Division, Washington, DC 20520.

(3) The agency employing office will maintain a health benefits file for the former spouse as a file separate from the personnel records of the employee or former employee. The retirement system acting as employing office for the former spouse may file the former spouse health benefits records in with the annuitant's retirement records.

(4) The former spouse will be required to certify that he or she meets the requirements listed in § 890.803 and that he or she will notify the employing office within 31 days of an event that results in failure to meet one or more of the requirements.

(c) *Qualifying court order.* Subject to a 31-day extension period for conversion, the duration of health benefits coverage will coincide with any period specified in the qualifying court order providing for an annuity. A court order not meeting the requirements under part 838 of this chapter will not be used to establish or continue entitlement to a former spouse's health benefits coverage.

(d) *Premium payments.* (1) The former spouse must remit to the employing office the full subscription charge for the enrollment for every pay period during which the enrollment continues, exclusive of the 31-day temporary extension of coverage for conversion provided in §§ 890.401 and 890.807(a)(2). Payment must be made after the pay period in which the former spouse is covered in accordance with a schedule established by the employing office (see definition of *pay period* under § 890.101(a)). If the employing office does not receive payment by the due date the employing office must notify the former spouse in writing that continuation of coverage depends upon payment being made within 15 days (45 days for enrollees residing overseas) after receipt of the notice. If no subsequent payments are made, the employing office terminates the enrollment 60 days (90 days for enrollees residing overseas) after the date of the notice. Termination for nonpayment of premium is considered a voluntary cancellation under § 890.807(d). A former spouse whose enrollment is terminated because of nonpayment of premium may not reenroll or reinstate coverage except as provided in paragraph (d)(2) of this section.

(2) If the individual was prevented by circumstances beyond his or her control from making payment within 15 days after receipt of the notice, he or she may request reinstatement of coverage by writing to the employing office. Such a request must be filed within 30 calendar days from the date of termination and must be accompanied by verification that the individual was prevented by circumstances beyond his

or her control from paying within the time limit. The employing office will determine if the individual is eligible for reinstatement of coverage; and, when the determination is affirmative, the individual's coverage may be reinstated retroactively to the date of termination. If the determination is negative, the individual may request a review of the decision from the employing agency as provided under § 890.104.

(3) The employing office will submit all premium payments collected from former spouses along with its regular health benefits payments to OPM in accordance with procedures established by that Office.

(e) *Withholding from annuity.* The retirement system acting as employing office for a former spouse will establish a method for withholding the full subscription charge from the former spouse's annuity check. When the annuity is insufficient to cover the full amount of health benefits premium due, the retirement system will provide information to the former spouse regarding the available plans and notify him or her in writing of the opportunity to either: register to be enrolled in any plan with a full premium not in excess of the annuity; or make payment of the premium directly to the retirement system in accordance with § 890.808(d). If the former spouse is enrolled in the high option of a plan that has two options, and does not elect a plan at a cost to him or her not in excess of the annuity or does not elect to pay premiums directly, he or she is deemed to have elected enrollment in the standard option of the same plan unless the annuity is insufficient to pay the full withholdings for the standard option.

[51 FR 15748, Apr. 28, 1986, as amended at 52 FR 2506, Jan. 23, 1987; 52 FR 39497, Oct. 22, 1987, and 53 FR 32368, Aug. 25, 1988; 53 FR 45071, Nov. 8, 1988; 56 FR 25997, June 6, 1991; 57 FR 21192, May 19, 1992; 57 FR 33598–33599, July 29, 1992; 59 FR 60297, Nov. 23, 1994; 59 FR 67607, Dec. 30, 1994; 61 FR 37810, July 22, 1996]

Subpart I—Limit on Inpatient Hospital Charges, Physician Charges, and FEHB Benefit Payments

SOURCE: 57 FR 10610, Mar. 27, 1992, unless otherwise noted.

§ 890.901 Purpose.

This subpart identifies the individuals whose charges and FEHB benefit payments for inpatient hospital services and/or physician services may be limited and sets forth the circumstances of the limit.

[60 FR 26668, May 18, 1995]

§ 890.902 Definition.

For purposes of this subpart, *Retired enrolled individual* means an individual who:

(a)(1) Is covered by a Federal Employees Health Benefits plan (including individuals covered under 5 U.S.C. 8905a) described by 5 U.S.C. 8903(1), (2) and (3), or 5 U.S.C. 8903a and is:

(i) An annuitant as defined in 5 U.S.C. 8901(3); or

(ii) A former spouse as defined in 5 U.S.C. 8901(10) or enrolled for continued coverage under 5 U.S.C. 8905a(f); or

(2) Is a family member covered by the family enrollment of an annuitant or former spouse as defined in 5 U.S.C. 8901, or a former spouse enrolled for continued coverage under 5 U.S.C. 8905a(f); and

(b) Is not employed in a position which confers FEHB coverage; and

(c) Is age 65 or older or becomes age 65 while receiving inpatient hospital services or physician services; and

(d) Is not covered by Medicare part A and/or part B.

[57 FR 10610, Mar. 27, 1992, as amended at 60 FR 26668, May 18, 1995]

§ 890.903 Covered services.

(a) The limitation on the charges and FEHB benefit payments for inpatient hospital services apply to inpatient hospital services which are:

(1) Covered under both Medicare part A and the retired enrolled individual's FEHB plan; and

(2) Supplied to a retired enrolled individual who does not have Medicare part A; and

(3) Provided by hospital providers who have in force participation agreements with the Secretary of Health and Human Services (HHS) consistent with sections 1814(a) and 1866 of the Social Security Act, and receive Medicare part A payments in accordance with the diagnosis related group (DRG) based prospective payment system (PPS).

(b) The limitation on the charges and FEHB benefit payments for physician services apply to physician services, (as defined in section 1848(j) of the Social Security Act), which are:

(1) Covered under both Medicare part B and the retired enrolled individual's FEHB plan; and

(2) Supplied to a retired enrolled individual who does not have Medicare part B.

[60 FR 26668, May 18, 1995]

§ 890.904 Determination of FEHB benefit payment.

(a) The FEHB plan's benefit payment for inpatient hospital services under this subpart is the amount calculated by the FEHB plan, using information and instructions provided by the Department of Health and Human Services (HHS) and guidelines specified by OPM, as equivalent to the Medicare Part A payment under the DRG-based PPS (this is, the amount payable before the Medicare deductible, coinsurance and lifetime limits are applied), reduced by any FEHB plan deductible, coinsurance, copayment, or preadmission certification penalty that is the responsibility of the retired enrolled individual.

(b) The FEHB plan's benefit payment for physician services under this subpart is determined by taking the lower of the following amounts:

(1) The amount determined by the FEHB plan, which is equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule for Medicare participating physicians and the Medicare Nonparticipating Physician Fee Schedule for Medicare nonparticipating physicians (the amount payable before the Medicare deductible and coinsurance are applied); or

(2) The actual billed charges; and

(3) Reducing the lower amount by any FEHB plan deductible, coinsurance, or copayment that is the responsibility of the retired enrolled individual.

[58 FR 38663, July 20, 1993, as amended at 60 FR 26668, May 18, 1995]

§ 890.905 Limits on inpatient hospital and physician charges.

(a) Hospitals may not collect from FEHB plans and retired enrolled individuals for inpatient hospital services more than the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) Medicare participating providers may not collect from FEHB plans and retired enrolled individuals for physician services more than the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule.

(c) Medicare nonparticipating providers may not collect from FEHB plans and retired enrolled individuals for physician services more than the amount determined to be equivalent to the Medicare limiting charge amount.

[60 FR 26668, May 18, 1995; 60 FR 28019, May 26, 1995]

§ 890.906 Retired enrolled individuals coinsurance payments.

(a) A retired enrolled individual's coinsurance responsibility for inpatient hospital services is calculated in accordance with the plan's contractual benefit structure and is based on the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) A retired enrolled individual's coinsurance responsibility for physician services is calculated in accordance with the plan's contractual benefit structure and is based on the lower of the actual charges or the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule for Medicare participating

physicians and the Medicare Nonparticipating Physician Fee Schedule for Medicare nonparticipating physicians.

[60 FR 26668, May 18, 1995]

§ 890.907 Effective dates.

(a) The limitation specified in this subpart applies to inpatient hospital admissions commencing on or after January 1, 1992.

(b) The limitation specified in this subpart applies to physician services supplied on or after January 1, 1995.

[60 FR 26668, May 18, 1995]

§ 890.908 Notification of HHS.

An FEHB plan, under the oversight of OPM, will notify the Secretary of HHS, or the Secretary's designee, if the plan finds that:

(a) A hospital knowingly and willfully collects, on a repeated basis, more than the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) A Medicare participating physician or supplier knowingly and willfully collects, on a repeated basis, more than the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule.

(c) A Medicare nonparticipating physician or supplier knowingly and willfully charges, on a repeated basis, more than the amount determined to be equivalent to the Medicare limiting charge amount.

[60 FR 26668, May 18, 1995]

§ 890.909 End-of-year settlements.

Neither OPM, nor the FEHB plans, will perform end-of-year settlements with, or make retroactive adjustments as a result of retroactive changes in the Medicare payment calculation information to, hospital providers who have received FEHB benefit payments under this subpart.

[57 FR 10610, Mar. 27, 1992. Redesignated at 60 FR 26668, May 18, 1995]

§ 890.910 Provider information.

The hospital provider information used to calculate the amount equivalent to the Medicare part A payment will be updated on an annual basis.

[57 FR 10610, Mar. 27, 1992. Redesignated at 60 FR 26668, May 18, 1995]

Subpart J—Debarments, Civil Monetary Penalties and Assessments Imposed Against Providers

SOURCE: 54 FR 43940, Oct. 30, 1989, unless otherwise noted.

§ 890.1001 [Reserved]

§ 890.1002 Definitions.

(a) For the purposes of this subpart, the terms *convicted* and *provider* have the meanings set forth in section 8902a of title 5, United States Code.

(b) *Debarment* means that services or supplies furnished by a specific provider will no longer be reimbursed by the various carriers or health plans under title 5, United States Code, or this part.

(c) *Sanction* means any of the three penalties provided by section 8902a of title 5, United States Code, for the offenses cited therein. The three penalties are debarment, civil monetary penalties of not more than $10,000 for any item or service involved, and assessments of not more than twice the amount claimed for each such item or service.

§ 890.1003 Standards for OPM determinations of excessive charges, overprescribing, and services or supplies of a poor quality in connection with claims presented under this chapter.

(a) *Basis for sanctions.* Section 8902a(c) of title 5, United States Code, provides OPM the authority to impose sanctions against health care providers for cited offenses against the FEHB Program.

(b) *Standards.* (1) In making a determination that a provider has charged for health care services or supplies in an amount substantially in excess of such provider's customary charges for such services or supplies, OPM may rely, in part, upon a statistical sampling of previous claims and requests for payment filed by that provider and obtained either from FEHB carrier

files, other Government programs, private sector insurance sources or from the provider's own records. OPM shall take into consideration whether such charges deemed to be excessive are justified by unusual circumstances or medical complications requiring additional time, effort, or expense in localities in which it is acceptable medical practice to make an extra charge in such case.

(2) In making a determination that a provider has charged for health care services or supplies which are substantially in excess of the needs of the insured or which are of a quality that fails to meet professionally recognized standards for such services or supplies, OPM may rely, in part, upon reports, including sanction reports, from the following sources:

(i) The Professional Standards Review Organization or the Peer Review Organization for the area served by the provider;

(ii) State or local licensing or certification authorities;

(iii) Peer review committees of health plan carriers;

(iv) State or local professional societies; or

(v) Other sources deemed appropriate by OPM.

§890.1004 Standards for determining either the period of debarment or the amount of civil monetary penalties or assessments.

(a) In determining either the period of debarment or the amount of any civil monetary penalty or assessment, OPM shall take into account the specifics of section 8902a(e) of title 5, United States Code; i.e., the nature of any claims involved and the circumstances under which they were presented; the degree of culpability, history of prior offenses or improper conduct of the provider involved, and such other matters as justice may require.

(b) The following standards will be used when taking into account the factors listed in paragraph (a) of this section:

(1) *Criminal convictions.* The nature of the offense, the severity and magnitude of the crime, the extent of the provider's involvement and the provider's previous record, if any, will be of paramount importance in determining the period of debarment under 8902a(b) of title 5, United States Code.

(2) *Nature and circumstances of claims.* It shall be considered a mitigating circumstance if all the items or services subject to a determination under 8902a(c) of title 5, United States Code, included in the action brought under this part were of the same type and occurred within a short period of time, or were few in number and the total amount claimed was less than $1,000. It shall be considered an aggravating circumstance if such items or services were of several types, occurred over a lengthy period of time, were numerous (or the nature and circumstances indicate a pattern of claims for such items or services), or the amount claimed for such items or services was substantial.

(3) *Degree of culpability*. It shall be considered a mitigating circumstance if the claim was the result of an unintentional and unrecognized error in the process the provider followed in presenting claims, and corrective steps were taken promptly after the error was discovered. It shall be considered an aggravating circumstance if, for example, the provider knew or should have known he or she had previously been suspended from participation and such suspension was still in effect.

(4) *Prior offenses.* It shall be considered an aggravating circumstance if at any time prior to the presentation of the claim at issue in the debarment deliberations the provider was held liable for criminal, civil, or administrative sanctions in connection with the program covered by this part or any other public or private program of reimbursement for medical services.

(5) If there are substantial or several mitigating circumstances, OPM shall set any period of debarment at a minimum period of at least two years. If there are substantial or several mitigating circumstances, OPM shall set the aggregate amount of any civil monetary penalty and assessment at an amount equivalent to at least 25% of the maximums allowed by 8902a(c) of title 5, United States Code. However, unless there are extraordinary mitigating circumstances, the aggregate amount of the civil monetary penalty and assessment must be at least double

the estimated amount of damages sustained by the FEHB Program as a result of the claim(s) in question.

(6) If there are substantial or several aggravating circumstances, OPM shall set a period of debarment at a minimum period of at least 4 years. If there are substantial or several aggravating circumstances, OPM shall set the aggregate amount of any civil monetary penalty and assessment at an amount equivalent to at least 75% of the maximum allowed by 8902a(c) of title 5, United States Code.

§ 890.1005 Effective dates and notices.

(a) If OPM proposes to invoke any sanctions under section 8902a (b) or (c) of title 5, United States Code, OPM will send written notice of its intent, including the reasons for the proposed sanction(s), the proposed duration of the debarment, if any, and the proposed amount of any civil monetary penalty or assessment to the provider and advise the provider of the right to a reconsideration within OPM.

(b) Within 30 days of the date of the notice, the provider may submit:

(1) Documentary evidence and written argument against the proposed sanction; or

(2) A written request to present evidence or argument orally to an OPM official.

(c) For good cause shown by the provider, OPM may extend the 30-day period.

(d) If, after the provider has exhausted the reconsideration rights within OPM or failed to exercise his or her right to reconsideration within OPM, OPM decides to invoke any sanctions, it will send written notice of its decision to the provider at least 30 days before the proposed effective date of the sanction(s). The written notice will set forth:

(1) The basis for the sanction;

(2) The duration of the debarment, if any, and the factors used in determining the duration;

(3) The requirements and procedures for reinstatement, if applicable;

(4) The amount of the civil monetary penalty or assessment, if any, and how such penalty and/or assessment was determined;

(5) The right to a hearing.

(e) If the right to a hearing is waived, OPM will implement the effective date of the sanction(s) as provided in the notice required by paragraph (d) of this section. If the right to a hearing is exhausted and OPM is upheld by the hearing officer, OPM shall set the date of the sanction(s) to become effective within 31 days of the final decision of the hearing officer.

§ 890.1006 Payment of claims for service or supplies furnished by debarred providers.

Health plans may not deny claims for services or supplies based on debarment of the provider under this subpart if the claimant did not know or could not reasonably be expected to have known of the debarment. In any such instance, the carrier involved must take appropriate measures to ensure that the individual is informed of the debarment and the minimum period of time remaining under the terms of the debarment.

[59 FR 24030, May 10, 1994]

§§ 890.1007—890.1009 [Reserved]

Subpart K—Temporary Continuation of Coverage

SOURCE: 54 FR 52339, Dec. 21, 1989, unless otherwise noted.

§ 890.1101 Purpose.

This subpart identifies the individuals who may temporarily continue coverage after the coverage would otherwise terminate under this part and sets forth the circumstances of their enrollment.

§ 890.1102 Definitions.

In this subpart—

Gross misconduct means a flagrant and extreme transgression of law or established rule of action for which an employee is separated and concerning which a judicial or administrative finding of gross misconduct has been made.

Qualifying event means any of the following events that qualify an individual for temporary continuation of coverage under subpart K of this part:

(1) A separation from Government service.

(2) A divorce or annulment.

(3) A change in circumstances that causes an individual to become ineligible to be considered an unmarried dependent child under this part.

§890.1103 Eligibility.

(a) Except as provided by paragraph (b) of this section, individuals described by this section are eligible to elect temporary continuation of coverage under this subpart. Eligible individuals are as follows:

(1) Former employees whose coverage ends because of a separation from Federal service under any circumstances except an involuntary separation for gross misconduct.

(2) Individuals whose coverage as children under the family enrollment of an employee, former employee, or annuitant ends because they cease meeting the requirements for being considered unmarried dependent children. For the purpose of this section, children who are enrolled under this part as survivors of deceased employees or annuitants are considered to be children under a family enrollment of an employee or annuitant at the time of the qualifying event.

(3) Former spouses of employees, of former employees having continued family coverage under this subpart, or of annuitants, if the former spouse would be eligible for continued coverage under subpart H of this part except for failure to meet the requirement of §890.803(a) (1) or (3) of this part or the documentation requirements of §890.806(a) of this part, including former spouses who lose eligibility under subpart H within 36 months after termination of the marriage because they ceased meeting the requirement of §890.803(a) (1) or (3) of this part.

(b) An individual who is otherwise eligible for benefits under this part (excluding the temporary extension of coverage and conversion privilege set forth in subpart D of this part) is not entitled to continued coverage under this subpart.

§890.1104 Notification by agency.

(a) In the case of a former employee who is eligible to elect temporary continuation of coverage under §890.1103(a)(1), the employing office must notify the former employee concerning his or her rights under this subpart no later than 30 days after the end of the temporary extension of coverage provided under §890.401.

(b)(1) In the case of a child who is eligible to elect temporary continuation of coverage under §890.1103(a)(2), the enrollee may, within 60 days after the qualifying event, provide written notice to the employing office of the child's change in status and requesting information about temporary continuation of coverage. The written notice must include the child's name and address and the date of the terminating event.

(2) If the notice described in paragraph (b)(1) is received by the employing office within 60 days after the date on which the child ceased meeting the requirements for being considered an unmarried dependent child, the employing office must notify the child of his or her rights under this subpart within 14 days after receiving the notice.

(3) This paragraph does not preclude the employing office from notifying the child of his or her rights based on oral or written notification by the child, another family member, or any other source that the child no longer meets the requirements for being considered an unmarried dependent child.

(c)(1) In the case of a former spouse who is eligible to elect temporary continuation of coverage under §890.1103(a)(3), the employee or the former spouse may, within 60 days after the termination of the marriage or the loss of coverage under subpart H of this part, notify the employing office of the terminating event and request information about temporary continuation of coverage. The notice must include the name and address of the former spouse and the date of the terminating event.

(2) The employing office must notify the former spouse of his or her rights under this subpart within 14 days after receiving the notice described in paragraph (c)(1) of this section.

(d) If the employing office cannot give the notice required by this section to the employee, child, or former spouse directly, it must send the notice by first class mail. A notice that is

mailed is deemed to be received 5 days after the date of the notice.

[54 FR 52339, Dec. 21, 1989, as amended at 57 FR 21192, May 19, 1992]

§ 890.1105 Elections.

(a) The election of temporary continuation of coverage may be in the form of a Standard Form 2809, letter, or written statement to the employing office.

(b) A former employee's election under this subpart must be submitted to the employing office within 60 days after the later of—

(1) The date of separation; or

(2) The date the former employee received the notice from the agency.

(c) A child's election under this subpart must be submitted to the employing agency within 60 days after the later of—

(1) The date of the qualifying event; or

(2) If the employee notified the employing agency within the 60-day time period specified under § 890.1104(b)(1) of this part, the date the child received the notice from the employing agency. If the employee did not notify the employing agency within the specified time period, the child's opportunity to elect continued coverage ends 60 days after the qualifying event.

(d) A former spouse's election must be received by the employing office within 60 days after the later of—

(1) The date of the qualifying event; or

(2) The date coverage under subpart H of this part was lost because of remarriage or loss of qualifying court order, if the loss of coverage under subpart H occurred before the expiration of the 36-month period specified in § 890.1107(c) of this part; or

(3) If the employee or former spouse notified the agency of the termination of the marriage within the time period specified in § 890.1104(c)(1), the date the former spouse received the notice from the agency described in § 890.1104(c)(2). If neither the employee nor the former spouse notified the agency within the specified time period, the former spouse's opportunity to elect continued coverage ends 60 days after the qualifying event.

(e) If an individual who is eligible for temporary continuation of coverage under this section is unable to file an election on his or her own behalf because of a mental or physical disability, an election may be filed by a court-appointed guardian.

(f) Except as provided in paragraphs (c)(2) and (d)(3), when an employing office determines that an eligible individual was unable, for cause beyond his or her control, to register to be enrolled within the time limits prescribed by this section, that office must accept the registration within 31 days after it advises him or her of that determination.

§ 890.1106 Coverage.

(a) *Type of enrollment.* An individual who enrolls under this subpart may elect coverage for self alone or self and family.

(1) For an enrollee who is eligible for continued coverage under § 890.1103(a)(1) or (2), a covered family member is an individual whose relationship to the enrollee meets the requirements of 5 U.S.C. 8901(5) and who meets any applicable requirements of 5 CFR 890.302 of this part.

(2) For a former spouse who is eligible for continued coverage under § 890.1103(3) of this part, a covered family member is an individual who meets the requirements of § 890.804 of this part.

(b) *Plans and options.* An individual who elects to continue coverage under this subpart may enroll in a plan or option different from the plan or option covering the individual at the time of the qualifying event.

§ 890.1107 Length of temporary continuation of coverage.

(a) In the case of a former employee who is eligible for continued coverage under § 890.1103(a)(1), the temporary continuation of coverage ends on the date that is 18 months after the date of separation, unless it is terminated earlier under the provisions of § 890.1110.

(b)(1) Except as provided in paragraph (b)(2) of this section, in the case of individuals who are eligible for continued coverage under § 890.1103(a)(2) of this part, the temporary continuation of coverage ends on the date that is 36

months after the date the individual first ceases to meet the requirements for being considered an unmarried dependent child, unless it is terminated earlier under the provisions of §890.1110.

(2) The temporary continuation of coverage ends on the date that is 36 months after the date of the separation from service on which the former employee's continuation of coverage is based, unless it is terminated earlier under the provisions of §890.1110, in the case of individuals who—

(i) Are eligible for continued coverage under §890.1103(a)(2); and

(ii) As of the day before ceasing to meet the requirements for being considered unmarried dependent children, were covered family members of a former employee receiving continued coverage under this subpart; and

(iii) Cease meeting the requirements for being considered unmarried dependent children before the end of the 18-month period specified in paragraph (a) of this section.

(c)(1) Except as provided in paragraph (c)(2) of this section, in the case of former spouses who are eligible for continued coverage under §890.1103(a)(3), the temporary continuation of coverage ends on the date that is 36 months after the former spouse ceased meeting the requirements for coverage as a family member, unless it is terminated earlier under the provisions of §890.1110.

(2) The temporary continuation of coverage ends on the date that is 36 months after the date of the separation from service on which the former employee's continuation of coverage is based, unless it is terminated earlier under the provisions of §890.1110, in the case of a former spouse—

(i) Who is eligible for continued coverage under §890.1103(a)(3); and

(ii) Whose marriage to the former employee terminates after the former employee's separation but before the expiration of the 18-month period specified in paragraph (a) of this section.

§890.1108 Effective date of coverage.

(a) Except as provided in paragraph (b) of this section, the effective date of coverage is the day after other coverage under this part expires, including temporary extension of coverage under §890.401 of this part. If an individual registers for temporary continuation of coverage before the expiration of the election period under §890.1105, but after the temporary extension of coverage expires, coverage is restored retroactively, with appropriate contributions and claims, to the same extent and effect as though no break in coverage occurred.

(b) In the case of a former spouse, the effective date of coverage is the later of—

(1) The date determined under paragraph (a) of this section; or

(2) The date of the divorce or annulment.

[55 FR 22891, June 5, 1990]

§890.1109 Premium payments.

(a) Except as provided in paragraph (b) of this section, the enrollee must pay the full enrollment charge as determined under §890.503(a), including both the Government contributions and employee withholdings, plus the administrative charge described under §890.1113, for every pay period during which the enrollment continues, exclusive of the 31-day temporary extension of coverage for conversion provided under §890.401 of this part.

(b) If the enrollee is not covered under this subpart for the full pay period, he or she pays the premium charge for only the days actually covered. The daily premium rate is an amount equal to the monthly rate (including the administrative charge) multiplied by 12 and divided by 365.

(c) The enrollee must make the payment after the pay period during which he or she is covered in accordance with a schedule established by the employing office. If the employing office does not receive the payment by the date due, the employing office must notify the enrollee in writing that continuation of coverage depends upon payment being made within 15 days (45 days for enrollees residing overseas) after receipt of the notice. If no subsequent payments are made, the employing office terminates the enrollment 60 days (90 days for enrollees residing overseas) after the date of the notice. An enrollee whose coverage terminates

because of nonpayment may not reenroll or reinstate coverage except as provided under paragraph (d) of this section.

(d)(1) If the enrollee was prevented by circumstances beyond his or her control from making payment within the timeframe specified in paragraph (c) of this section, he or she may request reinstatement of coverage by writing to the employing office. The request must be filed within 30 calendar days from the date of termination and must be accompanied by verification that the enrollee was prevented by circumstances beyond his or her control from paying within the time limit.

(2) The employing office determines whether the individual is eligible for reinstatement of coverage. If the determination is affirmative, coverage is reinstated retroactively to the date of termination. If the determination is negative, the individual may request a review of the decision from the employing agency as provided under § 890.104.

[54 FR 52339, Dec. 21, 1989, as amended at 59 FR 67607, Dec. 30, 1994; 61 FR 37810, July 22, 1996]

§ 890.1110 Termination of enrollment or coverage.

(a) *General.* An enrollment under this subpart terminates at midnight of the earlier of the following dates:

(1) The date the temporary continuation of coverage expires as set forth in § 890.1107, subject to the temporary extension of coverage for conversion.

(2) The last day of the pay period in which the enrollee dies.

(3) The day before the effective date of coverage under another provision of this part.

(4) The date provided under paragraphs (b) or (c) of this section.

(b) *Failure to pay premiums.* Termination of enrollment for failure to pay premiums within the timeframe established under § 890.1109 of this part is retroactive to the end of the last pay period for which payment was timely received. The enrollee and covered family members, if any, are not entitled to the temporary extension of coverage for conversion or to convert to an individual contract for health benefits.

(c) *Cancellation.* An enrollee may cancel his or her enrollment as provided under § 890.304(d) of this part.

(d) *Family member coverage.* The coverage of a family member terminates under the conditions set forth in § 890.304(c). Covered family members of former employees and former spouses are entitled to temporary continuation of coverage only as set forth under § 890.1103.

§ 890.1111 Employing office responsibilities.

(a) *Providing information to employees.* Employing offices are responsible for providing employees who are eligible to enroll under this part with literature developed by OPM that sets forth their rights under this subpart. This literature must be distributed to employees prior to each open season occurring under § 890.301.

(b) *Administration of the enrollment process.* The employing office must establish procedures for notifying the former employee, child, or former spouse about his or her eligibility to enroll, including what documents are needed to determine eligibility, and for accepting enrollment registrations.

(c) *Collecting premiums.* (1) Collection of the contributions is the responsibility of the employing office of the employee or annuitant at the time of the qualifying event.

(2) The employing office must submit all premium payments collected from enrollees along with its regular health benefits payments to OPM in accordance with procedures established by that Office.

(d) *Health benefits file.* The employing office must maintain a health benefits file for the enrollee as a file separate from the personnel records of the employee or former employee. This file may be destroyed 2 years after the end of the calendar year during which the 18- or 36-month period described in § 890.1107 (a) or (b)(1) expires.

[54 FR 52339, Dec. 21, 1989, as amended at 55 FR 22891, June 5, 1990]

§890.1112 Denial of continuation of coverage due to involuntary separation for gross misconduct.

(a) *Notice of denial.* (1) When an employing office determines that the offense for which an employee is being removed constitutes gross misconduct for the purpose of this subpart, the employing office must notify the employee in writing of its intention to deny temporary continuation of coverage. The notice must set forth the reason for the denial and give the employee a reasonable amount of time to respond. The notice must be made no later than the date of separation.

(2) If the employee is being removed under the authority of part 752 of this chapter (or other law, Executive Order, or regulation that prescribes procedures for removing employees because of misconduct), the notification requirement of paragraph (a)(1) of this section may be combined with the notification requirement of such authority.

(b) *Employee's response.* (1) The employee must be allowed a reasonable time for response, but not less than 7 days. The employee may respond orally or in writing and is entitled to be represented by an attorney or other representative.

(2) The agency must designate an official to hear the employee's oral answer who has the authority either to make or recommend a final decision on the denial. The right to answer orally does not include the right to a formal hearing with examination of witnesses.

(c) *Final decision.* If the employee responds to the notice of denial, the employing office must issue a final decision in writing that fully sets forth its findings and conclusions. The agency's decision is not subject to reconsideration by OPM.

(d) *Resignation in lieu of involuntary separation.* If an employee resigns after receiving the employing office's notification of intent to separate the employee involuntarily but before the scheduled separation date, his or her separation is considered involuntary for the purpose of this subpart.

§890.1113 The administrative charge.

(a) OPM has determined that the administrative charge as provided under 5 U.S.C. 8905a(d)(1)(A)(ii) is 2 percent of the enrollment charge described in §890.503(a).

(b) It is OPM's responsibility to establish procedures for receiving the administrative payment into the Employees Health Benefits Fund and for making this amount available to the employing office.

[54 FR 52339, Dec. 21, 1989, as amended at 55 FR 22891, June 5, 1990]

Subpart L—Benefits for United States Hostages in Iraq and Kuwait and United States Hostages Captured in Lebanon

SOURCE: 55 FR 50537, Dec. 7, 1990, unless otherwise noted.

§890.1201 Purpose.

This subpart sets forth the circumstances under which individuals are covered under this part in accordance with the provisions of section 599C of Public Law 101–513.

§890.1202 Definitions.

In this subpart—

Covered family members as it applies to individuals covered under this subpart has the same meaning as set forth in §890.101(a). For eligible survivors of individuals enrolled under this subpart, a family enrollment covers only the survivor or former spouse and unmarried dependent natural or adopted child of both the survivor or former spouse and hostage.

Hostage and *hostage status* have the meaning set forth in section 599C of Public Law 101–513.

Pay period for individuals enrolled under this subpart means the pay period established by the U.S. Department of State for paying individuals covered under Public Law 101–513.

Period of eligibility means the period beginning on the effective date set forth in §890.1204 of this subpart and ending 60 months after hostage status ended for hostages in Lebanon and 12 months after hostage status ended for hostages in Iraq and Kuwait.

[55 FR 50537, Dec. 7, 1990, as amended at 57 FR 43132, Sept. 18, 1992]

§ 890.1203 Coverage.

(a) An individual is covered under this subpart when the U.S. Department of State determines that the individual is eligible for coverage under section 599C of Public Law 101–513.

(b) An individual who is covered under this subpart is covered under the Standard Option of the Service Benefit Plan. The individual has a self and family enrollment unless the U.S. Department of State determines that the individual is unmarried and has no dependent children. Unmarried individuals who have no eligible dependent children have a self only enrollment.

(c) Individuals covered under this subpart are deemed ineligible for enrollment in any FEHB plan or option other than the Standard Option of the Service Benefit Plan.

(d) Eligible surviving family members of an individual covered under this subpart whose hostage status ended because of death or who dies during the 60 months or 12 months following the end of hostage status are eligible to continue enrollment under this part. The enrollment terminates no later than 60 months or 12 months after hostage status ended.

(e) An individual covered by this subpart is not considered an employee for the purpose of this part.

(f) Eligibility for coverage under this subpart shall be subject to the availability of funds under section 599C(e) of Public Law 101–513.

[55 FR 50537, Dec. 7, 1990, as amended at 57 FR 43132, Sept. 18, 1992]

§ 890.1204 Effective date of coverage.

Unless the U.S. Department of State determines that a later date is appropriate, coverage under § 890.1203(b) is effective on August 2, 1990, for hostages in Iraq and Kuwait and on the later of the date hostage status began or June 1, 1982, for hostages in Lebanon.

[57 FR 43132, Sept. 18, 1992]

§ 890.1205 Change in type of enrollment.

(a) Individuals covered under this subpart or eligible survivors enrolled under this subpart may change from self only to self and family coverage if they acquire an eligible family member. The change may be made at the written request of the enrollee at any time after the family member is acquired. A change in enrollment under this paragraph becomes effective on the 1st day of the pay period after the pay period during which the request is received by the U.S. Department of State, except that a change based on the birth or addition of a child as a new family member is effective on the 1st day of the pay period during which the child is born or otherwise becomes a new family member.

(b) Individuals covered under this subpart or eligible survivors enrolled under this subpart may change from a self and family enrollment to a self only when the last eligible family member (other than the enrollee) ceases to be a family member. The change may be made at the written request of the enrollee at any time after the last family member is lost and it becomes effective on the 1st day of the pay period after the pay period during which the request is received by the U.S. Department of State.

(c) A family member may file a request to change the type of enrollment on behalf of a hostage during the period of hostage status or on behalf of an eligible former hostage who cannot file the election on his or her own behalf because of a mental or physical disability.

§ 890.1206 Cancellation of coverage.

(a) An individual who is covered under § 890.1203(b) may cancel his or her enrollment at any time by written request. The cancellation is effective on the 1st day of the pay period after the pay period in which it is received by the U.S. Department of State.

(b) An individual who cancels his or her coverage under this section cannot reacquire coverage unless the U.S. Department of State determines that it would be against equity and good conscience not to allow the individual to be enrolled.

(c) A cancellation of coverage must be made by the enrolled individual and cannot be made by a representative acting on the individual's behalf.

§890.1207 Termination of coverage.

(a) Coverage of an individual under §890.1203(b) terminates 60 months or 12 months after hostage status ended unless the individual cancels the coverage earlier.

(b) Enrollees and family members are eligible for temporary extension of coverage for conversion as set forth in subpart D of this part unless the covering enrollment is terminated by cancellation.

[55 FR 50537, Dec. 7, 1990, as amended at 57 FR 43132, Sept. 18, 1992]

§890.1208 Premiums.

(a) Government and employee contributions (premiums) required under §§890.501 and 890.502 of this part are paid from the appropriation provided under section 599C(e) of Public Law 101–513.

(b) If the individual is not covered under this subpart for the full pay period, premiums are paid only for the days he or she is actually covered. The daily premium rate is an amount equal to the monthly premium rate multiplied by 12 and divided by 365.

(c) The payments required by this section may be accepted by OPM from the State Department appropriation in advance if necessary to fund the 12-month period of coverage beginning on the earlier of:

(1) The day after sanctions or hostilities end; or

(2) The day after the individual's period of hostage status ends.

(d) OPM will place any funds received under paragraph (c) of this section in an account established for this purpose. OPM will make the disbursements specified under 48 CFR subpart 1632.170 from this account when the appropriate pay period occurs.

[55 FR 50537, Dec. 7, 1990, as amended at 57 FR 14325, Apr. 20, 1992]

§890.1209 Responsibilities of the U.S. Department of State.

(a) The U.S. Department of State functions as the ''employing office'' for individuals covered under this subpart.

(b) The U.S. Department of State must determine the eligibility of individuals who qualify under Public Law 101–513 for coverage under this part. This determination includes the determination as to whether the individual is barred from coverage under chapter 89 of title 5 U.S. Code by reason of other health insurance coverage as provided in section 599C of Public Law 101–513.

(c) The U.S. Department of State must determine whether eligible individuals are married or single for the purpose of coverage under a self only or a self and family enrollment as set forth in §890.1203(b). If the marital status of the individual cannot be determined, the U.S. Department of State must enroll the individual for self and family coverage.

§890.1210 Reconsideration and appeal rights.

(a) Under procedures set forth by the U.S. Department of State, an individual may request the U.S. Department of State to reconsider an initial decision it has made denying coverage or a change in the type of enrollment under this subpart.

(b) Neither the initial decision nor the reconsideration decision of the U.S. Department of State is subject to reconsideration by OPM.

PART 891—RETIRED FEDERAL EMPLOYEES HEALTH BENEFITS

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