Subpart E—Standards for Uniform Plan and Carrier

§ 891.501 Standards for uniform plan.

The uniform plan shall be open to all eligible retired employees and members of their families, without regard to race, sex, health status, or age. It shall not deny or limit benefits because of any preexisting condition. It shall offer basic plus major medical coverage. It shall provide a 31-day extension of coverage on termination of subscription other than by change of election or termination of the contract. A person confined in hospital for care or treatment on the 31st day of the extension of coverage shall be entitled to continuation of the benefits of the contract during the continuance of the confinement, but not beyond the 60th day following the end of the extension of coverage. The uniform plan shall be experience-rated.

[33 FR 12516, Sept. 4, 1968, as amended at 43 FR 35018, Aug. 8, 1978]

§ 891.502 Standards for carrier of uniform plan.

In the most recent year for which data are available, the carrier of the uniform plan shall have made at least 1 percent of all group health insurance benefit payments in the United States. If the carrier is an insurance company, it must be licensed to issue group health insurance in all the States of the United States and the District of Columbia.

PART 892—FEDERAL FLEXIBLE BENEFITS PLAN: PRE-TAX PAYMENT OF HEALTH BENEFITS PREMIUMS

Subpart A—Administration and General Provisions

Subpart B—Eligibility and Participation

Subpart C—Contributions and Withholdings

Subpart D—Reemployed Annuitants and Survivor Annuitants

AUTHORITY: 5 U.S.C 8913; 5 U.S.C. 1103(a)(7); 26 U.S.C. 125; Sec. 892.101 also issued under sec. 311 of Pub. L. 111–3, 123 Stat. 64.

SOURCE: 65 FR 44646, July 19, 2000, unless otherwise noted.

Subpart A—Administration and General Provisions

§ 892.101 Definitions.

Days mean calendar days.

Dependent means a family member who is both eligible for coverage under the FEHB Program and either a dependent as defined in section 152 of the Internal Revenue Code or a child as defined in section 152(f)(1) of the Internal Revenue Code who is under age 27 as of the end of the employee's taxable year.

FEHB Program means the Federal Employees Health Benefits Program described in 5 U.S.C. 8901.

Open Season means the period of time each year as described in § 890.301(f) of this chapter when all individuals eligible for FEHB coverage have the opportunity to enroll or change their enrollment. These changes become effective with the first pay period that begins in the following year. For additional open seasons authorized by OPM, the effective date is specified.

OPM means the Office of Personnel Management.

Qualifying life event means an event that may permit changes to your FEHB enrollment as well as changes to your premium conversion election as described in Treasury regulations at 26 CFR 1.125–4. For purposes of determining whether a qualifying life event has occurred under this part, a stepchild who is the child of an employee's domestic partner as defined in part 890 of this chapter shall be treated as though the child were a dependent within the meaning of 26 CFR 1.125–4 even if the child does not so qualify under such Treasury regulations. Such events include the following:

(1) Change in family status that results in an increase or decrease in the number of eligible family members as follows:

(i) Marriage, divorce, annulment, legal separation;

(ii) Birth, adoption, acquiring a foster child that meets the definition in § 890.101(a) or a stepchild, issuance of a court order requiring an employee to provide coverage for a child;

(iii) Last dependent child loses coverage, for example, the child reaches age 26, disabled child becomes capable of self support, child acquires other coverage by court order; and

(iv) Death of a spouse or dependent.

(2) Any change in employment status that could result in entitlement to coverage; for example:

(i) Reemployment after a break in service of more than 3 days;

(ii) Return to pay status from nonpay status if employee previously elected to terminate coverage (if employee did not elect to terminate see § 892.101 (5);

(iii) Return to receiving pay sufficient to cover premium withholdings if coverage terminated;

(iv) Your spouse or dependent changes hours from either full-time to part-time status, or the reverse, which significantly affects their eligibility for coverage;

(v) Start or end of a period of unpaid leave of absence (leave without pay [LWOP], or other non-pay status) by you or your spouse. A period of unpaid leave is a continuous unpaid leave of absence of more than one pay period; and

(vi) Start or end of your spouse's employment that affects you or your spouse's eligibility for coverage.

(3) Any change in employment status that could affect the cost of insurance, including:

(i) Change from temporary appointment with eligibility for coverage under 5 U.S.C. 8906a to an appointment that permits receipt of government contribution; and

(ii) Change from full-time to part-time status or the reverse.

(4) An employee is restored to a civilian position after serving in uniformed services as described in § 890.304 (a)(vi)(vii).

(5) Start of non-pay status and end of non-pay status if employee did not terminate coverage (if coverage terminated see § 892.101 (2)(ii)).

(6) An employee enrolled in a health maintenance organization (HMO) or a covered family member moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already lives or works outside the area, moves further from this area.

(7) Transfer from a post of duty within the United States to a post of duty outside the United States, or the reverse.

(8) Separation from Federal employment when the employee or employee's spouse is pregnant.

(9) An employee becomes entitled to Medicare. (For change to self only, cancellation, or change in premium conversion status see § 892.101 (11)).

(10) An employee or eligible family member loses coverage under FEHB or another group insurance coverage including the following:

(i) Loss of coverage due to termination of membership in an employee organization sponsoring the FEHB plan;

(ii) Loss of coverage of employee or eligible family member due to discontinuance in whole or part of FEHB plan;

(iii) Loss of coverage under another Federally-sponsored health benefits program, including, TRICARE, Medicare, or Indian Health Service;

(iv) Loss of coverage under Medicaid or similar State-sponsored program of medical assistance for the needy; and

(v) Loss of coverage under a non-Federal health plan, including foreign, State or local government, or private sector group health plan as described in § 890.301 (i)(6).

(11) An employee or eligible family member gains coverage under FEHB or another group insurance plan, including the following:

(i) Another Federally-sponsored health benefits program, including, TRICARE, Medicare, or Indian Health Service;

(ii) Medicaid or similar State-sponsored program of medical assistance for the needy; and

(iii) A non-Federal health plan, including foreign, State or local government, or private sector group plan.

(12) A change in an employee's spouse or dependent's coverage options, for example:

(i) Employer starts offering a different type of coverage;

(ii) Employer stops offering the type of coverage that the employee's spouse or dependent has (if no other coverage is available);

(iii) A health maintenance organization (HMO) adds a geographic service area that now makes the employee's spouse eligible to enroll in that HMO;

(iv) Employee's spouse is enrolled in an HMO that removes a geographic area that makes the spouse ineligible for coverage under that HMO, but other health plans or options are available (if no other coverage is available see § 892.101 (10); and

(v) Change in the cost of coverage.

(13) 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 change his or her enrollment from self only to self and family, 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 a State Children's Health Insurance Program. 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.

[65 FR 44646, July 19, 2000, as amended at 68 FR 56527, Oct. 1, 2003; 75 FR 76616, Dec. 9, 2010; 78 FR 64878, Oct. 30, 2013]

§ 892.102 What is premium conversion and how does it work?

Premium conversion is a method of reducing your taxable income by the amount of your contribution to your FEHB insurance premium. If you are a participant in the premium conversion plan, Section 125 of the Internal Revenue Code allows you to reduce your salary (through an employer allotment) and provide that portion of your salary back to your employer. Instead of being paid to you as taxable income, this allotted amount is used to purchase your FEHB insurance for you. The effect is that your taxable income is reduced. Because taxable income is reduced, the amount of tax you pay is reduced. You save on Federal income tax, Social Security and Medicare tax and in most States and localities, State and local income taxes. There is one exception, however. If your FEHB enrollment covers a stepchild who is the child of a domestic partner as defined in part 890 of this chapter, and that stepchild does not qualify for favorable tax treatment under applicable tax laws, then the portion of the allotted amount described above that represents the employee's contribution toward the fair market value of FEHB coverage provided to the child will be separately imputed to the employee as income and subject to applicable taxes.

[65 FR 44646, July 19, 2000, as amended at 78 FR 64878, Oct. 30, 2013]