Family and Medical Leave Act, for performance of duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act of 1994, 38 U.S.C. 4301 et seq., for receiving medical treatment under Executive Order 5396 (Jul. 7 1930), and for periods during which workers compensation is received under the Federal Employees Compensation Act, 5 U.S.C. chapter 81.

(5) Each temporary employee who is initially eligible for FEHB coverage on the basis of this paragraph (j) is entitled to enroll in accordance with § 890.301(a). A temporary employee who is currently eligible under 5 U.S.C. 8906a (with no Government contribution) but who is not enrolled on November 17, 2014, and who would also meet eligibility requirements on the basis of paragraph (j), is entitled to enroll (with a Government contribution) on the basis of paragraph (j) in accordance with § 890.301(h)(4)(ii). A temporary employee who is enrolled under 5 U.S.C. 8906a (with no Government contribution) on November 17, 2014, and who would also meet eligibility requirements on the basis of paragraph (j), is entitled to change enrollment (with a Government contribution) on the basis of paragraph (j) in accordance with § 890.301(h)(4)(ii).

(k) The Director, upon written request of an employer of employees other than those covered by 5 U.S.C. 8901(1)(A), may, in his or her sole discretion, waive application of paragraph (j) of this section to its employees when the employer demonstrates to the Director that the waiver is necessary to avoid an adverse impact on the employer's need to manage its workforce. However, a Tribal employer participating under 25 U.S.C. 1647b may provide a written notification to the Director that it has chosen not to apply paragraph (j) of this section for its workforce.

[33 FR 12510, Sept. 4, 1968]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 890.102, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

§ 890.103 Correction of errors.

(a) The employing office may make prospective corrections of administrative errors as to enrollment at any time. The employing office may make retroactive corrections of administrative errors that occur after December 31, 1994.

(b) OPM may order correction of an administrative error upon a showing satisfactory to OPM that it would be against equity and good conscience not to do so.

(c) The employing office may make retroactive correction of enrollee enrollment code errors if the enrollee reports the error by the end of the pay period following the one in which he or she received the first written documentation (i.e. pay statement or enrollment change confirmation) indicating the error.

(d) OPM may order the termination of an enrollment in any comprehensive medical plan described in section 8903(4) of title 5, United States Code, and permit the individual to enroll in another health benefits plan for purposes of this part, upon a showing satisfactory to OPM that the furnishing of adequate medical care is jeopardized by a seriously impaired relationship between a patient and the comprehensive medical plan's affiliated health care providers.

(e) Retroactive corrections are subject to withholdings and contributions under the provisions of § 890.502.

[45 FR 23637, Apr. 8, 1980, as amended at 53 FR 2, Jan. 4, 1988; 54 FR 52336, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 59 FR 66437, Dec. 27, 1994; 62 FR 38435, July 18, 1997]

§ 890.104 Initial decision and reconsideration on enrollment.

(a) *Who may file.* Except as provided under § 890.1112, an individual may request an agency or retirement system to reconsider an initial decision of its employing office denying coverage or change of enrollment.

(b) *Initial employing office decision.* An employing office's decision is considered an initial decision as used in paragraph (a) of this section when rendered by the employing office in writing and stating the right to an independent level of review (reconsideration) by the agency or retirement system. However,

an initial decision rendered at the highest level of review available within OPM is not subject to reconsideration.

(c) *Reconsideration.* (1) A request for reconsideration must be made in writing, must include the claimant's name, address, date of birth, Social Security number, name of carrier, reason(s) for the request, and, if applicable, retirement claim number.

(2) The reconsideration review must be an independent review designated at or above the level at which the initial decision was rendered.

(d) *Time limit.* A request for reconsideration of an initial decision must be filed within 30 calendar days from the date of the written decision stating the right to a reconsideration. The time limit on filing may be extended when the individual shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit. An agency or retirement system decision in response to a request for reconsideration of an employing office's decision is a final decision as described in paragraph (e) of this section.

(e) *Final decision.* After reconsideration, the agency or retirement system must issue a final decision, which must be in writing and must fully set forth the findings and conclusions.

[59 FR 66437, Dec. 27, 1994]

§ 890.105 Filing claims for payment or service.

(a) *General.* (1) Each health benefits carrier resolves claims filed under the plan. All health benefits claims must be submitted initially to the carrier of the covered individual's health benefits plan. If the carrier denies a claim (or a portion of a claim), the covered individual may ask the carrier to reconsider its denial. If the carrier affirms its denial or fails to respond as required by paragraph (c) of this section, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the carrier and OPM review processes specified in this section before seeking judicial review of the denied claim.

(2) This section applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) *Time limits for reconsidering a claim.* (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the carrier in which to submit a written request for reconsideration to the carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the carrier's notice requesting additional information. The carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this section if the carrier fails to act within the time limit set forth in this paragraph (b)(2)(iii).

(3) The covered individual may write to OPM and request that OPM review the carrier's decision if the carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this section. The