

§ 890.106

(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 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

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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 Will OPM waive requirements for continued coverage during retirement?

(a) Under 5 U.S.C. 8905(b), OPM may waive the eligibility requirements for health benefits coverage as an annuitant for an individual when, in its sole discretion, it determines that due to exceptional circumstances it would be against equity and good conscience not to allow a person to be enrolled in the FEHB Program as an annuitant.

(b) The individual's failure to satisfy the eligibility requirements must be due to exceptional circumstances. An individual requesting a waiver must provide OPM with evidence that:

(1) The individual intended to have FEHB coverage as an annuitant (retiree);

(2) The circumstances that prevented the individual from meeting the requirements of 5 U.S.C. 8905(b) were beyond the individual's control; and

(3) The individual acted reasonably to protect his or her right to continue coverage into retirement.

[72 FR 19100, Apr. 17, 2007]

§ 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 compensation 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 fol-

lowing 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