office of SIPC. All submissions should refer to file number SIPC–96–1. Comments also may be submitted electronically at the following E–Mail address: rule-comments@sec.gov. All comment letters should refer to file number SIPC–96–1. This rule number should be included on the subject line if E-mail is used. Electronically submitted comment letters will be posted on the Commission's Internet web site (http://www.sec.gov).

FOR FURTHER INFORMATION CONTACT: Michael A. Macchiaroli, Associate Director, 202/942–0131, Peter R. Geraghty, Assistant Director, 202/942–0177, or Louis A. Randazzo, Special Counsel, 202/942–0191, Division of Market Regulation, Securities and Exchange Commission, 450 Fifth Street, NW, Washington, DC 20549.

SUPPLEMENTARY INFORMATION: Pursuant to Section 3(e)(2)(A) of SIPA,[4] notice is hereby given that SIPC filed with the Securities and Exchange Commission on October 10, 1996, the proposed rule change as described in Item I below, which item has been prepared primarily by SIPC. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. SIPC's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, SIPC included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified above. SIPC has prepared the following summary of the purpose of and statutory basis for the proposed rule change.[5]

Section 8(e) of SIPA requires SIPC to adopt rules with respect to the closeout of contracts with a debtor for the purchase or sale of securities in the ordinary course of its business.[6] The purpose of the proposed rule change is to amend SIPC's Series 300 Rules, which address the closeout or completion of contracts for the purchase or sale of securities made by debtors in a liquidation under SIPA with other brokers or dealers, to be consistent with Commission Rule 15c6–1.[7] Rule 15c6–1, which became effective in June of 1995,[8] establishes three business days as the standard settlement timeframe for most securities transactions.[9] The adoption of a three business day settlement timeframe affected SIPC Rules 300 and 301, which currently refer to a five business day settlement timeframe.[10] Because Rule 15c6–1 does not affect SIPC Rules 302 through 307, SIPC does not propose to amend these rules. The proposed rule change also makes a technical correction to conform a statutory citation in Rule 300 to the correct section SIPA.[11]

II. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within thirty-five days of the date of publication of this notice in the Federal Register, or within such longer period (i) as the Commission may designate up to ninety days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which SIPC consents, the Commission will:

(A) By order approve such proposed rule change or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

To allow public access to SIPC's rules, SIPC rules that are approved by the Commission are published under Part 300 of 17 CFR Chapter II.

III. Statutory Analysis

Pursuant to SIPA and particularly Section 3(e),[12] SIPC proposes to amend 300.300 and 300.301 of Title 17 of the Code of Federal Regulations in the manner set forth below.

IV. List of Subjects in 17 CFR Part 300

Brokers, Securities, Securities Investor Protection Corporation.

In accordance with the foregoing, Title 17, Chapter II of the Code of Federal Regulations is proposed to be amended as follows:

PART 300—RULES OF THE SECURITIES INVESTOR PROTECTION CORPORATION

1. The authority citation for part 300 continues to read as follows:

Authority: Section 3, 84 Stat. 1636, as amended; 15 U.S.C. 78ccc.

§ 300.300 [Amended]

2. Section 300.300 is proposed to be amended by removing the reference to ''section 16(8)'' and adding ''section 16(7)'' in paragraph (a), and removing the reference to ''five business days'' and adding ''three business days'' in paragraph (c).

§ 300.301 [Amended]

3. Section 300.301 is proposed to be amended by removing the references to ''five business days'' and adding ''three business days'' in paragraphs (a)(2)(i) and (a)(2)(ii).

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[13]

Dated: October 25, 1996.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 96–28007 Filed 10–31–96; 8:45 am]

BILLING CODE 8010–01–M

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AE64

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: This document proposes to amend regulations concerning medical care for survivors and dependents of certain veterans, hereinafter referred to as the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). These proposed regulations would establish basic policies and procedures governing the

[4] 15 U.S.C. 78ccc(e)(2)(A) (1995).

[5] The Commission has modified the language in this section.

[6] 15 U.S.C. 78ccc(8)(e) (1995).

[7] 17 CFR 240.15c6–1 (1996).

[8] *See* Securities Exchange Act Release No. 33023 (October 6, 1993), 58 FR 52891 (October 13, 1993).

[9] Specifically, Rule 15c6–1 provides, among other things, that a broker-dealer shall not effect or enter into a contract for the purchase or sale of a security that provides for payment of funds and delivery of securities later than the third business day after the date of the contract unless otherwise expressly agreed to by the parties at the time of the transaction. Prior to the effective date of Rule 15c6–1, the settlement cycle for securities transactions was five business days. *See* Release No. 33023, *supra* note 8.

[10] In order to remain consistent with the Commission's three business day settlement timeframe, SIPC proposes to amend the term ''open contractual commitment'' in Rule 300(c) by replacing the reference to five business days with three business days. Specifically, Rule 300(c) is proposed to be amended, in part, to provide that the term ''open contractual commitment'' means a failed to receive or a failed to deliver which had a settlement date prior to the filing date and the respective obligations of the parties remained outstanding on the filing date or had a settlement date which occurs on or within three business days subsequent to the filing date. In addition, SIPC proposes to amend Rule 301 by replacing the references to five business days with three business days.

[11] SIPC proposes to amend Rule 300(a) by replacing the reference to section 16(8) of SIPA with section 16(7) of SIPA.

[12] U.S.C. 78ccc(3)(e) (1995).

[13] 17 CFR 200.30–3(f)(3) (1996).

administration of the CHAMPVA program, including CHAMPVA claims processing procedures and a description of benefits and services.

DATES: Comments must be received on or before December 31, 1996.

ADDRESSES: Mail or hand deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW, Room 1154, Washington, DC 20420. Comments should indicate that they are submitted in response to ''RIN 2900–AE64.'' All written comments will be available for public inspection at the above address in the Office of Regulations Management, Room 1158, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays).

FOR FURTHER INFORMATION CONTACT: Susan Schmetzer, Health Administration Center (formerly CHAMPVA Center), P.O. Box 65023, Denver, CO 80206–5023, at (303) 331–7552. (This is not a toll-free number).

SUPPLEMENTARY INFORMATION: The provisions of 38 U.S.C. 1713 authorize VA to provide medical care to the dependents and survivors of certain veterans ''in the same or similar manner and subject to the same or similar limitations'' as medical care is furnished by the Department of Defense (DoD) to certain dependents and survivors of active duty and retired members of the Armed Forces under 10 United States Code, Chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This document proposes to amend VA regulations to include CHAMPVA claims processing procedures.

It is also noted that during the past several years VA has made changes with respect to CHAMPVA claims processing services. Previously, VA had an agreement with DoD to contract with commercial claims processors (fiscal intermediaries) for the processing of VA claims. However, in an effort to both contain costs and to improve services to the beneficiaries, VA now conducts its own claims processing services and has consolidated the operations in Denver, Colorado.

The Secretary hereby certifies that these regulatory amendments would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. § 601–612. These amendments would not cause significant economic impact on health care providers, suppliers, or entities since only a small portion of their business concerns CHAMPVA beneficiaries. The proposed rule would mostly impact individuals who are VA beneficiaries. Pursuant to 5 U.S.C. 605(b), these amendments are exempt from the initial and final regulatory flexibility analyses requirements of sections 603 and 604.

The Catalog of Federal Domestic Assistance Program numbers are 64.009, 64.010, 64.011.

Lists of Subjects in 38 CFR Part 17

Alcoholism, Claims, Dental services, Drug abuse, Foreign relations, Government contracts, Grant programs-Health, Health care, Health facilities, Health professions, Medical devices, Medical research, Mental health programs, Nursing home care, Philippines, Veterans.

Approved

Jesse Brown,

Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 17 is proposed to be amended as set forth below:

PART 17—MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, 1721, unless otherwise noted.

2. Section 17.84 is removed.

3. A new center heading consisting of §§ 17.270–17.278 is added to read as follows:

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)—Medical Care for Survivors and Dependents of Certain Veterans

Sec.

§ 17.270 General Provisions.

(a) CHAMPVA is the Civilian Health and Medical Program of the Department of Veterans Affairs. Pursuant to 38 U.S.C. 1713, VA is authorized to provide medical care in the same or similar manner and subject to the same or similar limitations as medical care furnished to certain dependents and survivors of active duty and retired members of the Armed Forces. The CHAMPVA program is designed to accomplish this purpose. Under CHAMPVA, VA shares the cost of medically necessary services and supplies for eligible beneficiaries as set forth below.

(b) For purposes of this section, the definitions of ''child,'' ''service-connected condition/disability,'' ''spouse,'' and ''surviving spouse'' shall be those set forth further in 38 U.S.C. 101. The term ''fiscal'' year refers to October 1, through September 30.

(Authority: 38 U.S.C. 1713)

§ 17.271 Eligibility.

(a) The following persons are eligible for CHAMPVA benefits provided that they are not eligible for CHAMPUS or Medicare Part A (except as noted in 17.271).

(1) The spouse or child of a veteran who has been adjudicated by VA as having a permanent and total service-connected disability;

(2) The surviving spouse or child of a veteran who died as a result of an adjudicated service-connected condition(s); or who, at the time of death, was adjudicated permanently and totally disabled from a service-connected condition(s);

(3) The surviving spouse or child of a person who died on active military service and in the line of duty and not due to such person's own misconduct; and

(4) An eligible child who is pursuing a full-time course of instruction approved under 38 U.S.C. Chapter 36, and who incurs a disabling illness or injury while pursuing such course (between terms, semesters or quarters; or during a vacation or holiday period) which is not the result of his or her own willful misconduct and which results in the inability to continue or resume the chosen program of education shall remain eligible for medical care until:

(i) the end of the six-month period beginning on the date the disability is removed; or

(ii) the end of the two-year period beginning on the date of the onset of the disability; or

(iii) the twenty-third birthday of the child, whichever occurs first.

(Authority: 38 U.S.C. 1713)

(b) Persons who lose eligibility for CHAMPVA by becoming potentially eligible for Medicare Part A as a result of reaching age 65 or who qualify for Medicare Part A benefits on the basis of a disability, including end stage renal disease, may re-establish CHAMPVA eligibility by submitting documentation from the Social Security Administration (SSA) certifying their non-entitlement to or exhaustion of Medicare Part A benefits. Persons under age 65 who are enrolled in both Medicare Part A and B

may become potentially eligible for CHAMPVA as a secondary payer to Medicare. In cases where CHAMPVA eligibility is restored upon exhaustion of Medicare benefits, CHAMPVA coverage will extend even during subsequent periods of Medicare eligibility. When both CHAMPVA and Medicare eligibility exist, CHAMPVA shall be the secondary payer.

(Authority: 38 U.S.C. 1713(d))

§ 17.272 Benefits Limitations/Exclusions.

(a) Benefits cover allowable expenses for medical services and supplies that are medically necessary and appropriate for the treatment of a condition and that are not specifically excluded from program coverage. Covered benefits may have limitations. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the charge an allowable expense, even though it is not listed specifically as an exclusion. The following are specifically excluded from program coverage:

(1) Services, procedures or supplies for which the beneficiary has no legal obligation to pay, or for which no charge would be made in the absence of coverage under a health benefits plan.

(2) Services and supplies required as a result of an occupational disease or injury for which benefits are payable under workers' compensation or similar protection plan (whether or not such benefits have been applied for or paid) except when such benefits are exhausted and are otherwise not excluded from CHAMPVA coverage.

(3) Services and supplies that are paid directly or indirectly by a local, state or Federal government agency (Medicaid excluded), including court-ordered treatment.

(4) Services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered condition (including mental disorder) or injury.

(5) Radiology, laboratory, and pathological services and machine diagnostic testing not related to a specific illness or injury or a definitive set of symptoms.

(6) Services and supplies above the appropriate level required to provide necessary medical care.

(7) Services and supplies related to an inpatient admission primarily to perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis.

(8) Postpartum inpatient stay of a mother for purposes of staying with the newborn infant (primarily for the purpose of breast feeding the infant) when the infant (but not the mother) requires the extended stay; or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (but not the newborn infant) requires extended postpartum inpatient stay.

(9) Therapeutic absences from an inpatient facility or residential treatment center (RTC).

(10) Custodial care.

(11) Inpatient stays primarily for domiciliary care purposes.

(12) Inpatient stays primarily for rest or rest cures.

(13) Services and supplies provided as a part of, or under, a scientific or medical study, grant, or research program.

(14) Services and supplies not provided in accordance with accepted professional medical standards or related to experimental or investigational procedures or treatment regimens.

(15) Services or supplies prescribed or provided by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household.

(16) Services and supplies that are (or are eligible to be) payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare.

(17) Service or supplies subject to preauthorization (see § 17.273) which were obtained without the required preauthorization; and services and supplies which were not provided according to the terms of the preauthorization.

(18) Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

(19) Services and supplies in connection with cosmetic surgery.

(20) Electrolysis.

(21) Dental care with the following exceptions:

(i) Dental care that is medically necessary in the treatment of an otherwise covered medical condition is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition.

(ii) Dental care required in preparation for, or as a result of, radiation therapy for oral or facial cancer.

(iii) Gingival Hyperplasia.

(iv) Loss of jaw substance due to direct trauma to the jaw or due to treatment of neoplasm.

(v) Intraoral abscess when it extends beyond the dental alveolus.

(vi) Extraoral abscess.

(vii) Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.

(viii) Repair of fracture, dislocation, and other injuries of the jaw, to include removal of teeth and tooth fragments only when such removal is incidental to the repair of the jaw.

(ix) Treatment for stabilization of myofascial pain dysfunction syndrome, also referred to as temporomandibular joint (TMJ) syndrome. Authorization is limited to initial radiographs, up to four office visits, and the construction of an occlusal splint.

(x) Total or complete ankyloglossia.

(xi) Adjunctive dental and orthodontic support for cleft palate.

(xii) Prosthetic replacement of jaw due to trauma or cancer.

(22) Nonsurgical treatment of obesity or morbid obesity for dietary control or weight reduction (with the exception of gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity when determined to be medically necessary).

(23) Services and supplies related to transsexualism or other similar conditions such as gender dysphoria (including, but not limited to, intersex surgery and psychotherapy, except for ambiguous genitalia which was documented to be present at birth).

(24) Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sexual deviations (e.g., transvestic fetish), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies.

(25) Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes.

(26) Services and supplies, to include psychological testing, provided in connection with a specific developmental disorder. The following exception applies: Diagnostic and evaluative services required to arrive at a differential diagnosis for an otherwise eligible child unless the state is required to provide those services under Public Law 94–142, *Education for All Handicapped Children Act of 1975 as amended, See 20 U.S.C. Chapter 33.*

(27) Surgery to reverse voluntary surgical sterilization procedures.

(28) Services and supplies related to artificial insemination (including semen donors and semen banks), in vitro fertilization, gamete intrafallopian

transfer and all other noncoital reproductive technologies.

(29) Nonprescription contraceptives.

(30) Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child.

(31) Preventive care (such as routine, annual, or employment-requested physical examinations; routine screening procedures; and immunizations). The following exceptions apply:

(i) Well-baby care from birth to the age of two years, including newborn examination, phenylketonuria (PKU) testing and newborn circumcision.

(ii) Rabies vaccine following an animal bite.

(iii) Tetanus vaccine following an accidental injury.

(iv) Rh immune globulin.

(v) Pap smears.

(vi) Mammography tests.

(vii) Genetic testing and counseling determined to be medically necessary.

(viii) Chromosome analysis in cases of habitual abortion or infertility.

(ix) Gamma globulin.

(32) Chiropractic and naturopathic services.

(33) Counseling services that are not medically necessary in the treatment of a diagnosed medical condition (such as educational counseling; vocational counseling; and counseling for socioeconomic purposes, stress management, life style modification, etc.).

(34) Acupuncture, whether used as a therapeutic agent or as an anesthetic.

(35) Hair transplants, wigs, or hairpieces, except that benefits may be extended for one wig or hairpiece per beneficiary (lifetime maximum) when the attending physician certifies that alopecia has resulted from treatment of malignant disease and the beneficiary certifies that a wig or hairpiece has not been obtained previously through the U.S. Government (including the Department of Veterans Affairs). The wig or hairpiece benefit does not include coverage for the following:

(i) Maintenance, wig or hairpiece supplies, or replacement of the wig or hairpiece.

(ii) Hair transplant or any other surgical procedure involving the attachment of hair or a wig or hairpiece to the scalp.

(iii) Any diagnostic or therapeutic method or supply intended to encourage hair growth.

(36) Self-help, academic education or vocational training services and supplies.

(37) Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club membership or other such charges or items.

(38) General exercise programs, even if recommended by a physician.

(39) Services of an audiologist or speech therapist, except when prescribed by a physician and rendered as a part of treatment addressed to the physical defect itself and not to any educational or occupational deficit.

(40) Eye exercises or visual training (orthoptics).

(41) Eye and hearing examinations except when rendered in connection with medical or surgical treatment of a covered illness or injury or in connection with well-baby care.

(42) Eyeglasses, spectacles, contact lenses, or other optical devices with the following exceptions:

(i) When necessary to perform the function of the human lens, lost as a result of intraocular surgery, ocular injury or congenital absence.

(ii) Pinhole glasses prescribed for use after surgery for detached retina.

(iii) Lenses prescribed as ''treatment'' instead or surgery for the following conditions:

(A) Contact lenses used for treatment of infantile glaucoma.

(B) Corneal or scleral lenses prescribed in connection with treatment of keratoconus.

(C) Scleral lenses prescribed to retain moisture when normal tearing is not present or is inadequate.

(D) Corneal or scleral lenses prescribed to reduce a corneal irregularity other than astigmatism.

(iv) The specified benefits are limited to one set of lenses related to one qualifying eye condition as set forth in (iii)(A–D) of this Section. If there is a prescription change requiring a new set of lenses, but still related to the qualifying eye condition, benefits may be extended for a second set of lenses, subject to medical review.

(43) Hearing aids or other auditory sensory enhancing devices.

(44) Prostheses with the following exceptions:

(i) Artificial limbs and eyes, or items inserted surgically in the body as an integral part of a surgical procedure.

(ii) Dental prostheses specifically required in connection with otherwise covered orthodontia directly related to the surgical correction of a cleft palate anomaly.

(45) Orthopedic shoes, arch supports, shoe inserts, and other supportive devices for the feet, including custom-made built-up shoes, or regular shoes later built up with the following exception: Shoes that are an integral part of an orthopedic brace and which cannot be used separately from the brace are covered.

(46) Services or advice rendered by telephone or other telephonic device, including remote monitoring, except for transtelephonic monitoring of cardiac pacemakers.

(47) Air conditioners, humidifiers, dehumidifiers, and purifiers.

(48) Elevators or wheelchair lifts.

(49) Alterations to living spaces or permanent features attached thereto, even when necessary to accommodate installation of covered durable medical equipment or to facilitate entrance or exit.

(50) Items of clothing, even if required by virtue of an allergy (such as cotton fabric versus synthetic fabric and vegetable-dyed shoes).

(51) Food, food substitutes, vitamins or other nutritional supplements, including those related to prenatal care for a home patient whose condition permits oral feeding.

(52) Enuretic (bed-wetting) devices; enuretic conditioning programs.

(53) Autopsy and post-mortem examinations.

(54) All camping, even when organized for a specific therapeutic purpose (such as diabetic camp or a camp for emotionally disturbed children), or when offered as a part of an otherwise covered treatment plan.

(55) Housekeeping, homemaker, or attendant services, including a sitter or companion.

(56) Personal comfort or convenience items, such as beauty and barber services, radio, television, and telephone.

(57) Smoking cessation services and supplies.

(58) Megavitamin psychiatric therapy; orthomolecular psychiatric therapy.

(59) All transportation except for specialized transportation with life sustaining equipment, when medically required for the treatment of a covered condition.

(60) Inpatient mental health services in excess of 30 days in any fiscal year (or in an admission), in the case of a patient 19 years of age or older; 45 days in any fiscal year (or in an admission), in the case of a patient under 19 years of age; or 150 days of residential treatment care in any fiscal year (or in an admission), unless a waiver for extended coverage is granted in advance.

(61) Outpatient mental health services in excess of 23 visits in a fiscal year, unless a waiver for extended coverage is granted in advance.

(62) Institutional services for partial hospitalization in excess of 60 treatment days in any fiscal year (or in an admission), unless a waiver for extended coverage is granted in advance.

(63) Detoxification in a hospital setting or rehabilitation facility in excess of seven days.

(64) Outpatient substance abuse services in excess of 60 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(65) Family therapy for substance abuse in excess of 15 visits during a benefit period. A benefit period begins with the first date of covered service and ends 365 days later.

(66) Services that are provided to a beneficiary who is referred to a provider of such services by a provider who has an economic interest in the facility to which the patient is referred, unless a waiver is granted.

(67) Abortion, except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term.

(68) Abortion counseling.

(69) Aversion therapy.

(70) Rental or purchase of biofeedback equipment.

(71) Biofeedback therapy for treatment of ordinary muscle tension states (including tension headaches) or for psychosomatic conditions.

(72) Drug maintenance programs where one addictive drug is substituted for another, such as methadone substituted for heroin.

(73) Immunotherapy for malignant diseases, except for treatment of Stage O and Stage A carcinoma of the bladder.

(74) Services and supplies provided by other than a hospital, such as nonskilled nursing homes, intermediate care facilities, halfway houses, homes for the aged, or other institutions of similar purpose.

(75) Services performed when the patient is not physically present.

(76) Medical photography.

(77) Special tutoring.

(78) Surgery for psychological reasons.

(79) Treatment of premenstrual syndrome (PMS).

(80) Medications not requiring a prescription, except for insulin.

(81) Thermography.

(82) Removal of tattoos.

(83) Penile implant/testicular prosthesis procedures and related supplies for psychological impotence.

(84) Dermabrasion of the face.

(85) Chemical peeling for facial wrinkles.

(86) Panniculectomy, body sculpting procedures.

(b) CHAMPVA-determined allowable amount.

(1) The term allowable amount is the maximum CHAMPVA-determined level of payment to a hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider for covered services. The CHAMPVA-allowable amount is determined prior to cost sharing and the application of deductibles and/or other health insurance.

(2) A Medicare-participating hospital must accept the CHAMPVA-determined allowable amount for inpatient services as payment-in-full. (Reference 42 CFR Parts 489 and 1003).

(3) An authorized provider of covered medical services or supplies shall accept the CHAMPVA-determined allowable amount as payment-in-full.

(4) A provider who has collected and not made an appropriate refund, or attempts to collect from the beneficiary, any amount in excess of the CHAMPVA-determined allowable amount may be subject to exclusion from Federal benefit programs.

(Authority: 38 U.S.C. 1713)

§ 17.273 Preauthorization.

(a) Preauthorization or advance approval is required for any of the following:

(1) Non-emergent inpatient mental health and substance abuse care, including admission of emotionally disturbed children and adolescents to residential treatment centers.

(2) All admissions to a partial hospitalization program (including alcohol rehabilitation).

(3) Outpatient mental health visits in excess of 23 per calendar year and/or more than two (2) sessions per week.

(4) Dental care.

(5) Durable medical equipment with a purchase price in excess of $300.00.

(6) Organ transplants.

(Authority: 38 U.S.C. 1713)

§ 17.274 Cost sharing.

(a) With the exception of services obtained directly from VA medical facilities, CHAMPVA is a cost-sharing program in which the cost of covered services is shared with the beneficiary. In addition to the beneficiary cost share, an annual (calendar year) outpatient deductible requirement ($50 per beneficiary or $100 per family) must be satisfied prior to the payment of outpatient benefits. There is no deductible for inpatient services. CHAMPVA pays the CHAMPVA-determined allowable amount less the deductible, if applicable, and less the beneficiary cost share. To provide financial protection against the impact of a long-term illness or injury, an annual cost limit or ''catastrophic cap'' has been placed on the beneficiary cost-share amount for covered services and supplies. This annual cap on cost sharing is $7,500 per CHAMPVA-eligible family. Credits to the annual catastrophic cap are limited to the applied annual deductible(s) and the beneficiary cost-share amount. Costs above the CHAMPVA-allowable amount, as well as costs associated with noncovered services, are not credited to the catastrophic cap computation.

(b) If the CHAMPVA benefit payment is under $1.00, payment will not be issued. Catastrophic cap and deductible will, however, be credited.

(Authority: 38 U.S.C. 1713)

§ 17.275 Claim filing deadline.

(a) Unless an exception is granted under paragraph (b) of this subsection, claims for medical services and supplies must be filed with the Center no later than:

(1) One year after the date of service; or

(2) In the case of inpatient care, one year after the date of discharge; or

(3) In the case of retroactive approval for medical services/supplies, 180 days following beneficiary notification of authorization; or

(4) In the case of retroactive approval of CHAMPVA eligibility, 180 days following notification to the beneficiary of authorization for services occurring on or after the date of first eligibility.

(b) Requests for an exception to the claim filing deadline must be submitted, in writing, to the Center and include a complete explanation of the circumstances resulting in late filing along with all available supporting documentation. Each request for an exception to the claim filing deadline will be reviewed individually and considered on its own merit. The Center Director may grant exceptions to the requirements in paragraph (a) if he or she determines that there was good cause for missing the filing deadline. For example, when dual coverage exists, the CHAMPVA allowable amount cannot be determined until after the primary insurance carrier has adjudicated the claim. In such circumstances an exception may be granted provided that the delay on the part of the primary insurance carrier is not attributable to the beneficiary. Delays due to provider billing procedures do not constitute a valid basis for an exception.

§ 17.276 Appeal/review process.

Notice of the initial determination regarding payment of CHAMPVA benefits will be provided to the beneficiary on a CHAMPVA

Explanation of Benefits (EOB) form. The EOB form is generated by the CHAMPVA automated payment processing system. If a beneficiary disagrees with the determination concerning covered services or calculation of benefits, he or she may request reconsideration. Such requests must be submitted to the Center in writing within one year of the date of the initial determination. The request must state why the beneficiary believes the decision is in error and must include any new and relevant information not previously considered. Any request for reconsideration that does not identify the reason for dispute will be returned to the claimant without further consideration. After reviewing the claim and any relevant supporting documentation, a CHAMPVA benefits advisor will issue a written determination to the beneficiary that affirms, reverses or modifies the previous decision. If the beneficiary is still dissatisfied, within 30 days of the date of the decision he or she may make a written request for review by the Center Director. The Director will review the claim and any relevant supporting documentation and issue a decision in writing that affirms, reverses or modifies the previous decision. The decision of the Director with respect to benefit coverage and computation of benefits is final.

(Authority: 38 U.S.C. 1713)

Note: Denial of CHAMPVA benefits based on legal eligibility requirements may be appealed to the Board of Veterans Appeals in accordance with 38 C.F.R. Part 20. Medical determinations are not appealable to the Board. 20 C.F.R. § 20.101.

§ 17.277 Third Part Liability/Medicare Cost Recovery.

The Center will actively pursue third party liability/medical care cost recovery in accordance with 38 CFR 1.900, *et seq.*

§ 17.278 Confidentiality of records.

Confidentiality of records will be maintained in accordance with 38 CFR 1.500, *et seq.*

[FR Doc. 96–27668 Filed 10–31–96; 8:45 am]

BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[CA 126–0011b; FRL–5616–7]

Approval and Promulgation of State Implementation Plans; California State Implementation Plan Revision; Mojave Desert Air Quality Management District; South Coast Air Quality Management District

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to approve revisions to the California State Implementation Plan (SIP) which control oxides of nitrogen (NO_X) from boilers and process heaters, internal combustion engines, residential water heaters, and gas turbines. The intended effect of proposing approval of these rules is to regulate emissions of NO_X in accordance with the requirements of the Clean Air Act, as amended in 1990 (CAA or the Act). In the Rules section of this Federal Register, EPA is approving the State's SIP revision as a direct final rule without prior proposal because the Agency views this as a noncontroversial action and anticipates no adverse comments. A detailed rationale for this approval is set forth in the direct final rule. If no adverse comments are received in response to this proposed action, no further activity is contemplated in relation to this action. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. The EPA will not institute a second comment period on this document. Any parties interested in commenting on this action should do so at this time.

DATES: Comments on this proposed rule must be received in writing by December 2, 1996.

ADDRESSES: Written comments on this action should be addressed to: Daniel A. Meer, Rulemaking Section (A–5–3), Air and Toxics Division, U.S. Environmental Protection Agency, Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Copies of the rules and EPA's evaluation report of each rule are available for public inspection at EPA's Region IX office during normal business hours. Copies of the submitted rules are also available for inspection at the following locations:

Environmental Protection Agency, Air Docket (6102), 401 ''M'' Street, SW., Washington, DC 20460.

California Air Resources Board, Stationary Source Division, Rule Evaluation Section, 2020 ''L'' Street, Sacramento, CA 95814.

Mojave Desert Air Quality Management District, 15428 Civic Drive, Suite 200, Victorville, CA 92392.

South Coast Air Quality Management District, 21865 E. Copley Drive, Diamond Bar, CA 91765–4182.

FOR FURTHER INFORMATION CONTACT: Mae Wang, Rulemaking Section (A–5–3), Air and Toxics Division, U.S. Environmental Protection Agency, Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901, Telephone: (415) 744–1200.

SUPPLEMENTARY INFORMATION: This document concerns Mojave Desert Air Quality Management District (MDAQMD) Rule 1157, Boilers and Process Heaters; MDAQMD Rule 1160, Internal Combustion Engines; South Coast Air Quality Management District (SCAQMD) Rule 1121, Control of Nitrogen Oxides from Residential Type Natural Gas-Fired Water Heaters; and SCAQMD Rule 1134, Emissions of Oxides of Nitrogen from Stationary Gas Turbines. MDAQMD Rule 1157 and Rule 1160 were submitted to EPA by the California Air Resources Board on November 30, 1994. SCAQMD Rule 1121 was submitted on May 24, 1995, and SCAQMD Rule 1134 was submitted on March 26, 1996. For further information, please see the information provided in the direct final action which is located in the Rules section of this Federal Register.

Authority: 42 U.S.C. 7401–7671q.

Date Signed: September 17, 1996.

Felicia Marcus,

Regional Administrator.

[FR Doc. 96–27847 Filed 10–31–96; 8:45 am]

BILLING CODE 6560–50–W

40 CFR Part 52

[CA 168–0019b; FRL–5641–8]

Approval and Promulgation of State Implementation Plans; California State Implementation Plan Revision, Sacramento Metropolitan Air Quality Management District

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to act on revisions to the California State Implementation Plan (SIP) which concern five negative declarations from