continuation of health benefits coverage into retirement.

[52 FR 3, Jan. 2, 1987]

§ 890.109 Exclusion of certain periods of eligibility when determining continued coverage during retirement.

(a) Except as provided in paragraph (b) of this section, periods during which temporary employees are eligible under 5 U.S.C. 8906a to receive health benefits by enrolling and paying the full subscription charge, but are not eligible to participate in a retirement system, are not considered when determining eligibility for continued coverage during retirement. For the purpose of continuing coverage during retirement, an employee is considered to have enrolled at his or her first opportunity if the employee registered to be enrolled when he or she received a permanent appointment entitling him or her to participate in a retirement system and to receive the Government contribution toward the health benefits premium payments.

(b) A temporary employee eligible under 5 U.S.C. 8906a may continue enrollment as a compensationer if he or she has been enrolled or covered as a family member under another enrollment under this part for:

(1) The 5 years of service immediately preceding the commencement of his or her monthly compensation; or

(2) During all periods of service since his or her first opportunity to enroll, if less than 5 years. For the purpose of this paragraph, an employee is considered to have enrolled at his or her first opportunity if the employee registered to be enrolled when he or she first became eligible under 5 U.S.C. 8906a.

[58 FR 47824, Sept. 13, 1993]

§ 890.110 Enrollment reconciliation.

(a) Each employing office must report to each carrier or its surrogate on a quarterly basis the names of the individuals who are enrolled in the carrier's plan in a format and containing such information as required by OPM.

(b) The carrier must compare the data provided with its own enrollment records. When the carrier finds in its total enrollment records individuals whose names do not appear in the report from the employing office of record, the carrier must request the employing office to provide the documentation necessary to resolve the discrepancy.

[63 FR 59459, Nov. 4, 1998; 63 FR 64761, Nov. 23, 1998]

Subpart B—Health Benefits Plans

§ 890.201 Minimum standards for health benefits plans.

(a) To qualify for approval by OPM, a health benefits plan shall meet the following standards. Once approved, a health benefits plan shall continue to meet the minimum standards. Failure on the part of the carrier's plan to meet the standards is cause for OPM's withdrawal of approval of the plan in accordance with 5 CFR 890.204. A health benefits plan shall:

(1) Comply with chapter 89 of title 5, United States Code, and this part, as amended from time to time.

(2) Accept the enrollment, in accordance with this part, and without regard to age, race, sex, health status, or hazardous nature of employment, of each eligible employee, annuitant, former spouse, former employee, or child, except that a plan that is sponsored or underwritten by an employee organization may not accept the enrollment of a person who is not a member of the organization, but it may not limit membership in the organization on account of the prohibited factors (age, race, sex, health status, or hazardous nature of employment). The carrier may terminate the enrollment of an enrollee other than a survivor annuitant, a former spouse continuing coverage under § 890.803, or person continuing coverage under § 890.1103(a) (2) or (3), in a health benefits plan sponsored or underwritten by an employee organization on account of termination of membership in the organization. A carrier that wants to terminate the enrollment of an enrollee under this paragraph may do so by notifying the employing office in writing, with a copy of the notice to the enrollee. The termination is effective at the end of the pay period in which the employing office receives the notice. A comprehensive medical plan need not enroll an employee, annuitant, former employee,

former spouse, or child residing outside the geographic areas specified by the plan.

(3) Provide health benefits for each enrollee and covered family member wherever they may be.

(4) Provide for conversion to a contract for health benefits regularly offered by the carrier, or an appropriate affiliate, for group conversion purposes, which must be guaranteed renewable, subject to such amendments as apply to all contracts of this class, except that it may be canceled for fraud, overinsurance, or nonpayment of periodic charges. A carrier must permit conversion within the time allowed by the temporary extension of coverage provided under § 890.401 for each enrollee and covered family member entitled to convert. When an employing office gives an enrollee written notice of his or her privilege of conversion, the carrier must permit conversion at any time before 31 days after the date of notice or 91 days after the enrollment is terminated, whichever is earlier. Belated conversion opportunities as provided in § 890.401(c) must also be permitted by the carrier. When OPM requests an extension of time for conversion because of delayed determination of ineligibility for immediate annuity, the carrier must permit conversion until the date specified by OPM in its request for extension. On conversion, the contract becomes effective as of the day following the last day of the temporary extension, and the enrollee or covered family member, as the case may be, must pay the entire cost thereof directly to the carrier. The nongroup contract may not deny or delay any benefit covered by the contract for a person converting from a plan approved under this part except to the extent that benefits are continued under the health benefits plan from which he or she converts.

(5) Provide that each enrollee receive an identification card or cards or other evidence of enrollment.

(6) Provide a standard rate structure which contains, for each option, one standard individual rate, and one standard family rate.

(7) Maintain statistical records regarding the plan, separately from those of any other activities conducted or benefits offered by the carrier sponsoring or underwriting the plan.

(8) Provide for a special reserve for the plan. The carrier shall account for amounts retained by it as reserves for the plan separately from reserves maintained by it for other plans. The carrier shall invest the special reserve and income derived from the investment of the special reserve shall be credited to the special reserve. If the contract is terminated or approval of the plan is withdrawn, the carrier shall return the special reserve to the Employees Health Benefits Fund. However, in the case of a comprehensive medical plan, the carrier, without regard to the foregoing provisions of this paragraph, shall follow such financial procedures as are mutually agreed on by the carrier and OPM.

(9) Provide for continued enrollment to the end of the current pay period, or termination date, if earlier, of each enrollee enrolled at the effective date of termination of a contract. The carrier is entitled to subscription charges for this continued enrollment.

(10) Provide that any covered expenses incurred from January 1 to the effective date of an open season change count toward the losing carrier's prior year deductible. If the prior year deductible or family limit on deductibles of the losing carrier had previously been met, the enrolled individual (and eligible family members) shall be eligible for reimbursement by the losing carrier for covered expenses incurred during the current year. Reimbursement of covered expenses shall apply only to covered expenses incurred from January 1 to the effective date of the open season change. This section shall not apply to any other permissible changes made during a contract year.

(11) Except where OPM determines otherwise, have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan at some time during the preceding two contract terms.

(b) To be qualified to be approved by OPM and, once approved, to continue to be approved, a health benefits plan shall not:

(1) Deny a covered person a benefit provided by the plan for a service performed on or after the effective date of

coverage solely because of a pre-existing physical or mental condition.

(2) Require a waiting period for any covered person for benefits which it provides.

(3) Have more than two options and a high deductible health plan (26 U.S.C. 223(c)(2)(A).

(4) Have an initiation, service, enrollment, or other fee or charge in addition to the rate charged for the plan, except that a comprehensive medical plan may impose an additional charge to be paid directly by the enrollee for certain medical supplies and services, if the supplies and services on which additional charges are imposed are clearly set forth in advance and are applicable to all enrollees. This subparagraph does not apply to charges for membership in employee organizations sponsoring or underwriting plans.

(5) Paragraphs (b)(1) and (2) of this section do not preclude a plan offering benefits for dentistry or cosmetic surgery, or both, limited to conditions arising after the effective date of coverage.

(c) The Director or his or her designee will determine whether to propose withdrawal of approval of the plan and hold a hearing based on the seriousness of the carrier's actions and its proposed method to effect corrective action.

[33 FR 12510, Sept. 4, 1968, as amended at 43 FR 52460, Nov. 13, 1978; 47 FR 14871, Apr. 6, 1982; 49 FR 48905, Dec. 17, 1984; 52 FR 10217, Mar. 31, 1987; 54 FR 52336, Dec. 21, 1989; 55 FR 9108, Mar. 12, 1990; 55 FR 22891, June 5, 1990; 69 FR 31721, June 7, 2004]

§ 890.202 Minimum standards for health benefits carriers.

The minimum standards for health benefits carriers for the FEHB Program shall be those contained in 48 CFR subpart 1609.70.

[57 FR 14324, Apr. 20, 1992]

§ 890.203 Application for approval of, and proposal of amendments to, health benefit plans.

(a) *New plan applications.* (1) The Director of OPM shall consider applications to participate in the FEHB Program from comprehensive medical plans (CMP's) at his or her discretion. CMP's are automatically invited to submit applications annually to participate in the FEHB Program unless otherwise notified by OPM. If the Director should determine that it is not beneficial to the enrollees and the Program to consider applications for a specific contract year, OPM will publish a notice with a 60 day comment period in the FEDERAL REGISTER no less than 7 months prior to the date applications would be due for the specific contract year for which applications will not be accepted.

(2) When applications are considered, CMP's should apply for approval by writing to the Office of Personnel Management, Washington, DC 20415. Application letters must be accompanied by any descriptive material, financial data, or other documentation required by OPM. Plans must submit the letter and attachments in the OPM-specified format by January 31, or another date specified by OPM, of the year preceding the contract year for which applications are being accepted. Plans must submit evidence demonstrating they meet all requirements for approval by March 31 of the year preceding the contract year for which applications are being accepted. Plans that miss either deadline cannot be considered for participation in the next contract year. All newly approved plans must submit benefit and rate proposals to OPM by May 31 of the year preceding the contract year for which applications are being accepted in order to be considered for participation in that contract year. OPM may make counter-proposals at any time.

(3) OPM may approve such comprehensive medical plans as, in the judgment of OPM, may be in the best interest of enrollees in the Program. In addition to specific requirements set forth in 5 U.S.C. chapter 89, in chapter 1 and other relevant portions of title 48 of the Code of Federal Regulations, and in other sections of this part, to be approved, an applicant plan must actually be delivering medical care at the time of application; must be in compliance with applicable State licensing and operating requirements; must not be a Federal, State, local, or territorial governmental entity; and must not be debarred, suspended, or ineligible to participate in Government contracting