§ 890.401

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 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, 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 confine-
ments 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 con-
tinue until the end of the confinement.

(c)(1) The employing agency must no-
tify the enrollee of the termination of
the enrollment and of the right to con-
vert to an individual policy within 60
days after the date the enrollment ter-
minates.

(2) The individual whose enrollment
terminates must request conversion in-
formation from the losing carrier with-
in 31 days of the date of the agency no-
tice of the termination of the enroll-
ment 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 re-
quest conversion to an individual pol-
icy by writing directly to the carrier.
Such a request must be filed within 6
months after the individual became eli-
gible to convert his or her group cov-
erage and must be accompanied by
verification of termination of the en-
rollment; e.g., an SF 50, showing the
individual’s separation from the serv-
cise. 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 de-
terminie if the individual is eligible to
convert; and when the determination is
affirmative, the individual may con-
vert within 31 days of the determina-
tion. If the determination by the car-
rir is negative, the individual may re-
quest a review of the carrier’s deter-
mination from OPM.

(4) When an individual converts his
or her coverage anytime after the
group coverage has ended, the indi-
vidual plan coverage is retroactive to
the day following the day the tempo-
rary extension of group coverage ended. The individual must pay the
premiums due for the retroactive pe-
riod.

(5) An individual who fails to exercise
his or her rights to convert to an indi-
vidual policy within 31 days after re-
ceiving notice of the right to convert
from the carrier is deemed to have de-
clined the right to convert unless the
carrier, or, upon review, OPM deter-
mines the failure was for cause beyond
his or her control.

[33 FR 12510, Sept. 4, 1968, as amended at 52
FR 10217, Mar. 31, 1967; 54 FR 52539, Dec. 21,
1989; 55 FR 22891, June 5, 1990; 57 FR 10609,
Mar. 27, 1992; 57 FR 21191, May 19, 1992; 60 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–

§ 890.501 Government contributions.

(a) The Government contribution to-
ward 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 av-
erage of subscription charges in effect
for each contract year, for self only,
self plus one, and self and family en-
rollments, as follows:

(1) The determination of the weight-
ed average of subscription charges will
only include those health benefits
plans which are continuing FEHB Pro-
gram 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 up-
coming contract year by September 1
of the current contract year, i.e., the