sector of the economy, productivity, competition,jobs, the environment, public health or safety, or State, local, or tribal governments or communities (also referred to as ''economically significant''); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement, grants, user fees, or loan programs or the rights and obligation of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.

Pursuant to the terms of the Executive Order, EPA has determined that this rule is not ''significant'' and is therefore not subject to OMB review. Pursuant to the requirements of the Regulatory Flexibility Act (Pub. L. 96-354, 94 Stat. 1164, 5 U.S.C. 601-612), the Administrator has determined that regulations establishing new tolerances or raising tolerance levels or establishing exemptions from tolerance requirements do not have a significant impact on a substantial number of small entities. A certification statement to this effect was published in the Federal Register of May 4, 1981 (46 FR 24950).

List of Subjects

40 CFR Part 180

Environmental protection, Administrative practice and procedure, Agricultural commodities, Pesticides and pests.

40 CFR Part 186

Environmental protection, Animal feeds, Feed additives.

Dated: March 22, 1996.

Stephen L. Johnson,

Director, Registration Division. Office of Pesticide Programs.

Therefore, chapter I of title 40 of the Code of Federal Regulations is amended as follows:

PART 180—[AMENDED]

1. In part 180:

a. The authority citation for part 180 continues to read as follows:

Authority: 21 U.S.C. 346a and 371.

b. In § 180.364, the table in paragraph (a) is amended by removing the entries for citrus, fruits at 0.2 ppm; soybean, straw at 200 ppm; soybeans at 20 ppm; soybeans, forage at 15 ppm; and soybeans, hay at 15 ppm; by revising the entries in the table to paragraph (b) for cattle, kidney; goats, kidney; hogs, kidney; horses, kidney; and sheep, kidney; and in paragraph (d) by adding alphabetically the raw agricultural commodities alfalfa, forage; alfalfa, hay; citrus fruits; soybeans; soybeans, grain; soybeans, forage; soybeans, hay; soybeans, aspirated grain fractions; and sunflower seed, to read as follows:

§ 180.364 Glyphosate; tolerances for residues.

* * * * *

(b) * * *

Commodity	Parts per million
* * * *	*
Cattle, kidney	4.0
* * * *	*
Goats, kidney	4.0
Hogs, kidney	4.0
* * * *	*
Horses, kidney	4.0
* * * *	*
Sheep, kidney	4.0
* * * *	*

* * * * *

(d) * * *

Commodity	Parts per million
* * * *	*
Alfalfa, forage	75.0
Alfalfa, hay	200.0
* * * *	*
Citrus, fruits	0.5
Soybeans	20.0
Soybeans, grain	20.0
Soybeans, aspirated grain fractions	50.0
Soybeans, forage	100.0
Soybeans, hay	200.0
Sunflower seed	0.1
* * * *	*

2. In part 186:

PART 186—[AMENDED]

a. The authority citation for part 186 continues to read as follows;

Authority: 21 U.S.C. 348.

b. In § 186.3500 by removing from the table in paragraph (a) the entries for citrus pulp, dried and soybean, hulls, and by adding new paragraph (b), to read as follows:

§ 186.3500 Glyphosate.

* * * * *

(b) A feed additive regulation is established permitting residues of glyphosate (*N*-(phosphonomethyl)glycine) in or on the following feed commodities.

Commodity	Parts per million
Citrus pulp, dried	1.5
Soybean, hulls	100.0

[FR Doc. 96–8142 Filed 4–4–96; 8:45 am]

BILLING CODE 6560–50–F

OFFICE OF PERSONNEL MANAGEMENT

48 CFR Parts 1604 and 1652

RIN 3206–AG30

Federal Employees Health Benefits Acquisition Regulation; Filing Health Benefit Claims; Addition of Contract Clause

AGENCY: Office of Personnel Management.

ACTION: Final rule.

SUMMARY: The Office of Personnel Management (OPM) is issuing final regulations to add a new contract clause in part 1652 of the Federal Employees Health Benefits Acquisition Regulation (FEHBAR). The clause clarifies for both FEHB carriers and covered individuals the circumstances under which OPM may render a decision regarding a covered individual who asks OPM to review a health benefits plan's denial of a claim if the plan has either affirmed its denial when the covered individual requested reconsideration, or failed to respond to the covered individual's request for reconsideration as provided by OPM's regulations. The clause further clarifies the circumstances under which claimants may seek court review of benefit denials under the FEHB Program. The purpose of these final regulations is to specify that covered individuals who wish to bring legal action regarding a denial of an FEHB benefit must pursue such claim against OPM. Further, the regulations clarify the administrative review process that must precede legal action in the courts.

EFFECTIVE DATE: May 6, 1996.

FOR FURTHER INFORMATION CONTACT: Margaret Sears, (202) 606–0004.

SUPPLEMENTARY INFORMATION: On March 29, 1995, OPM published interim regulations in the Federal Register (60 FR 16056) that require individuals who want to bring suit concerning the denial of their health benefits claims to bring

such suits against OPM instead of the health benefits carrier, as had been the case previously. The interim regulations also clarified the administrative review procedures that must precede legal action in the courts, the circumstances under which suits may be brought against OPM, and that the court's review is limited to the record that was before OPM when it made its decision.

OPM received 11 comments on the interim regulations. Three commenters suggested that we amend the regulations to clarify that the regulations apply to providers to whom the covered individual has assigned the right to pursue the claim. We have not accepted this suggestion because the right of access to the disputed claim process belongs to the covered individual. We have amended the interim regulations to clarify that another person or entity, whether or not a provider, can gain access to the disputed claims process only when acting on behalf of the covered individual and with the covered individual's specific written consent.

Two commenters thought that the one-year period for initiating the disputed claims process was too long. They suggested a 90-day period instead. The one-year period has been OPM's policy since the disputed claims process was created in 1975. However, we believe that the period can now be reduced to 6 months if there are sufficient safeguards to protect the interests of individuals who, because of medical problems or for other reasons are unable to request reconsideration within the 6 months time limit. Therefore, we are modifying the regulations to require that covered individuals who want to ask the plan to reconsider its denial must do so within 6 months after the denial unless the covered individual shows that he or she was prevented by a cause beyond his or her control from making the request within that time period. In addition, we are adding a provision to allow OPM to reopen a decision it made concerning a disputed claim if it receives evidence that was unavailable at the time OPM made its decision.

Two commenters said that the amount of time carriers have to respond to requests for reconsideration—30 days—is too short, especially when the issue is medical necessity. They suggested that the carriers be allowed 45 days, with the option to extend the period for an additional 30 days, if necessary. They further suggested that the carriers be given 45 days rather than 30 to review additional information received from the covered individual or provider. In both cases, the 30-day period has been in place for a number of years and has been working well enough that we believe that extending the time period to 45 days would unnecessarily lengthen the time required to complete the disputed claims process. Therefore, we have not accepted these suggestions.

Two commenters said that the time period for seeking judicial review should be tied to the date the covered individual receives OPM's decision rather than the date the care or service was provided. One commenter supported the provision basing the time limit on the date the care or service was provided and asked us not to change it. The interim regulations provide that legal action on a disputed claim may not be brought later than December 31 of the 3rd year after the year in which the care or service was provided. After considering these three comments we have decided not to modify our regulations at this time. This timeframe reflects our brochure language over the past several years. It is our experience that this timeframe works well; however, we will continue to monitor all timeframes in these regulations and make changes as warranted.

Four commenters suggested that the regulations should explicitly state that court actions are not to be brought against a carrier or a carrier's subcontractors. One commenter suggested that we amend the regulations to state that the carrier is an indispensable party to the lawsuit. After considering these five comments, we have modified the regulations to specify that court action is not to be brought against the carrier or the carrier's subcontractors. Since it is OPM's decision, not the carrier's, that is being contested, it is appropriate that OPM, rather than the carriers, be the focus of lawsuits related to denial of benefits.

Two commenters said that the interim regulations should be set aside because they adversely affect the covered individual's right (1) of access to State courts, (2) to seek monetary compensation for damages, (3) under State law to require insurer to prove that notice was given concerning changes in benefits and that contract language is clear, (4) to have the option to go to court without seeking OPM review, (5) to present evidence that OPM did not have when it made its determination, and (6) to seek an expedited ruling by the court when life or health is at issue. OPM's regulations have never offered such ''rights.'' The interim regulations simply clarified that these opportunities are not available to covered individuals under the FEHB program. The FEHB law includes a provision specifically stating that the FEHB contract provisions that relate to the extent of coverage or benefits supersede and preempt any State law that relates to health insurance or plans to the extent that such law is inconsistent with FEHB contractual provisions. Therefore, we believe the interim regulations accurately reflect the intent of the FEHB law. Further, it has been OPM's policy, and will continue to be OPM's policy, to expedite the dispute resolution process when there are issues of life and health at stake. Premature involvement of the courts at such time is unnecessary. The only real change made by the interim regulations was which party to the FEHB contracts should be named in a suit.

Two commenters said that the interim regulations should be set aside because they violated the Administrative Procedure Act in that they became effective before completing a comment period. The interim regulations were promulgated to provide immediate guidance and information to alleviate any burden on the FEHB enrollees in cases of possible litigation. It was OPM's view that immediate implementation of regulations that clarify and more fully explain the proper judicial review of an OPM decision sustaining a health benefit plan's denial of coverage would minimize unnecessary litigation and uncertainty. Thus, the interim regulations were intended to more clearly specify a review procedure that sometimes appeared to be unclear and was not always applied consistently.

One commenter inquired whether the interim regulations removed a restriction so that there was good cause for issuing them in this form. It was OPM's view that the interim regulations remove the restriction requiring that enrollees sue a health benefits carrier when contesting an OPM decision that affirmed the carrier's determination that the benefit is not covered under the carrier's plan. Previously, enrollees could not bring suit against OPM directly even though they ultimately were contesting OPM's decision.

One commenter asserted that the regulations should specify that they have no impact on an individual's rights under the Federal Sector Equal Employment Opportunity rule set forth in 29 CFR Part 1614. That is, individuals who believe they have been discriminated against in regard to insurance benefits because of disability or another protected basis are not required to pursue or exhaust the administrative remedy provided by these regulations before pursuing their rights under 29 CFR Part 1614. Since OPM has no authority concerning the provisions of title 29 of the Code of

Federal Regulations, it would not be appropriate to address an individual's rights under title 29 in this contract clause. Instead, the circumstances under which one may access remedies related to title 29 should be included in title 29.

One commenter felt that the interim regulations do not expressly prescribe time limits when the carrier fails to make its decision within 60 days after requesting, but not receiving, information from the covered individual. We have modified the regulations to clarify that this circumstance is included in the administrative process.

One commenter objected to the requirement that the claimants must express their reasons in terms of the brochure provisions because enrollees sometimes do not have brochures. Since a dispute about a claim must be based on whether or not the claim was payable under the FEHB contract and the brochure sets forth the contract provisions, individuals need a brochure in order to know whether they have a dispute. They also need a brochure to obtain information on the procedures for disputing carriers' denials of claims. Further, brochures are easily obtainable from the plan. We find that this requirement is important in encouraging the individual to express his or her reasons in a manner that will facilitate a successful result when there is a valid dispute.

Two commenters suggested that the regulations be revised to require that OPM's decision contain a notice of the covered individual's right to bring suit. We are not adopting that suggestion because we are adding that information to the brochures. The brochures will give complete information about the disputed claims process from the initial request to the carrier for reconsideration through the requirements for bringing suit when OPM concurs with the carrier's reconsideration decision to deny the claim.

We have also modified paragraph (g)(3) of the clause to clarify that recovery in the FEHB Program is accomplished through a directive from OPM to the carrier to make payment according to the court's order.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation merely incorporates administrative procedures and regulatory requirements into FEHB contracts.

List of Subjects in 48 CFR Parts 1604 and 1652

Government employees, Government procurement, Health insurance.

Office of Personnel Management.

James B. King,

Director.

Accordingly, OPM is amending 48 CFR chapter 16 as follows:

PART 1604—ADMINISTRATIVE MATTERS

1. The authority citation for parts 1604 and 1652 continue to read as follows:

Authority: 5 U.S.C. 8913; 40 U.S.C. 486(c); 48 CFR 1.301.

2. In part 1604; subpart 1604.71 is adopted as final and republished to read as follows:

Subpart 1604.71—Disputed Health Benefit Claims

§ 1604.7101 Filing Health Benefit Claims/Court Review of Disputed Claims.

Guidelines for a Federal Employees Health Benefit (FEHB) Program covered individual to file a claim for payment or service and for legal actions on disputed health benefit claims are found at 5 CFR 890.105 and 890.107, respectively. The contract clause at 1652.204–72 of this chapter, reflecting this guidance, must be inserted in all FEHB Program contracts.

PART 1652—CONTRACT CLAUSES

3. In subpart 1652.2, section 1652.204–72 is revised and adopted as final to read as follows:

Subpart 1652.2—Texts of FEHBP Clauses

§ 1652.204–72 Filing Health Benefit Claims/Court Review of Disputed Claims.

As prescribed in 1604.7101 of this chapter, the following clause must be inserted in all FEHB Program contracts.

Filing Health Benefit Claims/Court Review of Disputed Claims

(a) *General.* (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. 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 (b) of this clause, 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 clause before seeking judicial review of the denied claim.

(2) This clause 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 clause if the Carrier fails to act within the time limit set forth in this paragraph.

(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 clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier 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 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; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, 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 clause, 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.

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

(g) *Court review.* (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

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

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). 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 the 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.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

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

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

(End of Clause)

[FR Doc. 96–8372 Filed 4–4–96; 8:45 am]

BILLING CODE 6325–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 625

[Docket No. 951116270–5308–02; I.D. 031296B]

Summer Flounder Fishery; Adjustments to 1996 State Quotas

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Commercial quota adjustment.

SUMMARY: NMFS announces adjustments to the commercial quota for the 1996 summer flounder fishery. This action complies with regulations implementing the Fishery Management Plan for the Summer Flounder Fishery (FMP), which require that annual quota overages landed in any state be deducted from that state's quota for the following year. The public is advised that a quota adjustment has been made and is informed of the revised state quotas. The Director, Northeast Region, NMFS (Regional Director), has also determined that there is no Federal summer flounder quota available for those coastal states that did not receive a portion of the annual commercial summer flounder quota. Vessels issued a Federal moratorium permit for the summer flounder fishery may not land summer flounder in these states.

EFFECTIVE DATE: April 4, 1996, through December 31, 1996.

FOR FURTHER INFORMATION CONTACT: David Gouveia, 508–281–9280.

SUPPLEMENTARY INFORMATION: Regulations implementing Amendment 2 to the FMP are found at 50 CFR part 625 (December 4, 1992, 57 FR 57358). The regulations require annual specification of a commercial quota that is apportioned among the Atlantic coastal states from North Carolina through Maine. The process to set the annual commercial quota and the percent allocated to each state is described in § 625.20. Amendment 7 to the FMP (November 24, 1995, 60 FR 57955) revised the fishing mortality rate reduction schedule for summer flounder, and the revised schedule was the basis for establishing the 1996 quota. The commercial summer flounder quota for the 1996 calendar year, adopted to ensure achievement of the appropriate fishing mortality rate of 0.41 for 1996, is set to equal 11,111,298 lb (5.0 million kg) (January 4, 1996, 61 FR 291). The notification of a commercial quota transfer from the State of North Carolina to the Commonwealth of Virginia was published on March 13, 1996 (61 FR 10286). This quota transfer is reflected in Table 1.

Section 625.20(d)(2) provides that all landings for sale in a state shall be applied against that state's annual commercial quota. Any landings in excess of the state's quota will be deducted from that state's annual quota for the following year. Based on dealer reports and other available information, NMFS has determined that the States of Massachusetts, Rhode Island, New York, Delaware, and Virginia have exceeded their 1995 quotas. The remaining States of Maine, New Hampshire, Connecticut, New Jersey, Maryland, and North Carolina did not exceed their 1995 quotas. A complete summary of quota adjustments for 1996 is in Table 1.