(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. 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.

Subpart E—Contributions and Withholdings

§ 890.501 Government contributions.

(a) The Government contribution toward subscription charges under all
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health benefits plans, 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) In accordance with the provisions of 5 U.S.C. 8906(a) which take effect with the contract year that begins in January 1999, OPM will determine the amounts representing the weighted average of subscription charges in effect for each contract year, for self only enrollments and for self and family enrollments, as follows:

(1) The determination of the weighted average of subscription charges will only include those health benefits plans which are continuing FEHB Program participation from one contract year to the next.

(i) If OPM and the carrier for a plan that will continue participation have closed negotiations on rates for the upcoming contract year by September 1 of the current contract year, i.e., the determination year, OPM will use the plan’s negotiated subscription charges for the upcoming contract year in the determination of the weighted average of subscription charges.

(ii) If OPM and the carrier for a plan that applied to continue participation have not closed rate negotiations for the upcoming contract year by September 1 of the determination year, OPM will make a deemed adjustment to such plan’s subscription charges for the current contract year for purposes of counting eligible enrollees of the plan in the determination of weighted average charges for the upcoming contract year. The deemed adjustment will equal any increase or decrease OPM finds in its determination of the weighted average of subscription charges for the upcoming contract year for all plans with which OPM has closed rates on September 1 of the determination year.

(iii) There will be no subsequent adjustment in the weighted average charges applicable to the upcoming contract year to reflect rate negotiations closed after September 1 of the determination year.

(2) Except as otherwise specified in paragraphs (b)(2)(i) and (b)(2)(ii) of this section, the weight OPM gives to each subscription charge for purposes of determining the weighted average of subscription charges for the upcoming contract year will be proportionate to the number of individuals who, as of March 31 of the determination year, are enrolled in the plan or benefits option to which such charge applies and are eligible for a Government health benefits contribution in the upcoming contract year.

(i) When a subscription charge for an upcoming contract year applies to a plan that is the result of a merger of two or more plans which contract separately with OPM during the determination year, or applies to a plan which will cease to offer two benefits options, OPM will combine the self only enrollments and the self and family enrollments from the merging plans, or from a plan’s two benefits options, for purposes of weighting subscription charges in effect for the successor plan for the upcoming contract year.

(ii) When a comprehensive medical plan (CMP) varies subscription charges for different portions of the plan’s service area and the plan’s contract for the upcoming contract year will reconfigure geographic areas associated with subscription charges, so that there will not be a direct correlation between enrollment in the determination year and rating areas for the upcoming contract year, OPM will estimate what portion of the plan’s enrollees on March 31 of the determination year will be subject to each of the plan’s subscription rates for the upcoming contract year.

(3) After OPM weights each subscription charge as provided in paragraphs (b)(2), (b)(2)(i), and (b)(2)(ii) of this section, OPM will compute the total of subscription charges associated with self only enrollments, and the total of subscription charges associated with self and family enrollments. OPM will divide each subscription charge total by the total number of enrollments such amount represents to obtain the program-wide weighted average subscription charges for self only and for self and family enrollments, respectively.

(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
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§ 890.502 Withholdings, contributions, LWOP, premiums, and direct premium payment.

(a) Employee and annuitant withholdings and contributions. (1) Employees and annuitants are responsible for paying the enrollee share of the cost of enrollment for every pay period during which they are enrolled. An employee or annuitant incurs a debt to the United States in the amount of the proper employee or annuitant withholding required for each pay period during which they are enrolled if the appropriate health benefits withholdings or direct premium payments are not made.

(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 of this chapter are not considered eligible for coverage under 5 U.S.C. 8906a for the purpose of this paragraph.

(b) Procedures when an employee enters a leave without pay (LWOP) status or pay is insufficient to cover premium. The employing office must tell the employee about available health benefits choices as soon as it becomes aware that an employee’s premium payments cannot be made because he or she will be or is already in a leave without pay (LWOP) status or any other type of nonpay status. (This does not apply when nonpay is as a result of a lapse of appropriations.) The employing office must also tell the employee about available choices when an employee’s pay is not enough to cover the premiums.

(1) The employing office must give the employee written notice of the choices and consequences as described in paragraphs (b)(2)(i) and (ii) of this section and will send a letter by first class mail if it cannot give it to the.