

from submitting the additional information.

(c) *Information required to process requests for reconsideration.* (1) The covered individual must put the request to the carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) *Carrier determinations.* The carrier must provide written notice to the covered individual of its determination. If the carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) *OPM review.* (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the carrier's notice to the covered individual that the denial was affirmed;

(ii) If the carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this section, within 120 days after the date of the covered individual's timely request for reconsideration by the carrier; or

(iii) Within 120 days after the date the carrier requests additional infor-

mation from the covered individual, or the date the covered individual is notified that the carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the carrier, OPM may:

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the carrier, the carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this section, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the carrier.

(5) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

[61 FR 15178, Apr. 5, 1996]

§ 890.106 Delegation of authority for resolving certain contract disputes.

For the purpose of making findings of fact and to the extent that conclusions of law may be required under any proceeding conducted in accordance with

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the provisions of the disputes clause included in health benefits contracts, OPM delegates this function to the Armed Services Board of Contract Appeals.

[40 FR 50023, Oct. 28, 1975; 40 FR 55829, Dec. 2, 1975. Redesignated at 44 FR 37895, June 29, 1979 and 45 FR 23637, Apr. 8, 1980]

§ 890.107 Court review.

(a) A suit to compel enrollment under § 890.102 must be brought against the employing office that made the enrollment decision.

(b) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(c) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (5 U.S.C. chapter 89). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute.

(d) An action under paragraph (c) of this section to recover on a claim for health benefits:

(1) May not be brought prior to exhaustion of the administrative remedies provided in § 890.105;

(2) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(3) Will be limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits.

[61 FR 15179, Apr. 5, 1996]

§ 890.108 Waiver of requirements for continued coverage during retirement.

(a) OPM may waive the eligibility requirements under 5 U.S.C. 8905(b) for health benefits coverage as an annuitant in the case of an individual who fails to satisfy such requirements if OPM, in its sole discretion, determines that, because of exceptional cir-

cumstances, it would be against equity and good conscience not to allow such individual to be enrolled as an annuitant in a health benefits plan under this part.

(b) OPM may grant a waiver as described in paragraph (a) of this section to an annuitant in rare and unusual circumstances if the annuitant shows by the preponderance of the evidence that—

(1) There is evidence demonstrating that the individual intended to be covered as an annuitant;

(2) The circumstance(s) that prevented the completion of the requirements of 5 U.S.C. 8905(b) was (were) essentially outside the individual's control; and

(3) The individual exercised due diligence in protecting the right to coverage as an annuitant.

(c) OPM will not grant a waiver solely because—

(1) An individual's retirement is based on disability or an involuntary separation; or

(2) An individual was misadvised (or not advised) by his or her employing office regarding the requirements for 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.