otherwise have been a party to the initial administrative decision to issue a letter of intent to withdraw the plan's or carrier's approval. The hearing officer shall conduct the hearing unless it is waived in writing by the carrier. The carrier is entitled to appear by representative and present oral or documentary evidence, including rebuttal evidence, in opposition to the proposed action.

(i) A transcribed record shall be kept of the hearing and shall be the exclusive record of the proceeding.

(ii) After the hearing is held, or after OPM's receipt of the carrier's written waiver of the hearing, the Director shall make a decision on the record, taking into consideration any recommendation submitted by the hearing officer, and send it to the carrier by certified mail. A decision of the Director shall be considered a final decision for the purposes of this section. The Director, or his or her representative, may set a future effective date for withdrawal of approval.

(3) The Director, or his or her representative, may give written notice of non-renewal of the contract of a carrier whose plan does not meet the minimum enrollee requirement in § 890.201(a)(11). However, the Director may defer withdrawing approval of a plan not meeting the requirement in § 890.201(a)(11) of this part when, in the judgment of OPM, the carrier shows good cause. The Director or representative may authorize a plan with fewer than 300 employees or annuitants to remain in the FEHB Program when he or she determines, in his or her discretion, that it is in the best interest of the Program (e.g., when the plan is the only plan available to enrollees in a rural area).

(b) During a current contract term, the Director, in his or her discretion, may reinstate approval of a plan or carrier under this section on a finding that the reasons for withdrawing approval no longer exist.

[55 FR 9109, Mar. 12, 1990, as amended at 57 FR 14324, Apr. 20, 1992]

§ 890.205 Nonrenewal of contracts of health benefits plans.

(a) Either OPM or the carrier may terminate a contract by giving a written notice of nonrenewal which includes an indication of the reason for the intended action.

(b) Where termination by notice of intent not to renew is made by OPM, the carrier contesting that notice may request that OPM review the proposed decision. Such review shall be conducted by the Director or a representative designated by the Director, who shall not otherwise have been a party to the initial decision to issue a notice of intent not to renew. A request for such review, which may include a request that a representative of the carrier appear personally before OPM, shall be in writing. That request must be received within 10 calendar days of the carrier's receipt of the notice of intent not to renew. Such request shall include a detailed statement as to why the carrier disagrees with OPM's notice of nonrenewal and shall be accompanied by appropriate supporting documentation. Where a carrier has requested review under this section, the final decision by OPM not to renew a health benefits contract shall be communicated to the carrier in writing not more than 30 days after OPM's receipt of the carrier's request for review, unless a later date is mutually agreed upon.

(c) In the absence of a timely request for review as set forth in paragraph (b) of this section, OPM's notice of intent not to renew will become final without further notification.

[57 FR 19374, May 6, 1992]

Subpart C—Enrollment

§ 890.301 Opportunities for employees to enroll or change enrollment; effective dates.

(a) *Initial opportunity to enroll.* An employee who becomes eligible may elect to enroll or not to enroll within 60 days after becoming eligible.

(b) *Effective date—generally.* Except as otherwise provided, an enrollment or change of enrollment takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to enroll or change the enrollment and that follows a pay period during any part of which the employee is in pay status.

(c) *Belated enrollment.* When an employing office determines that an employee was unable, for cause beyond his or her control, to enroll or change the enrollment within the time limits prescribed by this section, the employee may enroll or change the enrollment within 60 days after the employing office advises the employee of its determination.

(d) *Enrollment by proxy.* Subject to the discretion of the employing office, an employee's representative, having written authorization to do so, may enroll or change the enrollment for the employee.

(e) *Decreasing enrollment type.* (1) Subject to two exceptions, an employee may decrease enrollment type at any time. *Exceptions:*

(i) An employee participating in health insurance premium conversion may decrease enrollment type during an open season or because of and consistent with a qualifying life event as defined in part 892 of this chapter.

(ii) An employee who is subject to a court or administrative order as discussed in paragraph (g)(3) of this section may not decrease enrollment type in a way that eliminates coverage of a child identified in the order as long as the court or administrative order is still in effect and the employee has at least one child identified in the order who is still eligible under the FEHB Program, unless the employee provides documentation to the agency that he or she has other coverage for the child(ren). The employee may not elect self only as long as he or she has one child identified as covered, but may elect self plus one.

(2) A decrease in enrollment type takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment, except that at the request of the enrollee and upon a showing satisfactory to the employing office that there was no family member eligible for coverage under the self plus one or self and family enrollment, or only one family member eligible for coverage under the self and family enrollment, as appropriate, the employing office may make the change effective on the first day of the pay period following the one in which there was, in the case of a self plus one enrollment, no family member or, in the case of a self and family enrollment, only one or no family member.

(f) *Open season.* (1) An open season will be held each year from the Monday of the second full workweek in November through the Monday of the second full workweek in December.

(2) The Director of the Office of Personnel Management may modify the dates specified in paragraph (f)(1) of this section or hold additional open seasons.

(3) With one exception, during an open season, an eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, may change from one plan or option to another, or may make any combination of these changes. *Exception:* An employee who is subject to a court or administrative order as discussed in paragraph (g)(3) of this section may not cancel his or her enrollment, decrease enrollment type, or change to a comprehensive medical plan that does not serve the area where his or her child or children live as long as the court or administrative order is still in effect, and the employee has at least one child identified in the order who is still eligible under the FEHB Program, unless the employee provides documentation to the agency that he or she has other coverage for the child(ren). The employee may not elect self only as long as he or she has one child identified as covered, but may elect self plus one.

(4)(i) An open season new enrollment takes effect on the first day of the first pay period that begins in the next following year and which follows a pay period during any part of which the employee is in a pay status.

(ii) An open season change of enrollment takes effect on the first day of the first pay period which begins in January of the next following year.

(5) When a belated open season enrollment or change of enrollment is accepted by the employing office under paragraph (c) of this section, it takes effect as required by paragraph (f)(4) of this section.

(g) *Change in family status.* (1) An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee's family status changes, including a change in marital status or any other change in family status. The employee must enroll or change the enrollment within the period beginning 31 days before the date of the change in family status, and ending 60 days after the date of the change in family status.

(2) An enrollment or change of enrollment made in conjunction with the birth of a child, or the addition of a child as a new family member in some other manner, takes effect on the first day of the pay period in which the child is born or becomes an eligible family member.

(3)(i) If an employing office receives a court or administrative order on or after October 30, 2000, requiring an employee to provide health benefits for his or her child or children, the employing office will determine if the employee has a self plus one or self and family enrollment, as appropriate, in a health benefits plan that provides full benefits in the area where the child or children live. If the employee does not have the required enrollment, the agency must notify him or her that it has received the court or administrative order and give the employee until the end of the following pay period to change his or her enrollment or provide documentation to the employing office that he or she has other coverage for the child or children. If the employee does not comply within these time frames, the employing office must enroll the employee involuntarily as stated in paragraph (g)(3)(ii) of this section.

(ii) If the employee is not enrolled or does not enroll, the agency must enroll him or her for self plus one or self and family coverage, as appropriate, in the option that provides the lower level of coverage in the Service Benefit Plan. If the employee is enrolled but does not increase the enrollment type in a way that is sufficient to cover the child or children, the employing office must change the enrollment to self plus one or self and family, as appropriate, in the same option and plan, as long as the plan provides full benefits in the area where the child or children live. If the employee is enrolled in a comprehensive medical plan that does not serve the area in which the child or children live, the employing office must change the enrollment to self plus one or self and family, as appropriate, in the option that provides the lower level of coverage in the Service Benefit Plan.

(4) Subject to two exceptions, the effective date of an involuntary enrollment under paragraph (g)(3) of this section is the 1st day of the pay period that begins after the date the employing office completes the enrollment request. *Exceptions:*

(i) If the court or administrative order requires an earlier effective date, the effective date will be the 1st day of the pay period that includes that date. Effective dates may not be retroactive to a date more than 2 years earlier, or prior to October 30, 2000.

(ii) If after an involuntary enrollment becomes effective and the employing office finds that circumstances beyond the employee's control prevented him or her from enrolling or changing the enrollment within the time limits in this section, the employee may change the enrollment prospectively within 60 days after the employing office advises the employee of its finding.

(h) *Change in employment status.* An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee's employment status changes. Except as otherwise provided, an employee must enroll or change the enrollment within 60 days after the change in employment status. Employment status changes include, but are not limited to—

(1) A return to pay status following loss of coverage under either—

(i) Section 890.304(a)(1)(v) due to the expiration of 365 days in leave without pay (LWOP) status, or

(ii) Section 890.502(b)(5) due to the termination of coverage during LWOP status.

(2) Reemployment after a break in service of more than 3 days.

(3) Restoration to a civilian position after serving in the uniformed services under conditions that entitle him or her to benefits under part 353 of this chapter, or similar authority.

(4)(i) A change from a temporary appointment in which the employee is eligible to enroll under 5 U.S.C. 8906a, which requires payment of the full premium with no Government contribution, to an appointment that entitles the employee to receive the Government contribution.

(ii) A change in entitlement to Government contribution as a result of becoming eligible for coverage under § 890.102(j).

(5) Separation from Federal employment when the employee or the employee's spouse is pregnant and the employee supplies medical documentation of the pregnancy. An employee who enrolls or changes the enrollment under this paragraph (h)(5) must do so during his or her final pay period. The effective date of an enrollment or a change of enrollment under this paragraph (h)(5) is the first day of the pay period which the employing office receives an appropriate request to enroll or change the enrollment.

(6) A transfer from a post of duty within a State of the United States or the District of Columbia to a post of duty outside a State of the United States or the District of Columbia, or the reverse. An employee who enrolls or changes the enrollment under this paragraph (h)(6) must do so within the period beginning 31 days before leaving the old post of duty and ending 60 days after arriving at the new post of duty.

(7) A change, without a break in service or after a separation of 3 days or less, to part-time career employment as defined in 5 U.S.C. 3401(2) and 5 CFR part 340, subpart B, or a change from such part-time career employment to full-time employment that entitles the employee to the full Government contribution.

(i) *Loss of coverage under this part or under another group insurance plan.* An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee or an eligible family member of the employee loses coverage under this part or another group health benefits plan. Except as otherwise provided, an employee must enroll or change the enrollment within the period beginning 31 days before the date of loss of coverage, and ending 60 days after the date of loss of coverage. Losses of coverage include, but are not limited to—

(1) Loss of coverage under another FEHB enrollment due to the termination, cancellation, or a change to self plus one or to self only, of the covering enrollment.

(2) Loss of coverage under another federally-sponsored health benefits program.

(3) Loss of coverage due to the termination of membership in an employee organization sponsoring or underwriting an FEHB plan.

(4) Loss of coverage due to the discontinuance of an FEHB plan in whole or in part. For an employee who loses coverage under this paragraph (i)(4):

(i) If the discontinuance is at the end of a contract year, the employee must change the enrollment during the open season, unless OPM establishes a different time. If the discontinuance is at a time other than the end of the contract year, OPM must establish a time and effective date for the employee to change the enrollment.

(ii) If the whole plan is discontinued, an employee who does not change the enrollment within the time set in (i)(4)(i) of this section will be enrolled in the lowest-cost nationwide plan option, as defined in paragraph (n) of this section;

(iii) If one or more options of a plan are discontinued, an employee who does not change the enrollment will be enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP).

(iv) If the discontinuance of the plan, whether permanent or temporary, is due to a disaster, an employee must change the enrollment within 60 days of the disaster, as announced by OPM.

If an employee does not change the enrollment within the time frame announced by OPM, the employee will be enrolled in the lowest-cost nationwide plan option, as defined in paragraph (n) of this section. The effective date of enrollment changes under this provision will be set by OPM when it makes the announcement allowing such changes;

(v) An employee who is unable, for causes beyond his or her control, to make an enrollment change within the 60 days following a disaster and is, as a result, enrolled in the lowest-cost nationwide plan as defined in paragraph (n) of this section, may request a belated enrollment into the plan of his or her choice subject to the requirements of paragraph (c) of this section;

(5) Loss of coverage under the Medicaid program or similar State-sponsored program of medical assistance for the needy.

(6) Loss of coverage under a non-Federal health plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee. An employee may enroll or change the enrollment within the period beginning 31 days before the date the employee leaves employment in the old commuting area and ending 180 days after entry on duty at place of employment in the new commuting area.

(7) Loss of coverage under a non-Federal health plan.

(j) *Move from comprehensive medical plan's area.* An employee in a comprehensive medical plan who moves or becomes employed outside the geographic area from which the plan accepts enrollments, or if already outside this area, moves or becomes employed further from this area, may change the enrollment upon notifying the employing office of the move or change of place of employment. Similarly, an employee whose covered family member moves outside the geographic area from which the plan accepts enrollments, or if already outside this area, moves further from this area, may change the enrollment upon notifying the employing office of the family member's move. The change of enrollment takes effect on the first day of the pay period that begins after the employing office receives an appropriate request.

(k) *On becoming eligible for Medicare.* An employee may change the enrollment from one plan or option to another at any time beginning on the 30th day before becoming eligible for coverage under title XVIII of the Social Security Act (Medicare). A change of enrollment based on becoming eligible for Medicare may be made only once.

(l) *Salary of temporary employee insufficient to pay withholdings.* If the salary of a temporary employee eligible under 5 U.S.C. 8906a is not sufficient to pay the withholdings for the plan in which the employee is enrolled, the employing office shall notify the employee of the plans available at a cost that does not exceed the employee's salary. The employee may enroll in another plan whose cost is no greater than his or her salary within 60 days after receiving such notification from the employing office. The change of enrollment takes effect immediately upon termination of the prior enrollment.

(m) *An employee or eligible family member becomes eligible for premium assistance under Medicaid or a State Children's Health Insurance Program (CHIP).* An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee or an eligible family member of the employee becomes eligible for premium assistance under a Medicaid plan or CHIP. An employee must enroll or change his or her enrollment within 60 days after the date the employee or family member is determined to be eligible for assistance.

(n) *Determination of lowest-cost nationwide plan option.* OPM will annually determine the lowest-cost nationwide plan option calculated based on the enrollee share of the cost of a self only enrollment. The plan option identified may not be a High Deductible Health Plan (HDHP) or an option from a health benefits plan that charges an association or membership fee. OPM reserves the right to designate an alternate plan for automatic enrollments if

OPM determines circumstances dictate this.

(o) *Pay status during a lapse in appropriations.* An employee, who is furloughed or excepted from furlough and working without pay as a result of a lapse in appropriations, is deemed to be in pay status, during the lapse, for purposes of this section.

(p) *Postal Service employees and Postal Service annuitants eligible to enroll only in PSHB plans.* After December 31, 2024, a Postal Service employee or Postal Service annuitant is not eligible to be enrolled in an FEHB plan but may only enroll in a PSHB plan in accordance with subpart P of this part.

[62 FR 38435, July 18, 1997; 62 FR 49557, Sept. 22, 1997, as amended at 65 FR 44646, July 19, 2000; 68 FR 56524, Oct. 1, 2003; 69 FR 56928, Sept. 23, 2004; 72 FR 1912, Jan. 17, 2007; 75 FR 76616, Dec. 9, 2010; 79 FR 62329, Oct. 17, 2014; 80 FR 55734, Sept. 17, 2015; 80 FR 65882, Oct. 28, 2015; 86 FR 17274, Apr. 2, 2021; 88 FR 20403, Apr. 6, 2023]

§ 890.302 Coverage of family members.

(a)(1) *Enrollment.* An enrollment for self plus one includes the enrollee and one eligible family member. An enrollment for self and family includes all family members who are eligible to be covered by the enrollment except as provided in § 890.308(h). Proof of family member eligibility may be required, and must be provided upon request, to the carrier, the employing office, or OPM. Except as provided in paragraph (a)(2) of this section, no employee, former employee, annuitant, child, or former spouse may enroll or be covered as a family member if they are already covered under another person's self plus one or self and family enrollment.

(2) *Dual enrollment.*—(i) *Prohibition on dual enrollment.* A dual enrollment exists when an individual is covered under more than one enrollment under this part. Dual enrollments are prohibited except when an eligible individual would otherwise not have access to coverage and the dual enrollment has been authorized by the employing office.

(ii) *Exception.* An individual described in paragraph (a)(2)(i) of this section may enroll if he or she or his or her eligible family members would otherwise not have access to coverage, in which case the individual may enroll in his or her own right for self only, self plus one, or self and family coverage, as appropriate. However, an eligible individual is entitled to receive benefits under only one enrollment regardless of whether he or she qualifies as a family member under a spouse's or parent's enrollment. To ensure that no person receives benefits under more than one enrollment, each enrollee must promptly notify the insurance carrier as to which person(s) will be covered under his or her enrollment. These individuals are not covered under the other enrollment. Examples include but are not limited to:

(A) To protect the interests of married or legally separated Federal employees, annuitants, and their children, an employee or annuitant may enroll in his or her own right in a self only, self plus one, or self and family enrollment, as appropriate, even though his or her spouse also has a self plus one or self and family enrollment if the employee, annuitant, or his or her children live apart from the spouse and would otherwise not have access to coverage due to a service area restriction and the spouse refuses to change health plans.

(B) When an employee who is under age 26 and covered under a parent's self plus one or self and family enrollment acquires an eligible family member, the employee may elect to enroll for self plus one or self and family coverage.

(iii) Children are entitled to receive benefits under only one enrollment regardless of whether the children qualify as family members under the enrollment of both parents or of a parent and a stepparent and regardless of whether the parents are married, unmarried, divorced, or legally separated. To ensure that no person receives benefits under more than one enrollment, each enrollee must promptly notify the insurance carrier as to which family members will be covered under his or her enrollment. These individuals are not covered under the other enrollment.

(b)(1) A child under the age of 26, or a child of any age who is incapable of self-support because of a mental or physical disability which existed before