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
§ 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