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.


### 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. 2561, 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
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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. If 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 paragraph (b)(2) of this section, OPM will compute the total of subscription charges associated with self only enrollments, self plus one enrollments, and self and family enrollments, respectively. 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 plus one and self and family enrollments, respectively.

   i. 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.

   ii. 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.
§ 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 benefit premium 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.

(4) The employing office must calculate 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 there is one. If that annuity is less than the amount required, withhold to the extent necessary from the annuity of the youngest child, and if necessary, from the annuity of the next older child, in succession, until the withholding is met.

(6) Surviving spouses who have a basic employee death benefit under 5 U.S.C. 8442(b)(1)(A) and annuitants whose health benefits premiums are more than the amount of their annuities may pay their portion of the health benefits premium directly to