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(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 information 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 Carrier entitlement to pursue subrogation and reimbursement recoveries.

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in

accordance with the terms of this section.

(b)(1) Any FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(2) Any health benefits plan contract that contains a subrogation or reimbursement clause shall provide that benefits and benefit payments are extended to a covered individual on the condition that the FEHB carrier may pursue and receive subrogation and reimbursement recoveries pursuant to the contract.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of 5 CFR 890.101 and is therefore not subject to the disputed claims process set forth at 5 CFR 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

[80 FR 29204, May 21, 2015]

§ 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.