(1) *Example.* An enrollee and his spouse divorce on May 4, 2017. The enrollee does not remove the former spouse from the enrollee's self and family enrollment, so the former spouse is receiving coverage but is not eligible. In this example, the former spouse is not eligible to receive an annuity listed in § 890.805(2). If the employing office later discovers the divorce, and removes the spouse from the enrollment on June 20, 2018, the former spouse is not eligible for a 31-day extension of coverage, conversion and/or temporary continuation of coverage because the regulatory window for election of 60 days outlined in § 890.805(1) has passed. The sixty-day window began on the final date of the divorce, May 4, 2017 and ended on July 3, 2017.

(2) [Reserved]

(h) *Removal from enrollment: Eligible family members.* (1) An eligible family member may be removed from a self plus one or a self and family enrollment if a request is submitted to the enrollee's employing office for approval at any time during the plan year in the following circumstances:

(i) In the case of a spouse, if the enrollee and his or her spouse provide a notarized request for removal.

(ii) In the case of a child who has reached the age of majority in the child's state of residence (the enrollee's state of residence if the child's is not known), if the enrollee provides proof that the child is no longer his or her dependent as described under § 890.302(b). The enrollee shall also provide the last known contact information for the child.

(iii) In the case of a child who has reached the age of majority in the child's state of residence, if the child provides a notarized request for removal to the employing office.

(2) For removals under paragraph (h)(1) of this section the effective date is the first day of the third pay period following the date the request is approved by the employing office for employees who pay bi-weekly and the second pay period following the date that the request is approved by the employing office for enrollees who pay premiums monthly.

(3) The family member's removal under this paragraph (h) is considered a cancellation under § 890.304(d) and removed family members are not eligible for temporary extension of coverage and conversion under § 890.401 or temporary continuation of coverage under § 809.1103.

(4) If an eligible family member is removed under this paragraph (h), he or she may only regain coverage under the applicable self plus one or self and family enrollment if requested by the enrollee during the annual open season or within 60 days of the family member losing other health insurance coverage. The enrollee must also provide written consent to reinstatement of coverage from the family member and demonstrate eligibility of the spouse or child as a family member to the employing office.

(5) If an employing office approves a request for removal, the employing office must notify the enrollee and the carrier of the removal immediately. For removals under paragraph (h)(1)(ii) of this section, the employing office must also immediately notify the child of the removal using the last known contact provided by the enrollee.

[63 FR 59459, Nov. 4, 1998, as amended at 83 FR 3061, Jan. 23, 2018]

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 only, self plus one, 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; 80 FR 55736, Sept. 17, 2015]

Subpart E—Contributions and Withholdings

AUTHORITY: 5 U.S.C. 8913; Sec. 890.303 also issued under Sec. 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; Subpart L also issued under Sec. 599C of Public Law 101–513, 104 Stat. 2064, as amended; Sec. 890.102 also issued under Secs. 11202(f), 11232(e), 11246(b) and (c) of Public Law 105–33, 111 Stat. 251; Sec. 721 of Public Law 105–261, 112 Stat. 2061 unless otherwise noted; Sec. 890.111 also issued under Sec. 1622(b) of Public Law 104–106, 110 Stat. 515.

§ 890.501 Government contributions.

(a) The Government contribution toward subscription charges under all 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, self plus one, and 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, the self plus one enrollments, and the self and family enrollments from the merging plans, or from a plan's 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