compliance times specified in, and in accordance with, European Union Aviation Safety Agency (EASA) AD 2020–0115, dated May 20, 2020 (''EASA AD 2020–0115''). Accomplishing the maintenance or inspection program revision required by this paragraph terminates the requirements of paragraph (g) of this AD.

(j) Exceptions to EASA AD 2020–0115

(1) The requirements specified in paragraphs (1) and (2) of EASA AD 2020–0115 do not apply to this AD.

(2) Paragraph (3) of EASA AD 2020–0115 specifies revising ''the approved AMP'' within 12 months after its effective date, but this AD requires revising the existing maintenance or inspection program, as applicable, to incorporate the ''limitations, tasks and associated thresholds and intervals'' specified in paragraph (3) of EASA AD 2020–0115 within 90 days after the effective date of this AD.

(3) The initial compliance time for doing the tasks specified in paragraph (3) of EASA AD 2020–0115 is at the applicable ''associated thresholds'' specified in paragraph (3) of EASA AD 2020–0115, or within 90 days after the effective date of this AD, whichever occurs later.

(4) The provisions specified in paragraphs (4) and (5) of EASA AD 2020–0115 do not apply to this AD.

(5) The ''Remarks'' section of EASA AD 2020–0115 does not apply to this AD.

(k) New Provisions for Alternative Actions or Intervals

After the maintenance or inspection program has been revised as required by paragraph (i) of this AD, no alternative actions (*e.g.,* inspections) or intervals are allowed unless they are approved as specified in the provisions of the ''Ref. Publications'' section of EASA AD 2020–0115.

(l) Terminating Actions for Certain Requirements in AD 2010–26–05

Accomplishing the actions required by paragraph (g) or (i) of this AD terminates the requirements of paragraph (g)(1) of AD 2010–26–05, for Dassault Aviation Model MYSTERE–FALCON 900 airplanes.

(m) Other FAA AD Provisions

The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, Large Aircraft Section, International Validation Branch, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. In accordance with 14 CFR 39.19, send your request to your principal inspector or local Flight Standards District Office, as appropriate. If sending information directly to the Large Aircraft Section, International Validation Branch, send it to the attention of the person identified in paragraph (n)(4) of this AD. Information may be emailed to: *9-AVS-AIR-730-AMOC@faa.gov.*

(i) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(ii) AMOCs approved previously for AD 2019–23–05 are approved as AMOCs for the corresponding provisions of EASA AD 2020–0115 that are required by paragraph (i) of this AD.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain instructions from a manufacturer, the instructions must be accomplished using a method approved by the Manager, Large Aircraft Section, International Validation Branch, FAA; or EASA; or Dassault Aviation's EASA Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(n) Related Information

(1) For information about EASA AD 2020–0115, contact the EASA, Konrad-Adenauer-Ufer 3, 50668 Cologne, Germany; phone: +49 221 8999 000; email: *ADs@easa.europa.eu;* internet: *www.easa.europa.eu.* You may find this EASA AD on the EASA website at *https://ad.easa.europa.eu.*

(2) For Dassault service information identified in this proposed AD, contact Dassault Falcon Jet Corporation, Teterboro Airport, P.O. Box 2000, South Hackensack, NJ 07606; phone: 201–440–6700; internet: *http://www.dassaultfalcon.com.*

(3) You may view this material at the FAA, Airworthiness Products Section, Operational Safety Branch, 2200 South 216th St., Des Moines, WA. For information on the availability of this material at the FAA, call 206–231–3195. This material may be found in the AD docket on the internet at *https://www.regulations.gov* by searching for and locating Docket No. FAA–2020–0778.

(4) For more information about this AD, contact Tom Rodriguez, Aerospace Engineer, Large Aircraft Section, International Validation Branch, FAA, 2200 South 216th St., Des Moines, WA 98198; phone and fax: 206–231–3226; email: *tom.rodriguez@faa.gov.*

Issued on August 13, 2020.

Lance T. Gant,

Director, Compliance & Airworthiness Division, Aircraft Certification Service.

[FR Doc. 2020–18026 Filed 8–18–20; 8:45 am]

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 9

RIN 2900–AQ53

Servicemembers' Group Life Insurance Traumatic Injury Protection Program Amendments

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its regulations that govern the Servicemembers' Group Life Insurance (SGLI) Traumatic Injury Protection (TSGLI) program, to clarify the eligibility criteria, add definitions, and explain the application and appeals processes, including the submission of supporting evidence and the interaction between the administrative appeals process and a Federal lawsuit on a claim. VA proposes to recodify the definitions in the current regulation that are pertinent to the schedule of losses, revise existing definitions, and add new definitions. VA would add a new regulation to codify the text at the beginning of the schedule of losses, recodify that schedule, and amend the criteria for certain losses in the schedule. This rulemaking also responds to a petition for rulemaking.

DATES: Comments must be received on or before October 19, 2020.

ADDRESSES: Written comments may be submitted through *http://www.Regulations.gov;* by mail or hand-delivery to: Director, Office of Regulation Policy and Management (00REG), Department of Veterans Affairs, 810 Vermont Ave. NW, Room 1064, Washington, DC 20420; or by fax to (202) 273–9026. (This is not a toll-free telephone number.) Comments should indicate that they are submitted in response to ''RIN 2900–AQ53 Servicemembers' Group Life Insurance Traumatic Injury Protection Program Amendments.'' Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1064, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461–4902 for an appointment. (This is not a toll-free telephone number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at *http://www.Regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Paul Weaver, Department of Veterans Affairs Insurance Center (310/290B), 5000 Wissahickon Avenue, Philadelphia, PA 19144, (215) 842–2000, ext. 4263. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: TSGLI provides up to $100,000 of traumatic injury coverage to all servicemembers enrolled in SGLI. TSGLI provides a financial benefit to seriously injured SGLI insureds to assist them with expenses incurred during long periods of recovery and rehabilitation. Since the program began issuing benefits on December 22, 2005, through June 30, 2019, over $1 billion has been paid to almost 18,500 injured servicemembers. TSGLI is modeled after commercial Accidental Death and Dismemberment

(AD&D) insurance coverage, specifically, the ''dismemberment'' portion of the coverage, although it deviates in some respects from the commercial AD&D model to account for the unique needs of military personnel. 70 FR 75,940 (Dec. 22, 2005). In developing these proposed amendments, VA considered industry practice and AD&D case law, the goals and purpose of the TSGLI authorizing statute, as well as analysis from a TSGLI Year-Ten Review and consultation with medical experts.

I. Year-Ten Review

After ten years of program implementation, VA initiated a comprehensive review of TSGLI regulations to assess proposals for improvements, clarify eligibility standards, identify opportunities for administrative and operational enhancements, and ensure consistency with congressional intent. VA reviewed approximately 1,850 TSGLI claims that had been adjudicated by the uniformed services and consulted with medical experts at 18 military, VA, and private medical facilities, including George Washington University Medical Center, Washington, DC; Navy Medical Center, San Diego, California; San Antonio Military Medical Center, San Antonio, Texas; University of Pennsylvania Hospital, Philadelphia, Pennsylvania; VA Amputation System of Care, VA Medical Center, Richmond, Virginia; VA Medical Center, Bay Pines, Florida; VA Polytrauma Center, Tampa, Florida; Walter Reed National Military Medical Center, Bethesda, Maryland; and Moss Rehabilitation Research Institute, Elkins Park, Pennsylvania (''experts'').

Areas addressed by the review include loss standards, application and appeals processes, forms, program exclusions, and definitions. A copy of the review can be found at *https://www.benefits.va.gov/INSURANCE/docs/TSGLI_YTR.pdf.* This comprehensive program review served as the basis for many aspects of this proposed rulemaking.

While VA was conducting the Year-Ten Review, a petition for rulemaking was submitted to the Secretary of Veterans Affairs on March 16, 2015. The petition is addressed in this notice of proposed rulemaking, which serves as the Secretary's response to the petition.

II. Proposed Amendments to § 9.20

A. New § 9.20(b)—Qualifying Traumatic Events

VA proposes to restructure current § 9.20(b)(1) and to add new qualifying traumatic events.

New paragraph (b)(1)(A)–(C) would incorporate the material in current § 9.20(b)(1) that defines a traumatic event to include damage caused by ''application of external force, violence, chemical, biological, or radiological weapons'' and ''accidental ingestion of a contaminated substance.'' As explained below, VA would add a definition of ''external force'' in new § 9.20(e)(6)(iv) and ''ingestion'' in new § 9.20(e)(6)(v).

New paragraph (b)(1)(D) would add exposure to low environmental temperatures, excessive heat, and documented non-penetrating blast waves as traumatic events based upon evidence showing increased occurrence of traumatic injuries resulting from such exposures. The incidence of heat illnesses in the uniformed services had risen between 2014 and 2018 creating a ''significant and persistent threat to both the health of U.S. military members and the effectiveness of military operations.'' Armed Forces Health Surveillance Branch, *Update: Heat Illness, Active Component, U.S. Armed Forces, 2018,* 26 Med. Surveillance Monthly Rep. 15, 19 (2019). Injury from cold weather increased among military troops by 19.6% in 2017–2018 compared to 2016–2017. Armed Forces Health Surveillance Branch, *Update: Cold Weather Injuries, Active and Reserve Components, U.S. Armed Forces, July 2013–June 2018,* 25 Med. Surveillance Monthly Rep. 10 (2018). Additionally, ''cold injuries have continued to affect hundreds of service members each year because of exposure to cold and wet environments'' and ''[s]uch environmental conditions pose the threat of hypothermia, frostbite, and nonfreezing cold injury such as immersion injury.'' *Id.* Whether in training or in forward operating locations, the risk of exposure to extreme temperatures can result in severe traumatic injuries, including amputations or coma. Finally, many servicemembers develop traumatic brain injury (TBI) from the effects of blast waves. Ralph G. DePalma, M.D., et al., *Blast Injuries,* 352 New Eng. J. of Med. 1335–1342 (2005); David S. Plurad, *Blast Injury,* 176 Mil. Med. 276, 281 (2011).

VA also proposes to state in new paragraph (b)(1)(E) that an insect bite or sting or animal bite would qualify as a traumatic event. We are adding such bites because they involve application of an external force to the body that transmits an allergen or poison into the body. *See Hargett* v. *Jefferson Standard Life Ins. Co.,* 128 S.E.2d 26, 31 (N.C. 1962); *Omberg* v. *U.S. Mut. Ass'n,* 40 S.W. 909, 910 (Ky. Ct. App. 1897).

B. New § 9.20(c)—Qualifying Traumatic Injury

VA proposes to recodify current § 9.20(c)(3) as new § 9.20(c)(4) and to add new paragraph (c)(3), which would state that anaphylaxis caused by a bug bite or sting or animal bite is a traumatic injury. VA is proposing to add anaphylaxis because this harm occurs immediately after such a sting or bite. This would be consistent with case law finding that an allergic reaction is covered under AD&D policies because it is not a disease. *See Escoe* v. *Metro. Life Ins. Co.,* 35 N.Y.S.2d 833, 834 (N.Y. Sup. Ct. 1942) (death from allergy to sulfapyridine given to treat pneumonia was accident, not disease); *Berkowitz* v. *N.Y. Life Ins. Co.,* 10 N.Y.S.2d 106, 111 (N.Y. App. Div. 1939) (''mere predisposing tendency cannot be held as a matter of law to be an infirmity or disease''); *Crisler* v. *Unum Ins. Co. of Am.,* 233 SW3d 658, 663 (Ark. 2006) (allergic reaction to injection of antibiotic was not disease).

C. New § 9.20(d)—Eligibility Requirements

1. New § 9.20(d)(2)—Causation

Section 1980A(c)(1) of title 38, United States Code, states that a qualifying loss must ''result[ ] directly from a traumatic injury . . . and from no other cause.'' VA codified this requirement in current 38 CFR 9.20(d)(2). In addition, current 38 CFR 9.20(e)(4) states that a loss is not covered if it results from a physical or mental illness or disease or mental disorder, ''whether or not caused by a traumatic injury,'' other than the exceptions noted in paragraph (e)(4)(i).

VA proposes to amend current § 9.20(d)(2) to restate the statutory requirement that a scheduled loss must ''result directly from a traumatic injury . . . and from no other cause.'' Some courts have interpreted this phrase in AD&D and Employee Retirement Income Security Act case law to mean that a loss is not covered if a preexisting condition or disease ''substantially contributed'' to the loss. *See, e.g., Dixon* v. *Life Ins. Co. of N. Am.,* 389 F.3d 1179, 1184 (11th Cir. 2004); *Ganapolsky* v. *Boston Mut. Life Ins. Co.,* 138 F.3d 446, 448 (1st Cir. 1998); *House* v. *Life Ins. Co. of N. Am.,* 399 F. Supp. 2d 1254, 1264–65 (N.D. Ala. 2005); *Danz* v. *Life Ins. Co. of N. Am.,* 215 F. Supp. 2d 645, 652 (D. Md. 2002) (citing *Quesinberry* v. *Life Ins. Co. of N. Am.,* 987 F.2d 1017, 1028 (4th Cir. 1993) (*en banc*)). Based upon this case law, we propose to add paragraph (d)(2)(A), which would explain that, under this standard, a scheduled loss does not result directly from a traumatic injury and no other

cause if a pre-existing disease, illness, or condition substantially contributed to the loss. Thus, for example, if a member suffers a qualifying loss such as leg amputation and the member also suffers from a pre-existing condition such as diabetes, the member would not be eligible for TSGLI if the pre-existing diabetes substantially contributed to the amputation of the leg.

We also propose to state in § 9.20(d)(2)(A) that a scheduled loss does not result directly from a traumatic injury and no other cause if a post-service injury substantially contributes to the loss. For example, if a member suffers a leg injury in service and a post-service injury to the same leg, and the member's leg is then amputated, the member would not be eligible for TSGLI if the post-service leg injury substantially contributed to the amputation.

VA also proposes to add new paragraph (d)(2)(B) to clarify that a scheduled loss is a direct result of a traumatic injury if the loss is caused by a diagnostic procedure or a medical or surgical procedure that was used to treat the traumatic injury. *Ins. Co. of N. Am.* v. *Thompson,* 381 F.2d 677, 681 (9th Cir. 1967); 10 Couch on Insurance 3d § 141:78, at 141–113 (1998). For example, if a member is injured in a motor vehicle accident, undergoes surgery to treat a back injury suffered in the accident, and is paralyzed because of the surgery, the scheduled loss would be covered by TSGLI. We would make a corresponding change in new § 9.20(e)(3)(i)(C) to explain that TSGLI would be payable if a scheduled loss is caused by a diagnostic or medical or surgical procedure that was necessary to treat a traumatic injury.

2. New § 9.20(d)(4)—Two-Year Loss Period

Current § 9.20(d)(4) requires a member to suffer a scheduled loss within two years of the traumatic injury. VA proposes to update the citation to the schedule of losses in § 9.20(d)(4) by deleting ''paragraph (e)(7) of this section'' and inserting instead ''§ 9.21(c).''

D. New § 9.20(e)—Scheduled Loss

1. New § 9.20(e)(1)—Definition of Scheduled Loss

VA proposes to update the reference to the schedule in current § 9.20(e)(1) by deleting ''paragraph (e)(7) of this section'' and inserting instead ''§ 9.21(c).'' VA also proposes to add ''from no other cause'' to the definition of scheduled loss to correspond to 38 U.S.C. 1980A(c)(1).

2. New § 9.20(e)(3)—Exclusions

a. New § 9.20(e)(3)(i)(C)—Medical Procedures & Treatment Exclusion

Consistent with new paragraph (d)(2)(B), VA proposes to add the phrase ''unless the diagnostic procedure or medical or surgical treatment is necessary to treat a traumatic injury'' to the end of the paragraph to clarify that a scheduled loss caused by a diagnostic procedure or medical or surgical treatment that is necessary to a traumatic injury would be eligible for a TSGLI payment. This is consistent with AD&D case law. *Thompson,* 381 F.2d at 681.

b. New § 9.20(e)(3)(ii)—Felony Exclusion

Current § 9.20(e)(3)(ii) specifies that TSGLI will not be paid if a member suffers a loss while committing or attempting to commit a felony. VA proposes to amend § 9.20(e)(3)(ii) to clarify that this exclusion applies if a member suffers a loss while committing an act that violated a penal law classifying it as a felony. This approach is consistent with AD&D industry practice. *See Williams* v. *Life Ins. Co. of N. Am.,* 117 F. Supp. 3d 1206, 1216 (W.D. Wash. 2015) (citing *Allstate Ins. Co.* v. *Raynor,* 969 P.2d 510, 516 (Wash. Ct. App. 1999)).

3. New § 9.20(e)(6)—Definitions

We propose to amend current § 9.20(e)(6) by recodifying paragraph (i)–(vi) and (xiii)–(xxix), which are relevant to the schedule of losses, in new § 9.21, adding definitions of the following terms that are relevant to § 9.20, and alphabetizing all the definitions in new paragraph (e)(6). For example, we propose to incorporate the definitions of ''quadriplegia,'' ''paraplegia,'' ''hemiplegia,'' ''uniplegia,'' and ''complete and irreversible paralysis'' in current § 9.20(e)(6)(i)–(v) and the definition of ''permanent'' in new § 9.21(a)(10) into the criteria for quadriplegia, paraplegia, hemiplegia, and uniplegia in new § 9.21(c)(4)–(7). In another example, we propose to incorporate the definitions in current § 9.20(e)(6)(xxi)–(xxix) and the definition of ''permanent'' in new § 9.21(a)(10) into the criteria for genitourinary losses in new § 9.21(c)(19).

a. External Force

VA would define ''external force'' in new § 9.20(e)(6)(iv) to mean a ''sudden or violent impact from a source outside of the body that causes an unexpected impact and is independent of routine body motions such as twisting, lifting, bending, pushing, or pulling.'' This proposed definition is consistent with AD&D practice that excludes such routine body activities as traumatic events. *See e.g., Mutual Life Ins. Co.* v. *Hassing,* 134 F.2d 714, 716 (10th Cir. 1943) (AD&D policy requiring bodily injury effected solely through external, violent, accidental means). For example, a sprained ankle suffered while running would not be considered a traumatic event because the damage was not caused by an external force but rather by stretching or tearing ligaments. *https://www.mayoclinic.org/diseases-conditions/sprained-ankle/symptoms-causes/syc-20353225.* However, a fall that causes a herniated disc would constitute a traumatic event because the damage to the body was caused by hitting the ground, *i.e.,* an external force.

b. Ingestion

VA proposes to define ''ingestion'' in new § 9.20(e)(6)(v) to mean ''to take into the gastrointestinal tract by means of the mouth.'' This definition is consistent with the common meaning of the term. *See United States* v. *Ten Cartons,* 888 F. Supp. 381, 393 (E.D.N.Y. 1995), *aff'd,* 10 F.3d 285 (2d Cir. 1995).

c. Medically Incapacitated

VA proposes to define the term ''medically incapacitated'' in new paragraph (e)(6)(vii) to mean an ''individual who has been determined by a medical professional to be physically or mentally impaired by physical disability, mental illness, mental deficiency, advanced age, chronic use of drugs or alcohol, or other causes that prevent sufficient understanding or capacity to manage his or her own affairs competently.''

E. New § 9.20(f)—TSGLI Application Process

VA proposes to recodify current § 9.20(f), which contains the schedule of losses, in new 38 CFR 9.21(c), recodify current § 9.20(h), which explains the TSGLI application process, as new § 9.20(f), and amend new paragraph (f).

VA proposes to clarify in new § 9.20(f)(1)(i) that a medical professional must complete and sign Part B of the Application for TSGLI Benefits Form in addition to the requirement that a member complete and sign Part A of the Application for TSGLI Benefits Form, *i.e.,* both Part A and Part B must be completed to initiate a claim for TSGLI benefits. VA would also explain that a member must submit evidence substantiating that the member suffered a traumatic injury and resulting loss. This clarification is intended to indicate

that Part A alone is insufficient documentation to support eligibility for TSGLI benefits.

VA would also add a requirement to new § 9.20(f)(1)(ii) that, if a medical professional certifies in Part B of the Application for TSGLI Benefits Form that a member is medically incapacitated, the Form must be signed by a guardian; an agent or attorney acting under a valid Power of Attorney; military trustee as available, in that order. We propose to change ''legally incapacitated'' to ''medically incapacitated'' to make the regulation consistent with 38 U.S.C. 1980A(k)(1) and (2)(B), which provides for appointment of a fiduciary or trustee of a servicemember who is ''medically incapacitated.''

VA would also recodify § 9.20(h)(1)(iii) as § 9.20(f)(1)(iii).

Finally, VA would recodify § 9.20(h)(2) as § 9.20(f)(2) and amend the paragraph by deleting the current citations to the schedule of losses and inserting citations to new § 9.21(c).

F. New § 9.20(g)—Uniformed Service Decision on TSGLI Claim

VA proposes to add a regulation explaining both who decides a TSGLI claim and the decision-making process, which would be codified as new § 9.20(g). Current § 9.20(g), which states that the uniformed service to which a member belongs certifies whether the member was insured under SGLI at the time of the traumatic injury and whether the member sustained a qualifying loss, would be recodified as new § 9.20(g)(1) with non-substantive changes.

Paragraph (g)(2) would state that the uniformed service office may request additional evidence from the member if the record does not contain sufficient evidence to decide the claim.

Paragraph (g)(3) would require the uniformed service office to consider all medical and lay evidence of record, including all evidence provided by the member, and determine its probative value. The probative value of medical evidence may depend upon whether a medical professional examined the servicemember; treated the member on an ongoing basis; provides relevant and objective evidence to support an opinion; or provides an opinion that is consistent with other evidence of record. The probative value of lay evidence may depend upon consistency with a member's service records and other lay and medical evidence of record.

Paragraph (g)(3) would also adopt the benefit of the doubt evidentiary standard for adjudication of TSGLI claims. The Supreme Court has long recognized that the character of the veterans' benefits statutes is strongly and uniquely pro-claimant. *See, e.g., Fishgold* v. *Sullivan Drydock & Repair Corp.,* 328 U.S. 275, 285 (1946) (liberally construing Selective Training and Service Act of 1940, 54 Stat. 885, 50 U.S.C. App. § 301, ''for the benefit of those who left private life to serve their country in its hour of great need''); *Coffy* v. *Republic Steel Corp.,* 447 U.S. 191, 196 (1980); *Brown* v. *Gardner,* 513 U.S. 115, 118 (1994). Congress itself has recognized and preserved the unique character and structure of the veterans' benefits system. When enacting the Veterans' Judicial Review Act, Public Law 100–687, 102 Stat. 4105 (1988), Congress stated its expectation that VA would ''resolve all issues by giving the claimant the benefit of any reasonable doubt.'' H.R. Rep. No. 100–963, at 13 (1988), *reprinted in* 1988 U.S.C.C.A.N. 5782, 5794–95.

Although TSGLI entitlement is adjudicated by the uniformed services not VA, we believe that the benefit of the doubt standard should similarly be applied to adjudication of entitlement to TSGLI, which provides benefits to members who were seriously injured while serving the United States and which VA administers on behalf of the uniformed services. 38 U.S.C. 1980A. In addition, the uniformed services apply the benefit of the doubt in determining a member's unfitness for service because of physical disability and when evaluating members for compensable conditions. DoD Instruction 1332.18, App'x 2 to Encl. 3, para. 6.a.(2) and App'x 3 to Encl. 3, para. 7.i. (2014); *see* Army Reg. 635–40, para. 5–6.a. (2017) (benefit of doubt will be resolved in favor of member's fitness for duty under presumption that member desires to be found fit for duty).

The benefit of the doubt would apply only when the positive and negative evidence relating to the member's TSGLI claim are approximately balanced. *E.g., Ortiz* v. *Principi,* 274 F.3d 1361, 1365–66 (Fed. Cir. 2001). If the preponderant evidence weighs against the member's TSGLI claim, the evidence is not approximately balanced, and the benefit of the doubt rule would not resolve the issue in favor of the member because there is no doubt to be resolved. *Id.*

New § 9.20(g)(4) would contain the first sentence of current paragraph (i)(1), which explains that notice of a decision on a TSGLI claim must include notice of appellate rights. VA would also state in new § 9.20(g)(4) that an adverse decision must include a statement of the reasons for the decision and a summary of the evidence considered. *See O'Neill* v. *United States,* No. 11–2584, 2013 WL 6579039 (D. Col. Dec. 13, 2013) (citing *Dickson* v. *Sec'y of Defense,* 68 F.3d 1396 (D.C. Cir. 1995)).

G. New § 9.20(h)—Appeal of TSGLI Decision

VA proposes to recodify the rest of current § 9.20(i), which addresses appeals of TSGLI decisions, as new § 9.20(h) and would amend the regulation as explained below.

New § 9.20(h)(1) would state that each uniformed service has established its own, three-tiered TSGLI appellate process, *i.e.,* reconsideration, followed by a second-level appeal and then a third-level appeal. The paragraph would also make clear that persons appealing an eligibility determination to the uniformed services must utilize the appeal process of the uniformed service that issued the original decision. *See, e.g.,* SECNAV Instruction 1770.4A, Encl. (1), para. 8. (2019) (following reconsideration by TSGLI branch-of-service adjudicator and review by TSGLI Appeals Board, member may appeal to Board for Correction Naval Records). The names of the reviewing offices may differ among the uniformed services, and the proposed rules thus would use the generic terms ''second-level'' and ''third-level'' to describe the common appellate structure. The notice provided by the uniformed services under proposed § 9.20(g)(4) will identify the relevant second-level or third-level office of the uniformed service as appropriate. VA would also include a reference to paragraph (f)(1)(ii) and (iii) in paragraph (h)(1) for the current list of persons other than the member who may submit an appeal.

New paragraph (h)(1)(A) would explain reconsideration, which is the first appellate tier. VA proposes to state in new paragraph (h)(1)(A)(i) that a member, or other person eligible to submit a claim under paragraph (f)(1)(ii) or (iii), initiates reconsideration of an eligibility determination, such as whether the loss occurred within 730 days of the traumatic injury, whether the member was insured under Servicemembers' Group Life Insurance when the traumatic injury was sustained, or whether the injury was self-inflicted or whether a loss of hearing was total and permanent, by filing a written notice of appeal within one year of the eligibility decision with the office of the uniformed service identified in the decision. This amendment would also require that the request for reconsideration identify the issues for which reconsideration is sought. As a result, VA would delete

current paragraph (i)(2), which states that appeal of whether a member was insured under SGLI must be appealed to the Office of Servicemembers' Group Life Insurance. Section 1980A(f) of title 38, United States Code, requires the Department of Defense or Secretary concerned to ''certify'' whether a member was ''insured under [SGLI]'' at the time of injury and ''sustained a qualifying loss.'' We believe that it would be consistent with this statute for the uniformed service to decide appeals of all issues including SGLI coverage.

Proposed paragraph (h)(1)(A)(i) would also state that an appeal of an eligibility determination, such as whether a loss occurred within ''730 days,'' rather than ''365 days'' (as stated in current § 9.20(i)(1)), must be in writing. This change in the number of days would comport with 38 CFR 9.20(d)(4), which states that a scheduled loss must occur within two years of the traumatic injury and corrects an oversight in a 2007 TSGLI rulemaking. 72 FR 10362 (Mar. 8, 2007).

New paragraph (h)(1)(A)(ii) would state that the uniformed service TSGLI office will reconsider the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and decide the claim.

New paragraph (h)(1)(B) would explain the second tier of appellate review. VA proposes to state in new paragraph (h)(1)(B)(i) that an appeal of a reconsideration decision is initiated by filing, with the second-level appeal office of the uniformed service within one year of the reconsideration decision, a written notice of appeal that identifies the issues being appealed. New paragraph (h)(1)(B)(ii) would state that the second-level appeal office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and decide the claim.

New paragraph (h)(1)(C) would explain the third tier of appellate review. VA proposes to state in new paragraph (h)(1)(C)(i) that an appeal of a decision by the second-level appeal office is initiated by filing, with the third-level appeal office of the uniformed service within one year of the date of the decision by the second-level appeal office of the uniformed service, a written notice of appeal that identifies the issues being appealed. New paragraph (h)(1)(C)(ii) would state that the third-level appeal office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and decide the claim.

New paragraph (h)(2) would state that, if a timely notice of appeal seeking reconsideration of the initial decision by the uniformed service or seeking review of the decision by the second-level uniformed service appeal office is not filed, the initial decision by the uniformed service or the decision by the second-level uniformed service appeal office, respectively, shall become final, and the claim will not thereafter be readjudicated or allowed except as explained in new paragraph (h)(3).

VA proposes in new paragraph (h)(3)(i) that, if new and material evidence is submitted with respect to a claim that has been finally disallowed, the uniformed service office will consider the evidence, determine its probative value, and readjudicate the claim. VA would define new and material evidence in paragraph (h)(3)(i) as ''evidence that was not previously part of the record before the uniformed service, is not cumulative or redundant of evidence of record at the time of the prior decision and is likely to have a substantial effect on the outcome.'' *See* 32 CFR 723.9 (defining new and material evidence for purposes of reconsideration of a final decision by Board for Correction of Naval Records); *Jackson* v. *Mabus,* 808 F.3d 933, 936 (D.C. Cir. 2015).

VA proposes to add paragraph (h)(3)(ii), which would state that a finding that the evidence submitted is not new and material may be appealed using the process in paragraph (h)(1).

VA would recodify current paragraph (i)(3) as new § 9.20(h)(4). New § 9.20(h)(4) would restate the sentence in current § 9.20(i)(3). VA also proposes to explain that a member who files suit in U.S. district court after an adverse initial decision on a TSGLI claim by a uniformed service would be precluded from filing an appeal with the uniformed service identified in the decision if the lawsuit is pending before a U.S. district court, U.S. court of appeals, or U.S. Supreme Court or the time for appeal or filing a petition for a writ of certiorari has not expired. Paragraph (h)(4) would also state that, if a member appeals a decision to a U.S. district court after filing an appeal with a uniformed service, the appeal with the uniformed service would be stayed if the lawsuit is pending before a U.S. district court, U.S. court of appeals, or U.S. Supreme Court or the time for appeal or a petition for a writ of certiorari has not expired. This amendment is intended to streamline the TSGLI appellate process and prevent multiple, concurrent reviews of TSGLI appeals.

H. New § 9.20(i)—Payment of TSGLI

VA would recodify current § 9.20(j) as new § 9.20(i). VA would delete the word ''title'' in the text preceding current § 9.20(j)(1) and would amend new paragraph (i)(1) to correspond to proposed § 9.20(f)(1)(ii). New paragraph (i)(1) would state that a member's guardian, agent or attorney acting under a valid Power of Attorney, or trustee will be paid the TSGLI benefit if a medical professional has certified that the member is medically incapacitated in Part B of the Application for TSGLI Benefits Form. As explained above, we have changed ''legally incapacitated'' to ''medically incapacitated'' to make the regulation consistent with 38 U.S.C. 1980A(k)(1) and (2)(B).

I. New § 9.20(j)—Administration of TSGLI Program

VA would recodify current § 9.20(k) as new § 9.20(j).

III. New § 9.21—Schedule of Losses

VA proposes to recodify current §§ 9.21 and 9.22 as new §§ 9.22 and 9.23. VA also proposes add new § 9.21, which would: (1) Recodify certain definitions that are pertinent to the schedule of losses and are currently in § 9.20(e)(6) in new § 9.21(a) and amend certain definitions; (2) move criteria for certain losses from the definitions to the schedule of losses; (3) recodify the text preceding the current schedule as new § 9.21(b); (4) recodify the schedule of losses in current § 9.20(f) as new § 9.21(c); and (5) amend the criteria for certain losses.

A. New § 9.21(a)—Definitions of Terms

VA proposes to recodify definitions in current § 9.20(e)(6) that are relevant to the schedule in new § 9.21(a), amend certain existing definitions pertinent to the schedule, and add new definitions for terms not currently defined. In addition, current 38 CFR 9.20(e)(6)(i)–(iv) and (xiv)–(xxix) are in fact criteria for losses in the schedule rather than definitions. VA would therefore recodify these criteria in the schedule itself in new § 9.21(c) rather than define them in new § 9.21(a). This would also make it easier for adjudicators to decide claims because they could find all relevant criteria in the schedule.

1. Avulsion

In new § 9.21(a)(5), VA would define the term ''avulsion'' for purposes of new § 9.21(c)(16) pertaining to facial reconstruction to mean a forcible

detachment or tearing of bone and/or tissue due to a penetrating injury.

2. Consecutive

In new § 9.21(a)(6), VA would define ''consecutive'' to mean ''to follow in uninterrupted succession.'' This definition is consistent with the well-accepted meaning of the term. *Black's Law Dictionary* 304 (6th ed. 1990) (defining ''consecutive'' as ''[s]uccessive; succeeding one another in regular order; to follow in uninterrupted succession''); *Hill* v. *Tenn. Rural Health Improvement Ass'n,* 882 SW2d 801, 803 (Tenn. Ct. App. 1994).

3. Discontinuity Defect

In new § 9.21(a)(7), VA proposes to define ''discontinuity defect'' pertaining to facial reconstruction under new § 9.21(c)(16) to mean the absence of bone and/or tissue from its normal bodily location, which interrupts the physical consistency of the face and impacts at least one of the following functions: Mastication, swallowing, vision, speech, smell, or taste. The requirement that a discontinuity defect must impact mastication, swallowing, vision, speech, smell, or taste is intended to provide TSGLI benefits to members who cannot perform key facial functions without replacement of the bone or tissue from another part of the body or manufactured bone or tissue.

4. Hospitalization

VA proposes to recodify the definition of ''hospitalization'' in current § 9.20(e)(6)(xiii) at new § 9.21(a)(8) and to amend the definition to mean admission to a ''hospital'' as defined in 42 U.S.C. 1395x(e), which includes both inpatient critical care and inpatient rehabilitation facilities, or a ''skilled nursing facility'' under 42 U.S.C. 1395i–3(a). Experts we consulted indicated that patients with severe physical injuries covered by the schedule of losses are usually treated in a hospital and then an inpatient rehabilitation or skilled nursing care. We therefore intend for the periods of hospitalization required by the schedule to continue if a member is receiving treatment in a hospital or skilled nursing facility.

5. Inability To Carry Out Activities of Daily Living (ADLs)

Congress specified in 38 U.S.C. 1980A(b)(1)(H) that the inability to carry out ADLs resulting from a TBI is a qualifying loss. In this rulemaking, VA proposes to recodify current § 9.20(e)(6)(vi) as new § 9.21(a)(9), amend the definition, and define terms used in the amended definition.

The term ''inability to carry out the activities of daily living'' is defined in 38 U.S.C. 1980A(b)(2)(D) and current 38 CFR 9.20(e)(6)(vi) as the ''inability to independently perform at least'' two of six functions. VA proposes to delete ''independently'' from the definition of ADL because it is subject to varying interpretations and to clarify the term by stating in new § 9.21(a)(9) that the inability to carry out activities of daily living means that a medical professional documents that a member is unable to perform two of the six functions without assistance from another person, even if the member uses accommodating equipment or adaptive behavior while performing the functions. In order to further explain this definition, VA proposes to define the terms ''accommodating equipment,'' ''adaptive behavior,'' and ''assistance from another person'' in new § 9.21(a)(1), (2), and (4), respectively.

VA would define ''accommodating equipment'' in new paragraph (a)(1) to mean tools or supplies that enable a member to perform an ADL without assistance from another person, including, but not limited to, the following: wheelchair; walker or cane; reminder applications; Velcro clothing or slip-on shoes; grabber or reach extender; raised toilet seat; wash basin; shower chair; or shower or tub modifications such as wheelchair access or no-step access, grab-bar, or handle.

VA proposes to define the term ''adaptive behavior'' in new paragraph (a)(2) to mean compensating skills that allow a member to perform an ADL without assistance from another person.

VA proposes to define the term ''assistance from another person'' in new paragraph (a)(4) to mean that a member, even while using accommodating equipment or adaptive behavior, is nonetheless unable to perform an activity of daily living unless a person physically supports the member, is needed to be within arm's reach of the member to provide assistance because the member's ability fluctuates, or provides oral instructions to the member while the member attempts to perform the ADL. A medical professional must document that a member requires assistance from another person, even while the member is using accommodating equipment and/or adaptive behavior, to perform two of the six ADLs.

VA also proposes to define each of the six functions in new § 9.21(a)(9)(A) through (F), as discussed below. These definitions are based primarily on the Katz Index of Independence in Activities of Daily Living, one of the most commonly used tools to assess basic ADLs. Michelle E. Mlinac and Michelle C. Feng, *Assessment of Activities of Daily Living, Self-Care, and Independence,* 31 Archives of Clinical Neuropsychology 506–516 (2016).

a. Bathing

VA proposes to define the term ''bathing'' to mean washing, while in a shower or bathtub or using a sponge bath, at least three of the six following regions of the body in its entirety: Head and neck, back, front torso, pelvis (including the buttocks), arms, or legs. For example, if a member is unable to bathe three or more regions of the body in a tub or shower without assistance from another person, even while the member uses accommodating equipment or adaptive behavior while bathing, the member would be unable to independently bathe. However, if a member is able to bathe all but two parts of the body via a sponge bath without such assistance, accommodating equipment or adaptive behavior, the member would be considered able to bathe.

b. Continence

VA proposes to define the term ''continence'' to mean complete control of bowel and bladder functions or management of a catheter or colostomy bag, if present.

c. Dressing

VA proposes to define the term ''dressing'' to mean obtaining clothes and shoes from a closet or drawers and putting on the clothes and shoes, excluding tying shoelaces or use of belts, buttons, or zippers. If a member can use accommodating equipment to obtain and put on clothes and shoes and does not require assistance from another person, the member would be able to perform this ADL. For example, if a member can use slip-on shoes, clothing without buttons, or clothing with elastic bands and does not require assistance from another person, the member would be able to dress.

d. Eating

VA proposes to define the term ''eating'' to mean moving food from a plate to the mouth or receiving nutrition via a feeding tube or intravenously, and to exclude preparing or cutting food or obtaining liquid nourishment through a straw or cup.

e. Toileting

VA proposes to define the term ''toileting'' to mean getting on and off the toilet, taking clothes off before toileting and putting on clothes after toileting, cleaning organs of excretion

after toileting, or using a bedpan or urinal.

f. Transferring

VA proposes to define the term ''transferring'' to mean moving in and out of a bed or chair.

6. Permanent

VA proposes to define the term ''permanent'' in new § 9.21(a)(10) to mean clinically stable and reasonably certain to continue throughout the lifetime of the member.

7. Therapeutic Trip

VA proposes to define the term ''therapeutic trip'' in new § 9.21(a)(11) as a hospital or facility-approved pass, signed by the member's attending physician, to leave a hospital or facility, as defined in 42 U.S.C. 1395x(e) or 1395i–3(a), respectively, accompanied or unaccompanied by hospital or facility staff, as part of a member's treatment plan and with which the member is able to return without having to be readmitted to the hospital or facility. VA research indicated that such trips are often part of the treatment plan for individuals with traumatic brain injury, allowing the member and treatment team to evaluate how the member handles outside stimuli in his or her home or other environments. Because these therapeutic trips are part of a member's treatment, we intend for any period of hospitalization to include such trips.

B. New § 9.21(b)—Requisite Period of Consecutive Days for Scheduled Losses

VA proposes to recodify the text preceding the schedule of losses in current § 9.20(f) in new § 9.21(b)(1)–(2) and to amend the text.

New § 9.21(b)(3) would explain the calculation of the required periods of consecutive days of losses in new § 9.21(c)(17), (18), (20), and (21). New § 9.21(b)(3)(A) would state that a period of consecutive days of loss that is interrupted by a day or more during which the criteria for the scheduled loss are not satisfied will not be added together with a subsequent period of consecutive days of loss. The counting of consecutive days starts over at the end of any period in which the criteria for a loss are not satisfied. For example, if a member has an ADL loss due to traumatic injury other than traumatic brain injury (OTI) for 31 days, regains the ability to carry out ADLs for two months, and then has a setback and is unable to carry out ADL for another 30 days, these two periods of ADL loss would not be added together to meet the 60-day payment milestone for ADL loss under paragraph (c)(20). Rather, the member would be entitled to an additional TSGLI payment under paragraph (c)(20) only if the second period of ADL loss lasts for 60 consecutive days.

New § 9.21(b)(3)(B) would state that, if a loss with a required time period milestone begins but is not completed within two years of the traumatic injury, the loss would nonetheless qualify for TSGLI if the requisite time period of loss continues uninterrupted and concludes after the end of the two-year period. For example, if a member suffered a TBI on January 1, 2018 and was unable to perform ADLs due to the TBI from December 15, 2019, through January 14, 2020, the member would be eligible for TSGLI for this time period because the period of ADL loss started within the two-year time limit and continued without interruption after the two-year limit.

Section 9.21(b)(3)(B) would also state that, if a member suffers a period of loss that continues uninterrupted immediately after the period of loss that concluded after expiration of the two-year time limit, the member would be entitled to TSGLI for this time period of loss. For example, if the member who suffered ADL loss from December 15, 2019, through January 14, 2020, suffered another loss of ADLs that continued uninterrupted from January 15, 2020, until February 14, 2020, the member would be entitled to a TSGLI benefit for this period of loss as well. However, if the second period of loss of ADLs did not commence until January 20, 2020, TSGLI would not be payable for another period of loss.

K. New § 9.21(c)(1)–(21)—Schedule of Losses

VA proposes to recodify current § 9.20(f)(1)–(21) as new § 9.21(c)(1)–(21), incorporate definitions in current § 9.20(e)(6)(i) through (v) and (xiv) through (xxix) in the paragraphs in new § 9.21(c) to which they pertain because they are in fact criteria rather than definitions for these losses, and amend certain losses as explained below.

1. New § 9.21(c)(2)—Total and Permanent Loss of Hearing

VA proposes to amend the criteria for total and permanent loss of hearing to explain that hearing acuity must be measured using pure tone audiometry (air conduction testing) without use of an amplification device. Pure tone audiometry is a very common and accepted method of testing hearing in the medical field. *See* 38 CFR 4.85(a).

2. New § 9.21(c)(7)—Uniplegia

VA proposes to amend the note in new § 9.21(c)(7) because of the new tiered payment structure for limb reconstruction under new § 9.21(c)(14) and (15). Under the current schedule in § 9.20(f)(7), the TSGLI payment for uniplegia cannot be combined with the payments for limb salvage or amputation of the same limb, because the initial payment for uniplegia, *i.e.,* $50,000, is the same for all three losses and provides financial support for the member during the rehabilitation period. 73 FR 71,926, 71,928 (Nov. 26, 2008). However, as explained below, VA proposes to amend new § 9.21(c)(14) and (15) to provide payments ranging from $25,000 to $50,000 for limb reconstruction, depending upon the number and type of surgeries required. VA therefore proposes to revise the note in new § 9.20(c)(7) to explain that: (1) Payment for uniplegia of the arm or leg cannot be combined with loss for amputation of the same arm under new paragraph (c)(9) or (10) or of the same leg under new paragraph (c)(11) or (12); and (2) the higher TSGLI payment will be made for uniplegia under new paragraph (c)(7) or limb reconstruction under new paragraph (c)(14) or (15) for the same limb.

3. New § 9.21(c)(8)—Burns

Under current § 9.20(e)(6)(xvii) and (f)(8), a TSGLI benefit of $100,000 is payable for ''2nd degree (partial thickness) or worse burns covering at least 20 percent of the body, including the face and head, or 20 percent of the face alone.'' However, the experts we consulted indicated that, even though the American Burn Association standard for referral to a Burn Center is partial thickness burns (or worse) of greater than 10% total body surface area (TBSA), patients with full thickness burns of at least 20% TBSA have more extensive rehabilitation needs and risk of complications than patients with partial thickness burns of at least 20% TBSA that do not require grafting. *http://ameriburn.org/wp-content/uploads/2017/05/acs-resources-burn-chapter-14.pdf.* Additionally, these specialists noted that the location of the burn on the body has a major impact on rehabilitation. For example, burns requiring skin grafts to joints and other body parts involved in ADL significantly lengthen rehabilitation periods.

VA proposes that new § 9.21(c)(8) pertaining to burns would incorporate current medical terminology for severity determinations of burns, specifically using ''partial thickness'' in place of

''2nd degree'' burns and ''full thickness'' in place of ''or worse.'' *http://ameriburn.org/quality-care/mass-casualty/burn-care-and-prevention.* Based upon the experts' advice, VA would also provide tiered payments based upon the varying levels of rehabilitation associated with various types and extent of burns. VA would state at the beginning of new paragraph (c)(8) that the percentage of the body burned may be measured using the Rule of Nines or any means of measurement generally accepted within the medical profession. Also, under new paragraph (c)(8), a member with partial thickness burns covering 20 percent of the face or body, without the need for skin grafting, would be entitled to $50,000. A member suffering partial thickness burns or worse located on the face, hands, feet, genitalia, perineum, ankles, knees, hips, wrists, elbows or shoulders that require skin grafting or full thickness burns covering 20 percent of the face or body would be entitled to $100,000.

VA also proposes to add a note at the end of new paragraph (c)(8) explaining that road rash is an abrasion and not a burn and therefore will be evaluated for loss purposes under new § 9.21(c)(20) or (21). *https://www.merriam-webster.com/dictionary/road%20rash.*

4. New § 9.21(c)(9)—Amputation of a Hand at or Above the Wrist

VA proposes to revise the note at the end of new § 9.21(c)(9) to state that: (1) Payment for amputation of the hand cannot be combined with payment for loss due to uniplegia under new paragraph (c)(7) or amputation at or above the metacarpophalangeal joints under new paragraph (c)(10) for the same hand; and (2) the higher payment will be made for either amputation of the hand under new paragraph (c)(9) or limb reconstruction of the arm under new paragraph (c)(14). As explained above, these proposed amendments are necessitated by the new tiered limb reconstruction standard.

5. New § 9.21(c)(10)—Amputation at or Above the Metacarpophalangeal Joint(s) of Either the Thumb or the Other 4 Fingers of 1 Hand

VA proposes to revise the note at the end of new § 9.21(c)(10) to state that: (1) Payment for amputation of 4 fingers on 1 hand or thumb alone cannot be combined with payment for loss due to uniplegia or amputation of the same hand under new paragraph (c)(7) or (c)(9), respectively; and (2) payment will be made for the higher payment for amputation of 4 fingers on 1 hand or thumb alone under new paragraph (c)(10) or loss due to limb reconstruction of the arm for the same hand/arm under new paragraph (c)(14). These proposed amendments are necessitated by the new tiered limb reconstruction standard.

6. New § 9.21(c)(11)—Amputation of a Foot at or Above the Ankle

VA proposes to amend the note at the end of new § 9.21(c)(11) to state that: (1) Payment for loss under new paragraph (c)(11) cannot be combined with the loss due to uniplegia or amputation of the foot below the ankle under new paragraph (c)(7) or (12), respectively; and (2) payment will be made for the higher payment for amputation of foot under new paragraph (c)(11) or amputation of toes under new paragraph (c)(13) or loss due to limb reconstruction of the leg under new paragraph (c)(15). These proposed amendments are necessitated by the new tiered limb reconstruction standard.

7. New § 9.21(c)(12)—Amputation at or Above the Metatarsophalangeal Joints of all Toes on 1 Foot

VA proposes to revise the note at the end of new § 9.21(c)(12) to state that: (1) Payment for amputation of all toes including the big toe on 1 foot cannot be combined with losses under new paragraph (c)(7) or (11) for the same foot; (2) the higher payment for amputation of all toes including the big toe on 1 foot under new paragraph (c)(12) or loss under new paragraph (c)(13) will be made for the same foot; and (3) the higher payment for amputation of all toes including the big toe on 1 foot under new paragraph (c)(12) or limb reconstruction of the leg under new paragraph (c)(15) will be made for the same foot. These proposed amendments are necessitated by the new tiered limb reconstruction standard.

8. New § 9.21(c)(13)—Amputation at or Above the Metatarsophalangeal Joint(s) of Either the Big Toe, or the Other 4 Toes on 1 Foot

VA proposes to add a note to new § 9.21(c)(13) stating that: (1) The higher payment for amputation of big toe only, or other 4 toes on 1 foot, under new paragraph (c)(13) or uniplegia under new paragraph (c)(7) will be made for the same foot; (2) the higher payment for amputation of big toe only, or other 4 toes on 1 foot, under new paragraph (c)(13) or amputation of the foot at or above the ankle under new paragraph (b)(11) will be made for the same foot; (3) the higher payment for amputation of big toe only, or other 4 toes on 1 foot, under new paragraph (c)(13) or amputation at or above the metatarsophalangeal joints under new paragraph (c)(12) will be made for the same foot; and (4) the higher payment for amputation of big toe only, or other 4 toes on 1 foot, under new paragraph (c)(13) or limb reconstruction of the leg under new paragraph (c)(15) will be made for the same foot. These proposed amendments are necessitated by the new tiered limb reconstruction standard.

9. New § 9.21(c)(14) and (15)—Limb Reconstruction

Current § 9.20(e)(6)(xix) defines the term ''limb salvage'' as ''a series of operations designed to save an arm or leg with all of its associated parts rather than amputate it,'' and also states that a surgeon must certify that the ''option of amputation of the limb(s) was a medically justified alternative to salvage, and the patient chose to pursue salvage.'' However, TSGLI claim adjudicators, medical professionals, and claimants have indicated that the decision to choose salvage over amputation is a choice that is often not clearly indicated in medical records and, therefore, it is difficult to substantiate a claim for this loss.

Also, experts we consulted indicated that surgical teams do not simply attempt to save or salvage a limb but also to reconstruct it to allow for a return to some degree of functionality for the patient. They also stated that the term ''reconstruction'' refers to rebuilding a limb's skin, bone, nerve, and vascular system rather than repairing a limb due to an open or closed fracture. Additionally, they stated that there are four types of injuries that require limb construction and four surgical procedures that constitute limb reconstruction. They stated that not every patient undergoes all four types of surgeries, but that at least one or more would be expected.

Based on this input, VA proposes to change the term ''limb salvage'' to ''limb reconstruction'' in new § 9.21(c)(14) and (15). To qualify for a loss based upon ''limb reconstruction,'' a surgeon would have to document that a member's limb has a: (1) Bony injury requiring bone grafting to re-establish stability and enable mobility of the limb; (2) soft tissue defect that requires grafting/flap reconstruction to reestablish stability and enable mobility of the limb; (3) vascular injury which requires vascular reconstruction to restore blood flow and support bone and soft tissue regeneration; or (4) nerve injury that requires nerve reconstruction to allow for motor and sensory restoration and muscle re-enervation. These criteria

would focus on the critical issue of whether the limb has such significant functional limitations from a traumatic event that a surgeon would be medically justified in offering a member the option of amputating the limb rather than reconstructing it.

VA also proposes to create a tiered standard for loss for reconstruction of an arm or leg based upon the number and types of surgery required in new paragraphs (c)(14) and (15). If a member undergoes one of four surgeries, the member would receive $25,000. If a member has two or more surgeries, the member would be entitled to $50,000.

VA also proposes to add a note to new paragraph (c)(14) stating that the higher payment for limb reconstruction of the arm or uniplegia under new paragraph (c)(7) will be made for the same arm. The note would also state that the higher payment for limb reconstruction of arm or amputation of a hand at or above the wrist under new paragraph (c)(9) will be made for the same arm, and that the higher payment for limb reconstruction of the arm or amputation at or above the metacarpophalangeal joint(s) of either the thumb or the other 4 fingers on 1 hand under new paragraph (c)(10) will be made for the same arm.

VA proposes to add a note in new § 9.21(c)(15) pertaining to limb reconstruction of a leg stating that: (1) The higher payment for limb reconstruction of leg or uniplegia under new paragraph (c)(7) will be made for the same leg; (2) the higher payment for limb reconstruction of the leg or amputation of a foot at or above the ankle under new paragraph (c)(11) will be made for the same leg; (3) the higher payment for limb reconstruction of leg or amputation at or above the metatarsophalangeal joints of all toes on 1 foot under new paragraph (c)(12) will be made for the same leg; and (4) the higher payment for limb reconstruction of leg or amputation at or above the metatarsophalangeal joint(s) of either the big toe, or the other 4 toes on 1 foot under new paragraph (c)(13) will be made for the same leg.

10. New § 9.21(c)(16)—Facial Reconstruction

VA proposes to amend the criteria for facial reconstruction in new § 9.21(c)(16) to clarify the nature and extent of loss required for each payment under this paragraph. Discontinuity of the upper or lower jaw and eyes would require bone loss; discontinuity of the nose would require loss of cartilage or tissue; discontinuity of the upper or lower lip would require tissue loss; and discontinuity of facial areas would require loss of bone or tissue. We also propose to add a requirement that a surgeon document that the criteria for ''facial reconstruction'' are satisfied in order to establish the loss.

VA also proposes to revise the second note in new paragraph (c)(16) by changing ''paragraphs 9.20(f)(1) through (18)'' to ''§ 9.21(c)(1) through (19)'' to incorporate the 2012 amendments to the schedule that added genitourinary system losses and to make the note consistent with the recodification of the schedule. VA also proposes to add a third note stating that bone grafts for teeth implants would not constitute facial reconstruction under new paragraph (c)(16) because teeth implants do not involve a ''discontinuity defect'' of the jaw, which would be defined in new § 9.21(a)(7) as ''the absence of bone and/or tissue from its normal bodily location.'' Teeth implants instead involve placing additional tissue on top of the existing jaw to build up the area for the implants. *https://www.colgate.com/en-us/oral-health/cosmetic-dentistry/implants/single-tooth-implants.*

11. New § 9.21(c)(17)—Coma or TBI

We have revised the title of this loss by omitting ''from traumatic injury'' because the phrase is redundant of new § 9.20(e)(1) defining a ''scheduled loss'' as a condition in new § 9.21(c) ''if directly caused by a traumatic injury.'' Current § 9.20(e)(6)(xviii) does not actually define ''coma,'' but rather contains the criterion for this scheduled loss. *i.e.,* a Glasgow Coma Scale (GCS) Score of 8 or less. The GCS possible values range from 3, indicating deep coma, to 15, indicating normal consciousness. *https://www.glasgowcomascale.org/faq.* According to the Centers for Disease Control, a GCS score of 8 or less indicates a severe head Injury. *https://www.cdc.gov/masstrauma/resources/gcs.pdf.* We therefore propose to incorporate the criterion for ''coma,'' *i.e.,* a Glasgow Coma Score of 8 or less, in the title of the loss.

12. New § 9.21(c)(18)—Hospitalization Due to TBI

VA proposes to revise the first note in new § 9.21(c)(18) to explain that: (1) Payment for hospitalization would replace only the first milestone in new § 9.21(c)(17), *i.e.,* 15 consecutive days of coma or ADL loss; and (2) payment would be made for the 15-day period of hospitalization or the first period of coma or ADL loss, whichever occurs earlier.

The note would also be amended to state that, once payment has been made under new § 9.21(c)(18) based on hospitalization, coma, or ADL loss, a member would not be entitled to additional payments for a subsequent 15-day period of hospitalization due to the same traumatic injury. This proposed amendment aligns with 38 U.S.C. 1980A(a)(2), which states that, ''[i]f a member suffers more than one . . . qualifying loss as a result of traumatic injury from the same traumatic event, payment shall be made under [the schedule] for the *single loss* providing the highest payment.'' (Emphasis added.)

Finally, VA would amend the note to state that, if a member receives a TSGLI payment under new § 9.21(c)(18) based upon hospitalization, such payment may replace only the first payment for loss of ADLs under new paragraph (c)(17), and the member would be entitled to an additional payment for loss of ADLs only if the member reaches a subsequent milestone for loss of ADLs. For example, if a member suffers a TBI and is hospitalized for 16 days, the member would be entitled to a TSGLI payment for 15 days of hospitalization under new paragraph (c)(18). To obtain an additional payment for TBI based on loss of ADLs under new paragraph (c)(17), the member would have to suffer a loss of ADLs for an additional 14 days immediately after discharge from the hospital to reach the next payment milestone of 30 consecutive days of ADL loss. If the member can perform ADLs immediately after discharge from the hospital and then later has a setback and loses ADLs, the consecutive day count would start anew.

VA would also amend the second note in current § 9.20(f)(18) to explain that the duration of hospitalization under new § 9.21(c)(17) includes any period of time for a therapeutic trip as defined in new § 9.21(a)(11).

Finally, TBI, mental illnesses, and brain or neurologic disorders can have similar symptomology and often require in-depth diagnostic assessment to discern which is present or if both may be present. *See* Jan E. Kennedy, et al., *Posttraumatic Stress Disorder and Posttraumatic Stress Disorder-Like Symptoms and Mild Traumatic Brain Injury,* 44 J. Rehabilitation Research & Dev. 895–920 (2007); D.G. Amen, et al., *Functional Neuroimaging Distinguishes Posttraumatic Stress Disorder from Traumatic Brain Injury in Focused and Large Community Datasets,* 10 Plos One 1–22 (2015). Therefore, VA proposes to add a note to new § 9.21(c)(18) stating that, if a member is hospitalized for 15 consecutive days for a diagnostic assessment for any mental illness and/or brain or neurologic disorder, and if

the assessment concludes that the member has a mental illness or brain or neurologic disorder only, the member would not be entitled to TSGLI under this paragraph. In such cases, the hospitalization would be caused solely by an illness or disease, such as posttraumatic stress disorder, which falls under the exclusions from traumatic injury pursuant to 38 CFR 9.20(c)(2)(i) and (ii). However, if a member is hospitalized for 15 consecutive days for a diagnostic assessment to determine whether the member has TBI, the loss would be payable if a member is diagnosed with TBI, TBI and PTSD, or PTSD and not TBI. If a member is hospitalized for 15 consecutive days for a diagnostic assessment to determine whether the member has PTSD, the loss would be payable if the member has TBI or TBI and PTSD.

13. New § 9.21(c)(21)—Hospitalization Due to OTI

VA proposes to amend the first and second notes under new § 9.21(c)(21) for loss based on hospitalization due to OTI. These amendments would be the same as the amendments to the first and second notes in new § 9.21(c)(18). The first note in current § 9.20(f)(21) states that ''[p]ayment for hospitalization replaces the first payment period in loss 19.'' VA proposes to amend the note to refer to ''loss 20'' for OTI resulting in inability to perform ADLs rather than loss 19 and to state that payment for hospitalization would only replace the first milestone in new § 9.21(c)(20), *i.e.,* 30 consecutive days of ADL loss. This corrects a scrivener's error in 2011 when genitourinary losses were added to the schedule of losses. 76 FR 75458 (Dec. 2, 2011).

The first note would also be amended to state that payment would be made for the 15-day period of hospitalization or the first period of ADL loss, whichever occurs earlier and that, once payment has been made under new § 9.21(c)(20) on the basis of hospitalization or ADL loss, a member would not be entitled to additional payments for a subsequent 15-day period of hospitalization due to the same OTI. For example, if a member suffers an OTI due to a motorcycle accident, is hospitalized for 10 days, and experiences loss of ADL for 30 days, the member would be entitled to a TSGLI payment based on loss of ADLs for 30 days. If the member is subsequently hospitalized for another consecutive 15 days, a month later for the same motorcycle accident, the member would not be entitled to an additional TSGLI payment for hospitalization. These proposed amendments are consistent with 38 U.S.C. 1980A(a)(2), which states for payment under the schedule ''for the single loss providing the highest payment'' if a member suffers more than one qualifying loss as a result of traumatic injury from the same traumatic event.

Finally, VA would amend the first note to state that, if a member receives a TSGLI payment under new paragraph (c)(20) based upon loss of ADLs, the member would be entitled to an additional payment for loss of ADLs under new paragraph (c)(20) only if the member reaches a subsequent milestone for loss of ADLs in new paragraph (c)(20), *i.e.,* 60, 90 or 120 consecutive days of ADL loss without a break in the consecutive day period where no ADL loss is present. This proposed amendment aligns with the design of the TSGLI program, which is to provide benefits payments for severe traumatic injuries that require an extended period of rehabilitation. 70 FR 75940. Requiring a member to reach the next payment milestone without a break between the consecutive days ensures that the injury is equivalent in severity to other losses under the schedule.

VA would also amend the second note in new § 9.21(c)(21) to explain that the duration of hospitalization includes a period of time between admission and discharge during which a member takes a therapeutic trip as defined in new § 9.21(a)(11).

III. Petition for Rulemaking

On March 16, 2015, a petition for rulemaking was submitted to the Secretary of Veterans Affairs requesting that VA:

1. Amend the definition of ''traumatic event'' in current § 9.20(b)(1) to include ''application of . . . explosive ordnance . . . causing damage to a living being.''
2. Amend the definition of ''traumatic injury'' in current § 9.20(c)(2)(ii) to include a ''physical illness or disease . . . caused by . . . explosive ordnance.''
3. Amend the list of exclusions in current § 9.20(e)(4)(i) to provide that a scheduled loss resulting from a ''physical illness or disease caused by explosive ordnance'' will not be excluded from TSGLI coverage.
4. Add the following definition of ''explosive ordnance'' to current § 9.20(e)(6): ''all munitions containing explosives, . . . includ[ing], but . . . not limited to, improvised explosive devices (IEDs).''

In considering this proposal, VA conducted a review of medical literature on the numbers, types, and onset period of illnesses and diseases resulting from explosive ordnance exposure. VA also interviewed a range of medical experts in the fields of traumatic brain injury, concussive force trauma, combat trauma, and retained toxic fragment impacts as well as epidemiologists and other medical researchers studying the impacts of blast injuries on today's military. Based upon this review of the issue, VA denies the petition for rulemaking for the following reasons.

A. Definition of ''Traumatic Event''

Current § 9.20(b) defines a ''traumatic event'' as ''the application of external force, violence, chemical, biological, or radiological weapons, or accidental ingestion of a contaminated substance causing damage to a living being.'' We agree with petitioner that IEDs are a unique hazard of military service. Therefore, since the start of the TSGLI program on December 1, 2005, explosion of an ordnance including an improvised explosive device causing damage to a living being has been considered as a traumatic event, *i.e.,* damage caused by application of external force due to fragments of debris propelled by the explosion or due to a member being thrown to the ground or into an object. *Gulf War & Health, Volume 7: Long-Term Consequences of Traumatic Brain Injury,* at 7 (2009). Between December 22, 2005, and July 31, 2019, the TSGLI program provided more than $357 million in benefits to 6,207 servicemembers who suffered a traumatic injury due to an improvised explosive device, mortar attack, shrapnel, or rocket propelled grenade that resulted in a scheduled loss. VA, therefore, sees no need to amend § 9.20(b)(1) to include an explosive ordnance or to add a definition of improvised explosive device to § 9.20(e)(6).

B. Illness or Disease Caused by Explosive Ordnance

The petition seeks to amend current 38 CFR 9.20(c)(2)(ii) and (e)(4)(i) to ensure TSGLI coverage of physical illness or disease caused by TBI, which has been called a signature injury of the conflict in Iraq. Petition at 12–15. Petitioner contends that the harm caused by explosion of an ordnance is ''just like'' application of chemical, biological, and radiological weapons and accidental ingestion of a contaminated substance because they ''produce immediate bodily harm but their biological effects may *not* immediately manifest'' and ''may have a latency of months to years before manifesting.'' Petition at 23. Petitioner's request is inconsistent with the nature

of TSGLI, which is modeled on AD&D insurance, and congressional intent.

The plain language of 38 U.S.C. 1980A(a)(1) and (2), (b)(1), (c)(1) and (2) authorizes TSGLI benefits for a qualifying loss resulting directly from a ''traumatic injury.'' The word ''disease'' does not appear in the statute. Consistent with the maxim ''*expressio unius est exclusio alterius,*'' Congress knows how to include TSGLI coverage for diseases if it so desires, and it did not do so. *See Russello* v. *United States,* 464 U.S. 16, 23 (1983) (''[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.'').

VA implemented 38 U.S.C. 1980A in 2005 by defining the term ''traumatic injury'' in current 38 CFR 9.20(c)(1) to mean ''physical damage . . . caused by'' the ''application of external force, violence, chemical, biological, or radiological weapons, or accidental ingestion of a contaminated substance.'' In the 2005 interim final-rule notice, VA stated that ''[w]e believe that inherent in the term 'traumatic injury' is the notion that the injury occurs immediately.'' 70 FR 75,941; *see* 10 Couch on Insurance § 139:28, at 139–64 (''accidental bodily injury has been defined as a localized abnormal condition of the living body directly and contemporaneously caused by accident''). VA expressly excluded losses caused by a ''disease'' from TSGLI coverage in current 38 CFR 9.20(c)(2)(ii) and (e)(4)(i), which states that ''traumatic injury'' does not include damage to a living body caused by a disease, whether physical or mental in nature. 70 FR 75,941. VA stated that the ''term 'injury' refers to the result of an external trauma rather than a degenerative process, while the ''term 'disease' . . . refers to some type of internal infection or degenerative process.'' *Id.* (citing VAOPGCPREC 86–90).

VA's conclusion that TSGLI only extends to traumatic injuries which cause immediate harm and require immediate treatment as compared to diseases is supported by the legislative history when 38 U.S.C. 1980A was enacted in 2005. TSGLI coverage was intended for injuries occurring immediately after a traumatic event, *e.g.,* wounds suffered on the battlefield, and to provide financial support when the wounded servicemembers return home and are undergoing rehabilitation prior to medical discharge from service. *See* 151 Cong. Rec. 7454–55 (2005).

VA, however, defined ''injury'' to include physical illness or disease ''caused by a pyogenic infection, chemical, biological or radiological weapons, or accidental ingestion of a contaminated substance'' because ''including immediate traumatic harm due to those unique hazards of military service is consistent with the purpose of TSGLI.'' 70 FR 75,941 (emphasis added); 38 CFR 9.20(c)(2)(ii). VA stated that the ''physical damage resulting in a covered loss would generally occur immediately and require prompt medical treatment.'' 70 FR 75,941.

Scientific reports indicate that the consequences of a TBI may not become manifest for a long period of time. For example, the Institute of Medicine report, *Long-Term Consequences of Traumatic Brain Injury,* at 7, found a ''weak but significant association between TBI and meningioma and of an increase in risk of brain tumors 10 years or more after TBI; that suggests a long latent period before clinical presentation.'' *See also id.* at 355. A study showing a link between TBI and increased risk of stroke in the first five years after injury found that, in the cohort studied, the average time between a patient's use of health care services and onset of stroke was 543 days for patients with TBI. Yi-Hua Chen, et al., *Patients with Traumatic Brain Injury: Population-Based Study Suggests Increased Risk of Stroke,* 42 Stroke 2733–39 (2011). Studies of occurrence of Parkinson's disease following TBI also show a delayed onset. Lindsay Wilson, *et al., Traumatic Brain Injury 4: The Chronic and Evolving Neurological Consequences of Traumatic Brain Injury,* 16 The Lancet 813–825 (2017).

Because Congress intended to provide TSGLI compensation for ''injuries'' rather than diseases occurring immediately after a traumatic event and that require prompt medical treatment, the Secretary denies the petition to provide TSGLI coverage for physical illness or disease caused by TBI that ''may not immediately manifest'' and ''may have a latency of months to years before manifesting.''

Paperwork Reduction Act

This proposed rule contains no provisions constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521).

Executive Orders 12866, 13563, and 13771

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this rule is not a significant regulatory action under Executive Order 12866.

VA's impact analysis can be found as a supporting document at *http://www.regulations.gov,* usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA's website at *http://www.va.gov/orpm* by following the link for ''VA Regulations Published From FY 2004 Through Fiscal Year to Date.''

This proposed rule is not expected to be an E.O. 13771 regulatory action because this proposed rule is not significant under E.O. 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule 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. The provisions contained in this proposed rulemaking are specifically managed, processed, and conducted within VA and through Prudential Insurance Company of America, which is not considered to be a small entity. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance number and title for the program affected by this document is 64.103, Life Insurance for Veterans.

List of Subjects in 38 CFR Part 9

Life insurance, Servicemembers, Veterans.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Brooks D. Tucker, Acting Chief of Staff, Department of Veterans Affairs, approved this document on July 17, 2020, for publication.

Luvenia Potts,

Regulation Development Coordinator, Office of Regulation Policy & Management, Office of the Secretary, Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs proposes to amend 38 CFR part 9 as follows:

PART 9—SERVICEMEMBERS' GROUP LIFE INSURANCE AND VETERANS' GROUP LIFE INSURANCE

■ 1. The authority citation for Part 9 continues to read as follows:

Authority: 38 U.S.C. 501, 1965–1980A, unless otherwise noted.

■ 2. Amend § 9.20 by:
■ a. Revising paragraph (b)(1);
■ b. Redesignating paragraph (c)(3) as (c)(4) and adding a new paragraph (c)(3);
■ c. Revising paragraphs (d)(2) and (4), and (e)(1), (e)(3)(i)(C) and (ii), and (e)(6);
■ c. Removing paragraph (f);
■ d. Revising paragraph (g);
■ e. Redesignating paragraph (h) as paragraph (f) and revising newly redesignated paragraph (f);
■ f. Redesignating paragraphs (i) through (k) as paragraphs (h) through (j) respectively and revising newly redesignated paragraphs (h) through (j).

The revisions read as follows:

§ 9.20 Traumatic injury protection.

* * * * *

(b) * * * (1) A traumatic event is damage to a living being occurring on or after October 7, 2001, caused by:

(i) Application of an external force;

(ii) Application of violence or chemical, biological, or radiological weapons;

(iii) Accidental ingestion of a contaminated substance;

(iv) Exposure to low environmental temperatures, excessive heat, or documented non-penetrating blast waves; or

(v) An insect bite or sting or animal bite.

* * * * *

(c) *What is a traumatic injury?*

* * * * *

(3) The term traumatic injury includes anaphylactic shock directly caused by an insect bite or sting or animal bite.

* * * * *

(d) * * *

(2) You must suffer a scheduled loss that results directly from a traumatic injury and from no other cause.

(i) A scheduled loss does not result directly from a traumatic injury and from no other cause if a pre-existing illness, condition, or disease or a post-service injury substantially contributed to the loss.

(ii) A scheduled loss results directly from a traumatic injury and no other cause if the loss is caused by a medical or surgical procedure used to treat the traumatic injury.

* * * * *

(4) You must suffer a scheduled loss under § 9.21(c) within two years of the traumatic injury.

(i) If a loss with a required time period milestone begins but is not completed within two years of the traumatic injury, the loss would nonetheless qualify for TSGLI if the requisite time period of loss continues uninterrupted and concludes after the end of the two-year period.

(ii) If a required time period for a loss is satisfied before the end of the two-year period and a member suffers another period of loss after expiration of the two-year time limit, the member is not entitled to TSGLI for this time period of loss.

* * * * *

(e) * * * (1) The term ''scheduled loss'' means a condition listed in the schedule in § 9.21(c) if directly caused by a traumatic injury and from no other cause. A scheduled loss is payable at the amount specified in the schedule.

* * * * *

(3) * * *

(i) * * *

(C) Diagnostic procedures, preventive medical procedures such as inoculations, medical or surgical treatment for an illness or disease, or any complications arising from such procedures or treatment, unless the diagnostic procedure or medical or surgical treatment is necessary to treat a traumatic injury;

* * * * *

(ii) Sustained while a member was committing an act that clearly violated a penal law classifying such an act as a felony.

* * * * *

(6) *Definitions.* For purposes of this section and § 9.21—

(i) The term *biological weapon* means biological agents or microorganisms intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(ii) The term *chemical weapon* means chemical substances intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(iii) The term *contaminated substance* means food or water made unfit for consumption by humans because of the presence of chemicals, radioactive elements, bacteria, or organisms.

(iv) The term *external force* means a sudden or violent impact from a source outside of the body that causes an unexpected impact and is independent of routine body motions such as twisting, lifting, bending, pushing, or pulling.

(v) The term *ingestion* means to take into the gastrointestinal tract by means of the mouth.

(vi) The term *medical professional* means a licensed practitioner of the healing arts acting within the scope of his or her practice, including, *e.g.,* a licensed physician, optometrist, nurse practitioner, registered nurse, physician assistant, or audiologist.

(vii) The term *medically incapacitated* means an individual who has been determined by a medical professional to be physically or mentally impaired by physical disability, mental illness, mental deficiency, advanced age, chronic use of drugs or alcohol, or other causes that prevent sufficient understanding or capacity to manage his or her own affairs competently.

(viii) The term *pyogenic infection* means a pus-producing infection.

(ix) The term *radiological weapon* means radioactive materials or radiation-producing devices intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(f) *How does a member make a claim for traumatic injury protection benefits?* (1)(i) A member who believes he or she qualifies for traumatic injury protection benefits must complete and sign Part A of the TSGLI Benefits Form and submit evidence substantiating the member's traumatic injury and resulting loss. A medical professional must complete and sign Part B of the Application for TSGLI Benefits Form.

(ii) If a medical professional certifies in Part B of the Application for TGSLI Benefits Form that a member is unable to sign Part A of the Form because the member is medically incapacitated, the Form must be signed by one of the following: The member's guardian; if none, the member's agent or attorney

acting under a valid Power of Attorney; if none, the member's military trustee.

(iii) If a member suffered a scheduled loss as a direct result of the traumatic injury, survived seven full days from the date of the traumatic event, and then died before the maximum benefit for which the service member qualifies is paid, the beneficiary or beneficiaries of the member's Servicemembers' Group Life Insurance policy should complete an Application for TSGLI Benefits Form.

(2) If a member seeks traumatic injury protection benefits for a scheduled loss occurring after submission of a completed Application for TSGLI Benefits Form for a different scheduled loss, the member must submit a completed Application for TSGLI Benefits Form for the new scheduled loss and for each scheduled loss that occurs thereafter and for each increment of a scheduled loss that occurs thereafter. For example, if a member seeks traumatic injury protection benefits for a scheduled loss due to coma from traumatic injury and/or the inability to carry out activities of daily living due to traumatic brain injury (§ 9.21(c)(17)), or the inability to carry out activities of daily living due to loss directly resulting from a traumatic injury other than an injury to the brain (§ 9.21(c)(20)), a completed Application for TSGLI Benefits Form must be submitted for each increment of time for which TSGLI is payable. Also, for example, if a member suffers a scheduled loss due to a coma, a completed Application for TSGLI Benefits Form should be filed after the 15th consecutive day that the member is in the coma, for which $25,000 is payable. If the member remains in a coma for another 15 days, another completed Application for TSGLI Benefits Form should be submitted and another $25,000 will be paid.

(g) *How will the uniformed service decide a TSGLI claim?*

(1) Each uniformed service will certify its own members for traumatic injury protection benefits based upon section 1032 of Public Law 109–13, section 501 of Public Law 109–233, and this section. The uniformed service will certify whether a member was insured under Servicemembers' Group Life Insurance at the time of the traumatic injury and whether the member sustained a qualifying traumatic injury and qualifying loss.

(2) The uniformed service office may request additional evidence from the member if the record does not contain sufficient evidence to decide the member's claim.

(3) The uniformed service office shall consider all medical and lay evidence of record, including all evidence provided by the member, and determine its probative value. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of TSGLI benefits, the uniformed service shall give the benefit of the doubt to the member.

(4) Notice of a decision regarding a member's eligibility for traumatic injury protection benefits will include an explanation of the procedure for obtaining review of the decision, and all negative decisions shall include a statement of the basis for the decision and a summary of the evidence considered.

(h) *How does a member or beneficiary appeal an adverse eligibility determination?* (1) Each uniformed service has a three-tiered appeal process. The first tier of appeal is called a reconsideration, followed by a second-level appeal and then a third-level appeal. A member, beneficiary, or other person eligible to submit a claim under paragraph (f)(1)(ii) or (iii) may submit an appeal using the appeal process of the uniformed service that issued the original decision.

(i) *Reconsideration.* (A) Reconsideration of an eligibility determination, such as whether the loss occurred within 730 days of the traumatic injury, whether the member was insured under Servicemembers' Group Life Insurance when the traumatic injury was sustained, or whether the injury was self-inflicted or whether a loss of hearing was total and permanent, is initiated by filing, with the office of the uniformed service identified in the eligibility decision within one year of the date of a denial of eligibility, a written notice of appeal that identifies the issues for which reconsideration is sought.

(B) The uniformed service TSGLI office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and issue a decision on the claim.

(ii) *Second-level appeal.* (A) A second-level appeal of the reconsideration decision is initiated by filing, with the second-level appeal office of the uniformed service within one year of the date of the reconsideration decision, a written notice of appeal that identifies the issues being appealed.

(B) The uniformed service second-level appeal office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and issue a decision on the claim.

(iii) *Third-level appeal.* (A) A third-level review of the second-level uniformed service appeal office is initiated by filing, with the third-level appeal office of the uniformed service within one year of the date of the decision by the second-level appeal office of the uniformed service, a written notice of appeal that identifies the issues being appealed.

(B) The uniformed service third-level appeal office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and issue a decision on the claim.

(2) If a timely notice of appeal seeking reconsideration of the initial decision by the uniformed service or seeking review of the decision by the second-level uniformed service appeal office is not filed, the initial decision by the uniformed service or the decision by the second-level uniformed service appeal office, respectively, shall become final, and the claim will not thereafter be readjudicated or allowed except as provided in paragraph (h)(3).

(3) New and material evidence. (i) If a member, beneficiary, or other person eligible to submit a claim under paragraph (f)(1)(ii) or (iii) submits new and material evidence with respect to a claim that has been finally disallowed as provided in paragraph (h)(2), the uniformed service office will consider the evidence, determine its probative value, and readjudicate the claim. New and material evidence is evidence that was not previously part of the record before the uniformed service, is not cumulative or redundant of evidence of record at the time of the prior decision and is likely to have a substantial effect on the outcome.

(ii) A decision finding that new and material evidence was not submitted may be appealed in accordance with paragraph (h)(1).

(4) Nothing in this section precludes a member from pursuing legal remedies under 38 U.S.C. 1975 and 38 CFR 9.13. However, if a member files suit in U.S. district court after an adverse initial decision on a TSGLI claim by a uniformed service, the member may not file an appeal pursuant to paragraph (h)(1) if the lawsuit is pending before a U.S. district court, U.S. court of appeals, or U.S. Supreme Court or the time for appeal or filing a petition for a writ of certiorari has not expired. If a member files suit in U.S. district court after filing an appeal pursuant to paragraph (h)(1), the appeal will be stayed if the lawsuit

is pending before a U.S. district court, U.S. court of appeals, or U.S. Supreme Court or the time for appeal or filing a petition for a writ of certiorari has not expired.

(i) *Who will be paid the traumatic injury protection benefit?* The injured member who suffered a scheduled loss will be paid the traumatic injury protection benefit in accordance with 38 U.S.C. 1980A except under the following circumstances:

(A) If a member has been determined by a medical professional, in Part B of the Application for TSGLI Benefits Form, to be medically incapacitated, the member's guardian or, or if there is no guardian, the member's agent or attorney acting under a valid Power of Attorney will be paid the benefit on behalf of the member.

(B) If no guardian, agent, or attorney is authorized to act as the member's legal representative, a military trustee who has been appointed under the authority of 37 U.S.C. 602 will be paid the benefit on behalf of the member. The military trustee will report the receipt of the traumatic injury benefit payment and any disbursements from that payment to the Department of Defense.

(C) If a member dies before payment is made, the beneficiary or beneficiaries who will be paid the benefit will be determined in accordance with 38 U.S.C. 1970(a).

(j) The Traumatic Servicemembers' Group Life Insurance program will be administered in accordance with this rule, except to the extent that any regulatory provision is inconsistent with subsequently enacted applicable law.

■ 3. Redesignate §§ 9.21 and 9.22 as §§ 9.22 and 9.23 and add a new § 9.21 to read as follows:

§ 9.21 Schedule of Losses.

(a) *Definitions.* For purposes of the Schedule of Losses in paragraph (c)—

(1) The term *accommodating equipment* means tools or supplies that enable a member to perform an activity of daily living without the assistance of another person, including, but not limited to, a wheelchair; walker or cane; reminder applications; Velcro clothing or slip-on shoes; grabber or reach extender; raised toilet seat; wash basin; shower chair; or shower or tub modifications such as wheelchair access or no-step access, grab-bar or handle.

(2) The term *adaptive behavior* means compensating skills that allow a member to perform an activity of daily living without the assistance of another person.

(3) The term *amputation* means the severance or removal of a limb or genital organ or part of a limb or genital organ resulting from trauma or surgery. With regard to limbs, an amputation above a joint means a severance or removal that is closer to the body than the specified joint is.

(4) The term *assistance from another person* means that a member, even while using accommodating equipment or adaptive behavior, is nonetheless unable to perform an activity of daily living unless another person physically supports the member, is needed to be within arm's reach of the member to provide assistance because the member's ability fluctuates, or provides oral instructions to the member while the member attempts to perform the activity of daily living.

(5) The term *avulsion* means a forcible detachment or tearing of bone and/or tissue due to a penetrating or crush injury.

(6) The term *consecutive* means to follow in uninterrupted succession.

(7) The term *discontinuity defect* means the absence of bone and/or tissue from its normal bodily location, which interrupts the physical consistency of the face and impacts at least one of the following functions: Mastication, swallowing, vision, speech, smell, or taste.

(8) The term *hospitalization* means admission to a ''hospital'' as defined in 42 U.S.C. 1395x(e) or ''skilled nursing facility'' as defined in 42 U.S.C. 1395i–3(a).

(9) The term *inability to carry out activities of daily living* means the inability to perform at least two of the six following functions without assistance from another person, even while using accommodating equipment or adaptive behavior, as documented by a medical professional.

(i) *Bathing* means washing, while in a bathtub or shower or using a sponge bath, at least three of the six following regions of the body in its entirety: Head and neck, back, front torso, pelvis (including the buttocks), arms, or legs.

(ii) *Continence* means complete control of bowel and bladder functions or management of a catheter or colostomy bag, if present.

(iii) *Dressing* means obtaining clothes and shoes from a closet or drawers and putting on the clothing and shoes, excluding tying shoelaces or use of belts, buttons, or zippers.

(iv) *Eating* means moving food from a plate to the mouth or receiving nutrition via a feeding tube or intravenously but does not mean preparing or cutting food or obtaining liquid nourishment through a straw or cup.

(v) *Toileting* means getting on and off the toilet; taking clothes off before toileting or putting clothes on after toileting; cleaning organs of excretion after toileting; or using a bedpan or urinal.

(vi) *Transferring* means moving in and out of a bed or chair.

(10) The term *permanent* means clinically stable and reasonably certain to continue throughout the lifetime of the member.

(11) The term *therapeutic trip* means an approved pass by the member's attending physician to leave a hospital as defined in 42 U.S.C. 1395x(e) or ''skilled nursing facility'' as defined in 42 U.S.C. 1395i–3(a), accompanied or unaccompanied by hospital or facility staff, as part of a member's treatment plan and with which the member is able to return without having to be readmitted to the hospital or facility.

(b)(1) For losses listed in paragraphs (c)(1) through (19) of this section—

(i) Except where noted otherwise, multiple losses resulting from a single traumatic event may be combined for purposes of a single payment.

(ii) The total payment amount may not exceed $100,000 for losses resulting from a single traumatic event.

(2) For losses listed in paragraphs (c)(20) and (21) of this section—

(i) Payments may not be made in addition to payments for losses under paragraphs (c)(1) through (19); instead, the higher amount will be paid.

(ii) The total payment amount may not exceed $100,000 for losses resulting from a single traumatic event.

(3) Required period of consecutive days of loss. For losses in paragraphs (c)(17) through (18) and (20) through (21)—

(i) A period of consecutive days of loss that is interrupted by a day or more during which the criteria for the scheduled loss are not satisfied will not be added together with a subsequent period of consecutive days of loss. The counting of consecutive days starts over at the end of any period in which the criteria for a loss are not satisfied.

(ii) A required period of consecutive days will be satisfied if a loss begins within two years of a traumatic injury and continues without interruption after the end of the two-year period. A subsequent period of consecutive days of a scheduled loss will be satisfied if it follows uninterrupted immediately after an initial period of consecutive days of loss that ended after expiration of the two-year period.

(c) *Schedule of Losses.* (1) *Total and permanent loss of sight* is:

(i) Visual acuity in the eye of 20/200 or less/worse with corrective lenses lasting at least 120 days;

(ii) Visual acuity in the eye of greater/better than 20/200 with corrective

lenses and a visual field of 20 degrees of less lasting at least 120 days; or

(iii) Anatomical loss of the eye.

(iv) The amount payable for the loss of each eye is $50,000.

(2) *Total and permanent loss of hearing* is:

(i) Average hearing threshold sensitivity for air conduction of at least 80 decibels, based on hearing acuity measured at 500, 1,000, and 2,000 Hertz via pure tone audiometry by air conduction, without amplification device

(ii) The amount payable for loss of one ear is $25,000. The amount payable for the loss of both ears is $100,000.

(3) *Total and permanent loss of speech* is:

(i) Organic loss of speech or the ability to express oneself, both by voice and whisper, through normal organs for speech, notwithstanding the use of an artificial appliance to simulate speech.

(ii) The amount payable for the loss of speech is $50,000.

(4) *Quadriplegia* is:

(i) Total and permanent loss of voluntary movement of all four limbs resulting from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for quadriplegia is $100,000.

(5) *Hemiplegia* is:

(i) Total and permanent loss of voluntary movement of the upper and lower limbs on one side of the body from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for hemiplegia is $100,000.

(6) *Paraplegia* is:

(i) Total and permanent loss of voluntary movement of both lower limbs resulting from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for paraplegia is $100,000.

(7) *Uniplegia* is:

(i) Total and permanent loss of voluntary movement of one limb resulting from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for the loss of each limb is $50,000.

(iii) Payment for uniplegia of arm cannot be combined with loss 9 or 10 for the same arm. The higher payment for uniplegia or loss 14 will be made for the same arm. Payment for uniplegia of leg cannot be combined with loss 11 or 12 for the same leg. The higher payment for uniplegia or loss 13 will be made for the same leg. The higher payment for uniplegia or loss 15 will be made for the same leg.

(8) *Burns:* (i) The percentage of the body burned may be measured using the Rule of Nines or any means of measurement generally accepted within the medical profession.

(ii) The amount payable for partial thickness burns covering 20% of face or body that do not require skin grafting is $50,000.

(iii) The amount payable for partial thickness burns or worse located on the face, hands, feet, genitalia, perineum, ankles, knees, hips, wrists, elbows, or shoulders that require grafting is $100,000.

(iv) The amount payable for full thickness burns covering 20% of the face or body is $100,000.

(v) Road rash, which is a skin abrasion caused by sliding on a hard or rough surface, will be evaluated under paragraphs (c)(20) and (21).

(9) *Amputation of a hand at or above the wrist:* (i) The amount payable for the loss of each hand is $50,000.

(ii) Payment for amputation of hand cannot be combined with payment for loss 7 or 10 for the same hand. The higher payment for amputation of hand or loss 14 will be made for the same hand.

(10) *Amputation at or above the metacarpophalangeal joint(s) of either the thumb or the other 4 fingers on 1 hand:* (i) The amount payable for the loss of each hand is $50,000.

(ii) Payment for amputation of 4 fingers on 1 hand or thumb alone cannot be combined with payment for loss 7 or 9 for the same hand. The higher payment for amputation of 4 fingers on 1 hand or thumb alone or loss 14 will be made for the same hand. Payment for loss of the thumb cannot be made in addition to payment for loss of the other 4 fingers for the same hand.

(11) *Amputation of a foot at or above the ankle:* (i) The amount payable for the loss of each foot is $50,000.

(ii) Payment for amputation of foot cannot be combined with loss 7 or 12 for the same foot. The higher payment for amputation of foot or Loss 13 will be made for the same foot. The higher payment for amputation of foot or Loss 15 will be made for the same foot.

(12) Amputation at or above the metatarsophalangeal joints of all toes on 1 foot: (i) The amount payable for the loss of each foot is $50,000.

(ii) Payment for amputation of all toes including the big toe on 1 foot cannot be combined with loss 7 or 11 for the same foot. The higher payment for amputation of all toes including the big toe on 1 foot or loss 13 will be made for the same foot. The higher payment for amputation of all toes including the big toe on 1 foot or loss 15 will be made for the same foot.

(13) *Amputation at or above the metatarsophalangeal joint(s) of either the big toe or the other 4 toes on 1 foot:* (i) The amount payable for the loss of each foot is $25,000.

(ii) The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 7 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 11 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 12 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 15 will be made for the same foot.

(14) *Limb reconstruction of arm (for each arm):* (i) A surgeon must certify that a member had surgery to treat at least one of the following injuries to a limb:

(A) Bony injury requiring bone grafting to re-establish stability and enable mobility of the limb;

(B) Soft tissue defect requiring grafting/flap reconstruction to reestablish stability;

(C) Vascular injury requiring vascular reconstruction to restore blood flow and support bone and soft tissue regeneration; or

(D) Nerve injury requiring nerve reconstruction to allow for motor and sensory restoration and muscle re-enervation.

(ii) The amount payable for losses involving 1 of the 4 listed surgeries is $25,000. The amount payable for losses involving 2 or more of the 4 listed surgeries is $50,000.

(iii) The higher payment for limb reconstruction of arm or loss 7 will be made for the same arm. The higher payment for limb reconstruction of arm or loss 9 will be made for the same arm. The higher payment for limb reconstruction of arm or loss 10 will be made for the same arm.

(15) *Limb reconstruction of leg (for each leg):* (i) A surgeon must certify that a member had at least one of the following injuries to a limb requiring the identified surgery for the same limb:

(A) Bony injury requiring bone grafting to re-establish stability and enable mobility of the limb;

(B) Soft tissue defect requiring grafting/flap reconstruction to reestablish stability;

(C) Vascular injury requiring vascular reconstruction to restore blood flow and support bone and soft tissue regeneration; or

(D) Nerve injury requiring nerve reconstruction to allow for motor and sensory restoration and muscle re-enervation.

(ii) The amount payable for losses involving 1 of the 4 listed surgeries is

$25,000. The amount payable for losses involving 2 or more of the 4 listed surgeries is $50,000.

(iii) The higher payment for limb reconstruction of leg or loss 7 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 11 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 12 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 13 will be made for the same leg.

(16) *Facial reconstruction:* (i) A surgeon must certify that a member had surgery to correct a traumatic avulsion of the face or jaw that caused a discontinuity defect to one or more of the following facial areas:

(A) Surgery to correct discontinuity loss involving bone loss of the upper or lower jaw-the amount payable for this loss is $75,000;

(B) Surgery to correct discontinuity loss involving cartilage or tissue loss of 50% or more of the cartilaginous nose-the amount payable for this loss is $50,000;

(C) Surgery to correct discontinuity loss involving tissue loss of 50% or more of the upper or lower lip-the amount payable for loss of one lip is $50,000, and the amount payable for loss of both lips is $75,000;

(D) Surgery to correct discontinuity loss involving bone loss of 30% or more of the periorbita-the amount payable for loss of each eye is $25,000;

(E) Surgery to correct discontinuity loss involving loss of bone or tissue of 50% or more of any of the following facial subunits: Forehead, temple, zygomatic, mandibular, infraorbital, or chin-the amount payable for each facial subunit is $25,000.

(ii) Losses due to facial reconstruction may be combined with each other, but the maximum benefit for facial reconstruction may not exceed $75,000.

(iii) Any injury or combination of losses under facial reconstruction may be combined with other losses in § 9.21(c)(1)–(19) and treated as one loss, provided that all losses are the result of a single traumatic event. However, the total payment amount may not exceed $100,000.

(iv) Bone grafts for teeth implants alone do not meet the loss standard for facial reconstruction from jaw surgery.

(17) *Coma (8 or less on Glasgow Coma Scale) AND/OR Traumatic Brain Injury resulting in inability to perform at least 2 activities of daily living (ADL):* (i) The amount payable at the 15th consecutive day of ADL loss is $25,000.

(ii) The amount payable at the 30th consecutive day of ADL loss is an additional $25,000.

(iii) The amount payable at the 60th consecutive day of ADL loss is an additional $25,000.

(iv) The amount payable at the 90th consecutive day of ADL loss is an additional $25,000.

(v) Duration of coma and inability to perform ADLs include date of onset of coma or inability to perform ADLs and the first date on which member is no longer in a coma or is able to perform ADLs.

(18) *Hospitalization due to traumatic brain injury:* (i) The amount payable at the 15th consecutive day of hospitalization is $25,000.

(ii) Payment for hospitalization may only replace the first ADL milestone in loss 17. Payment will be made for 15-day hospitalization, coma, or the first ADL milestone, whichever occurs earlier. Once payment has been made for the first payment milestone in loss 17 for coma or ADL, there are no additional payments for subsequent 15-day hospitalization due to the same traumatic injury. To receive an additional ADL payment amount under loss 17 after payment for hospitalization in the first payment milestone, the member must reach the next payment milestones of 30, 60, or 90 consecutive days.

(iii) Duration of hospitalization includes the dates on which member is transported from the injury site to a hospital as defined in 42 U.S.C. 1395x(e) or skilled nursing facility as defined in 42 U.S.C. 1395i–3(a), admitted to the hospital or facility, transferred between a hospital or facility, leaves the hospital or facility for a therapeutic trip, and discharged from the hospital or facility.

(iv) In cases where a member is hospitalized for 15 consecutive days for a diagnostic assessment for a mental illness and/or brain or neurologic disorder, and the assessment determines the member has a mental illness or brain or neurologic disorder, and not TBI, this loss is not payable because the loss was due to illness or disease and is excluded from payment. If a member is hospitalized for 15 consecutive days for a diagnostic assessment to determine whether the member has TBI and is diagnosed with TBI, TBI and PTSD, or PTSD and not TBI, the loss is payable for $25,000. If a member is hospitalized for 15 consecutive days for a diagnostic assessment to determine whether the member has PTSD and is diagnosed with TBI or TBI and PTSD, the loss is payable for $25,000.

(19) *Genitourinary losses:* (i) Amputation of the glans penis or any portion of the shaft of the penis above glans penis (*i.e.* closer to the body) or damage to the glans penis or shaft of the penis that requires reconstructive surgery-the amount payable for this loss is $50,000.

(ii) Permanent damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse-the amount payable for this loss is $50,000.

(iii) Amputation of or damage to a testicle that requires testicular salvage, reconstructive surgery, or both-the amount payable for this loss is $25,000.

(iv) Amputation of or damage to both testicles that requires testicular salvage, reconstructive surgery, or both-the amount payable for this loss is $50,000.

(v) Permanent damage to both testicles requiring hormonal replacement therapy-the amount payable for this loss is $50,000.

(vi) Complete or partial amputation of the vulva, uterus, or vaginal canal or damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery-the amount payable for this loss is $50,000.

(vii) Permanent damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse-the amount payable for this loss is $50,000.

(viii) Amputation of an ovary or damage to an ovary that requires ovarian salvage, reconstructive surgery, or both-the amount payable for this loss is $25,000.

(ix) Amputation of both ovaries or damage to both ovaries that requires ovarian salvage, reconstructive surgery, or both-the amount payable for this loss is $50,000.

(x) Permanent damage to both ovaries requiring hormonal replacement therapy-the amount payable for this loss is $50,000.

(xi) Permanent damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis-the amount payable for this loss is $50,000.

(xii) Losses due to genitourinary injuries may be combined with each other, but the maximum benefit for genitourinary losses may not exceed $50,000.

(xiii) Any genitourinary loss may be combined with other injuries listed in § 9.21(b)(1)–(18) and treated as one loss, provided that at all losses are the result of a single traumatic event. However, the total payment may not exceed $100,000.

(20) *Traumatic injury, other than traumatic brain injury, resulting in inability to perform at least 2 activities of daily living (ADL):* (i) The amount

payable at the 15th consecutive day of ADL loss is $25,000.

(ii) The amount payable at the 30th consecutive day of ADL loss is an additional $25,000.

(iii) The amount payable at the 60th consecutive day of ADL loss is an additional $25,000.

(iv) The amount payable at the 90th consecutive day of ADL loss is an additional $25,000.

(v) Duration of inability to perform ADL includes the date of the onset of inability to perform ADL and the first date on which member is able to perform ADL.

(21) *Hospitalization due to traumatic injury other than traumatic brain injury:* (i) The amount payable at 15th consecutive day of ADL loss is $25,000.

(ii) Payment for hospitalization may only replace the first ADL milestone in loss 20. Payment will be made for 15-day hospitalization or the first ADL milestone, whichever occurs earlier. Once payment has been made for the first payment milestone in loss 20, there are no additional payments for subsequent 15-day hospitalization due to the same traumatic injury. To receive an additional ADL payment amount under loss 20 after payment for hospitalization in the first payment milestone, the member must reach the next payment milestones of 60, 90, or 120 consecutive days.

(iii) Duration of hospitalization includes the dates on which member is transported from the injury site to a hospital as defined in 42 U.S.C. 1395x(e) or skilled nursing facility as defined in 42 U.S.C. 1395i–3(a), admitted to the hospital or facility, transferred between a hospital or facility, leaves the hospital or facility for a therapeutic trip, and discharged from the hospital or facility.

(Authority: 38 U.S.C. 501(a), 1980A)

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GENERAL SERVICES ADMINISTRATION

48 CFR Parts 8 and 38

[GSAR Case 2020–G502; Docket No. GSA–GSAR–2020–0014; Sequence No. 1]

RIN 3090–AK15

General Services Administration Acquisition Regulation (GSAR); Increasing Order Level Competition for Federal Supply Schedules

AGENCY: Office of Acquisition Policy, General Services Administration (GSA).

ACTION: Advance notice of proposed rulemaking.

SUMMARY: The General Services Administration (GSA) is issuing this advance notice of proposed rulemaking (ANPR) to seek public comments that can be used to assist in the implementation of Section 876 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2019 for the Federal Supply Schedule (FSS) program. Section 876 amended the United States Code by providing an exception to the requirement to consider price as an evaluation factor for the award of certain indefinite-delivery, indefinite-quantity contracts and Federal Supply Schedule contracts.

DATES: Interested parties should submit written comments at the address shown below on or before September 18, 2020 to be considered in the formulation of a proposed rule.

ADDRESSES: Submit comments in response to GSAR Case 2020–G502 to *https://www.regulations.gov.* Submit comments via the Federal eRulemaking portal by searching for ''GSAR Case 2020–G502''. Select the link ''Comment Now'' that corresponds with GSAR Case 2020–G502. Follow the instructions provided at the ''Comment Now'' screen. Please include your name, company name (if any), and ''GSAR Case 2020–G502'' on your attached document.

Instructions: Please submit comments only and cite GSAR Case 2020–G502 in all correspondence related to this case. Comments received generally will be posted without change to *https://www.regulations.gov,* including any personal and/or business confidential information provided. To confirm receipt of your comment(s), please check *https://www.regulations.gov* approximately two to three days after submission to verify posting.

FOR FURTHER INFORMATION CONTACT: Mr. Thomas O'Linn, Procurement Analyst, at 202–445–0390 or *thomas.olinn@gsa.gov* for clarification of content. For information pertaining to status or publication schedules, contact the Regulatory Secretariat Division at 202–501–4755 or *GSARegSec@gsa.gov.* Please cite GSAR Case 2020–G502.

SUPPLEMENTARY INFORMATION:

I. Background

The Federal Supply Schedule (FSS) program provides the Government with a simplified process of acquiring commercial supplies and services in varying quantities while obtaining volume discounts. Federal Acquisition Regulation (FAR) subpart 8.4 and part 38, along with various parts of the GSA Acquisition Regulation (GSAR) provide direction to customers, offerors, contractors, and GSA contracting officers as it relates to the FSS program. GSA is seeking public comment for purposes of assisting GSA in effectively implementing Section 876 of the NDAA for FY 2019 (Pub. L. 115–232) as it relates to the FSS program.

Section 876 amended 41 U.S.C. 3306(c) to modify the requirement to consider cost or price as an evaluation factor for the award of certain indefinite-delivery, indefinite-quantity multiple-award contracts and certain FSS contracts to qualifying offerors. Currently, offerors responding to solicitations for award of FSS contracts are required to submit commercial sales practice data, or other cost or price information with their proposals. Section 876 gives GSA the discretion to not include price as an evaluation factor in certain FSS contracts and other Indefinite Delivery Indefinite Quantity (IDIQ) contracts provided that (1) the agency intends to make a contract award to each qualifying offeror, (2) task or delivery orders will be based on hourly rates, and (3) competition takes place at the order level. To be eligible for award a ''qualifying offeror'' must be a responsible source; submit a proposal that conforms to the requirements of the solicitation; meet all technical requirements; and be otherwise eligible for award.

The Federal Acquisition Regulatory Council has opened FAR case 2018–014, Increasing Task-order Level for purposes of implementing 41 U.S.C. 3306(c), which provides an exception to the requirement to consider price as an evaluation factor for the award of certain indefinite-delivery, indefinite-quantity contracts and FSS contracts. Since the FAR case is still in development, GSA is issuing this ANPR to aid in thinking through a series of questions related to applying this authority to the FSS program.

GSA will consider comments received in response to this ANPR in future rulemaking: (i) To proceed with rulemaking through the publication of a proposed rule to amend the GSAR, (ii) to inform the Federal Acquisition Regulatory Council on its implementation of this authority within the FAR (*i.e.,* FAR case 2018–014), and (iii) to revise other GSA policies, procedures, and guidance that support the FSS program.

II. Expected Impact

Because of the length of the contracts, reach of the program, and unique statutory environment, GSA anticipates