Subpart A—Voluntary Separation Incentive Payments.

§ 576.101 Definitions.

Section 3521(1) of title 5, United States Code, contains the definition of *Agency,* and section 3521(2) of title 5, United States Code, contains the definition of *Employee,* as used in this subpart.

§ 576.102 Voluntary separation incentive payment implementation plans.

(a) Section 3522 of title 5, United States Code, specifies the information that the head of an agency must submit to the Office of Personnel Management (OPM). OPM will consult with the Office of Management and Budget (OMB) regarding the plan and will notify the agency head in writing when the plan is approved. The agency must have OPM approval before offering incentives under this authority.

(b) In submitting a plan to OPM under section 3522(a) of title 5, United States Code, the head of an agency may submit:

(1) A specific voluntary separation incentive payment implementation plan outlining the intended use of the incentive payments, or

(2) The agency's human capital plan, which outlines the intended use of the incentive payments and the expected changes in the agency's organizational structure after the agency has completed the incentive payments.

(c) In either case, the plan must include:

(1) Identification of the specific positions and functions to be reduced or eliminated, identified by organizational unit, geographic location, occupational category, grade level and any other factors related to the position, such as skills and knowledge;

(2) A description of the categories of employees who will be offered incentives identified by organizational unit, geographic location, occupational category, grade level and any other factors, such as skills, knowledge, or retirement eligibility;

(3) The time period during which incentives may be paid;

(4) The number and maximum amounts of voluntary separation incentive payments to be offered;

(5) A description of how the agency will operate without the eliminated or restructured positions and functions;

(6) A proposed organizational chart displaying the expected changes in the agency's organizational structure after the agency has completed the incentive payments; and

(7) If the agency has requested, or will request Voluntary Early Retirement Authority, a description of how that authority will be used in conjunction with separation incentives;

(8) If the agency is offering separation incentives under any other statutory authority, a description of how that authority is being used.

§ 576.103 Offering voluntary separation incentive payments to employees.

Section 3523 of title 5, United States Code, covers:

(a) The basis for an agency to offer a voluntary separation incentive payment;

(b) The computation of a voluntary separation incentive payment; and

(c) The appropriations or funds that the agency uses to pay the voluntary separation incentive payment.

§ 576.104 Additional agency requirements.

(a) After OPM approves an agency's plan for voluntary separation incentive payments, the agency is required to immediately notify OPM of any subsequent changes in the conditions that served as the basis for the approval of the voluntary separation incentive payments. OPM will consult with OMB and notify the agency in writing if there are changes in the OPM approval of the agency plan.

(b) Agencies are required to provide OPM with interim and final voluntary separation incentive payment reports, as covered in OPM's approval letter to the agency. OPM may suspend or cancel a voluntary separation incentive payment authority if the agency is not in compliance with the reporting requirements or reporting schedule specified in OPM's letter approving that authority.

§ 576.105 Existing voluntary separation incentive payment authorities.

As provided in section 1313(a)(3) of Public Law 107–296, any agency exercising voluntary separation incentive authority in effect on January 24, 2003, may continue to offer voluntary separation incentives consistent with that authority until that authority expires. An agency that is eligible to offer voluntary separation incentive payments under this authority and under any other statutory authority may choose which authority it wishes to use, or offer incentives under both.

Subpart B—Waiver of Repayment of Voluntary Separation Incentive Payments

§ 576.201 Definitions.

Section 3524(a) of title 5, United States Code, contains the definition of *Employment* as used in this subpart.

§ 576.202 Repayment requirement.

(a) Section 3524(b) of title 5, United States Code, contains the repayment requirement that applies if an executive branch employee who received a voluntary separation incentive payment as described in subpart A of this part, and accepts any employment for compensation with the Government of the United States within 5 years after the date of the separation on which the payment is based. The individual must repay the entire amount of the voluntary separation incentive payment to the agency that paid the voluntary separation incentive payment before the individual's first day of reemployment.

(b) An executive branch employee who received a voluntary separation incentive payment on or after March 30, 1994, under statutory authority other than subpart A of this part, and who accepts any employment for compensation with the Government of the United States within 5 years after the date of the separation on which the payment is based, may be required by the authorizing statute to repay the entire amount.

§ 576.203 Waivers of the voluntary separation incentive repayment requirement.

(a)(1) Section 3524(c)(1) of title 5, United States Code, covers the conditions under which the Director of OPM may, at the request of the head of the hiring agency, waive the repayment required in § 576.202.

(2) Section 3524(a)(2) of title 5, United States Code, provides that the waiver provision under section 3524(c)(1) of title 5, United States Code, does not extend to a repayment obligation resulting from employment under a personal services contract or other direct contract.

(b) For a voluntary separation incentive payment made under statutory authority other than subpart A of this part, the agency should review the authorizing statute and, if a waiver is permitted, submit a request as specified by that statute.

[FR Doc. 03–2766 Filed 1–31–03; 2:50 pm]

BILLING CODE 6325–38–P

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 875

RIN 3206–AJ71

Federal Long Term Care Insurance Regulation

AGENCY: Office of Personnel Management.

ACTION: Interim rule with request for comments.

SUMMARY: In compliance with the Long-Term Care Security Act, the Office of Personnel Management (OPM) is issuing interim regulations that set forth rules for the administration of the Federal Long Term Care Insurance Program (FLTCIP).

DATES: *Effective Date:* February 4, 2003.

Comment Date: Comments due on or before April 7, 2003.

ADDRESSES: Send or deliver written comments to Frank D. Titus, Assistant Director for Long Term Care, Office of Personnel Management, Room 2H24, 1900 E Street NW., Washington DC 20415, or by fax to (202) 606–2023. You may send comments electronically to *ltc@opm.gov,* using the subject line ''Comments on Proposed Regulations.''

FOR FURTHER INFORMATION CONTACT: Terry Schleicher, (202) 606–0417, or *tlschlei@opm.gov.*

SUPPLEMENTARY INFORMATION: On September 19, 2000, the Long-Term Care Security Act (Pub. L. 106–265) became law. The Act directs OPM to prescribe regulations necessary to carry out the law.

In new part 875, subpart A provides definitions, methods for contract and claims dispute resolution, and the authority for OPM to order correction of errors. It also sets out agency and OPM responsibilities under this Program.

The Act provides preemption of State insurance laws that relate to the nature, provision, or extent of coverage or benefits under FLTCIP. The regulations specify OPM's authority to act as the regulator for FLTCIP in accordance with the Act and the consumer protection provisions of the Health Insurance Portability and Accountability Act of 1996.

OPM has determined that the enrollee's proof of insurance will consist of a benefit booklet prepared by OPM and the Carrier, together with the schedule of benefits. The enrollee will also receive a copy of the approved application for coverage. The booklet will provide general FLTCIP provisions, definitions, exclusions, and limitations. The schedule of benefits will specify the coverage purchased (*e.g.*, waiting period, daily benefit amount, benefit period, type of inflation protection, and either a comprehensive package or a facilities only package). The approved application will show the specific information that provided the basis for issuing the coverage. This will help to reduce Program costs by eliminating the expense of preparing a customized certificate of insurance for each enrollee.

Subpart B specifies eligibility requirements for, and exclusions from, participation in the FLTCIP for Federal civilian employees, Postal employees, members of the uniformed services, civilian annuitants, retired members of the uniformed services, and their qualified relatives.

The FLTCIP law defines an eligible Federal or Postal employee as someone also eligible for Federal Employees Health Benefits (FEHB) participation. Therefore, Federal civilian and Postal eligibility for and exclusions from coverage are tied to FEHB regulations found in part 890 of this chapter. There are 2 exceptions, however. The FLTCIP law specifically excludes all District of Columbia employees from participation, even though some are eligible for FEHB coverage. The regulations make this exclusion clear. Also, Tennessee Valley Authority employees are eligible for FLTCIP participation, even though by law they may not be eligible for FEHB.

Civilian annuitants eligible to apply for coverage under the FLTCIP law include those who have retired on an immediate annuity, deferred annuitants when they begin to receive an annuity, and survivor annuitants.

The regulations specify that if an employee has separated from service under the Federal Employees Retirement System (FERS) Minimum Retirement Age (MRA) + 10 provision (5 U.S.C. 8412(g)), but has not begun drawing an annuity, he or she can apply for coverage under the FLTCIP. He or she will be considered an annuitant for underwriting purposes.

A retired member of the uniformed services is eligible to apply for coverage if he or she is entitled to retired or retainer pay, even if that member is receiving disability retirement pay. However, the FLTCIP law specifies that a former member of the uniformed services retired under chapter 1223 of title 10, United States Code, (a ''gray reservist'') is not eligible to apply for coverage until he or she starts receiving retirement pay at age 60.

If an individual applies as a qualified relative, the regulations specify that the workforce member (Federal civilian or Postal employee, Federal annuitant, member of the uniformed services, or retired member of the uniformed services) on whom the applicant bases the qualified relative status must be alive at the time the applicant applies for coverage. There is 1 exception to this rule. If the applicant is receiving an annuity as the spouse of a deceased workforce member, then he or she may apply for coverage.

A new employee or member of the uniformed services and his or her spouse will have a 60-day period after becoming eligible to apply for coverage with the same underwriting requirements provided to that eligible group during the most recent open season.

If a Federal civilian or Postal employee or member of the uniformed services held a position that did not convey eligibility for FLTCIP coverage, and then enters into a position that conveys eligibility, he or she also has a 60-day period to apply for coverage with the same underwriting requirements provided to that eligible group during the most recent open season, as well as his or her spouse, if any. For example, if an employee was not eligible because he or she was a temporary employee who had worked less than 1 year, and then took a permanent position, he or she would now be eligible to apply for FLTCIP coverage.

If a Federal civilian or Postal employee or member of the uniformed services is returning from a break in service of 180 days or more, he or she may apply for coverage with the same underwriting requirements provided to that eligible group during the most recent open season, as may his or her spouse, if any.

Other qualified relatives may apply for enrollment at any time with full underwriting.

If a Federal civilian or Postal employee or member of the uniformed services returns from nonpay status during an open season, he or she can apply for coverage within 60 days from return to pay status, or by the end of the open season, whichever provides more time. For example, if the open season runs from July 1 through December 31, and an individual returns on October 15, he or she still gets until December 31 to apply with the open season underwriting requirements for his or her eligibility group. If he or she returns on November 15, he or she will have until January 14 to apply. If he or she returns after the open season has ended, he or she can apply with the open season underwriting requirements of his or her eligibility group within 60 days from his or her return. This section only applies when the applicant is in nonpay status for more than one-half of the scheduled open season, unless he or she went into nonpay status for a reason beyond his or her control. If the applicant has been actively at work for at least one-half of the open season, he or she has already had ample opportunity to get information and apply for coverage without the need for the special provisions of this section.

The regulations prescribe that an applicant must state his or her employment/retirement status or relationship as a qualified relative when applying for coverage. If the applicant misrepresents his or her eligibility, he or she may lose his or her coverage or it may never become effective.

The applicant must remain a member of an eligible group for coverage to take effect. If he or she becomes ineligible between the date that the application is submitted and the coverage effective date, he or she will no longer be eligible for coverage. This may happen when the applicant separates from service without retiring or when he or she loses qualified relative status, such as through divorce. There are 2 exceptions to this rule, explained below.

If the separation from service is involuntary, such as through a reduction in force, the application (and the application of any qualified relatives) will proceed. If the application is approved, the applicant will be enrolled for coverage. However, if the individual had not applied for coverage before separation, he or she is no longer eligible at separation. Qualified relatives also lose their eligibility at the same time.

If an applicant's involuntary separation is due to misconduct or a dishonorable discharge, then he or she immediately becomes ineligible, regardless of whether the applicant had applied for coverage prior to separation. This is consistent with temporary continuation of coverage requirements under the FEHB Program, which do not allow for continued enrollment if the separation is due to misconduct.

The second exception is when an applicant loses qualified relative status through the death of a workforce member. If the person through whom the applicant is qualified for coverage dies after the applicant has submitted an application but before the application is approved, he or she does not lose eligibility. If the application is approved, he or she will be enrolled for coverage.

Eligibility status may change between the time of application for coverage and the coverage effective date. The applicant may have retired or separated from service under FERS MRA +10 provisions. Or, the applicant may have separated from service but still may be eligible because he or she is the qualified relative of an employee or annuitant. The applicant must reapply for coverage in these instances, submitting to the underwriting requirements specified for the eligible group of which he or she is now a part. For example, if an applicant separates from active service, but is also the spouse of an employee, he or she remains eligible for coverage. But, he or she will have to resubmit the application with the additional underwriting required of employees' spouses.

Subpart C addresses payment issues under the FLTCIP. As specified in the FLTCIP law, there is no Government contribution toward premiums for long term care insurance. The enrollee pays the entire cost.

If the enrollee underpays premiums, he or she must pay retroactive premiums to the Carrier. If he or she does not repay such premiums, the Carrier may cancel coverage. Conversely, if the enrollee has overpaid premiums, the Carrier will either reimburse the enrollee or apply the overpayment toward future premium payments due.

The regulations specify that an enrollee will not receive a refund of premiums if he or she decreases coverage, cancels coverage, or dies. The enrollee must pay for the coverage agreed to for the period that it was in effect. The enrollee is not entitled to a refund just because coverage was not used. This is consistent with Federal Employees' Group Life Insurance (FEGLI) Program rules, where there is no provision for the refund of premiums when an enrollee decides to reduce or cancel coverage. There are some exceptions for FLTCIP. Premiums paid in advance for the period beyond the date of death or for any period following the effective date of cancellation will be refunded. Any premiums paid will be returned if the enrollee cancels coverage within the ''free look'' period specified in the benefit booklet.

A requirement of the FLTCIP law is for the Carrier to account for FLTCIP funds separately from all other funds. This requirement, which is also found in FEHB and FEGLI regulations, ensures that Program funds can be traced and examined for accounting and audit purposes. The Carrier is also required to only use FLTCIP funds for purposes related specifically to the FLTCIP, such as administering the Program and paying claims.

Subpart D describes coverage requirements. Before the first open season for enrollment, OPM will determine the ways in which applicants can apply for coverage. OPM may allow enrollment on paper and various electronic formats. However, OPM does not believe it necessary to specify in regulation the different formats of enrollment applications. OPM believes FLTCIP is best served by using the most current technology available at any time without going through a regulatory process to do so.

It is not necessary for the workforce member to apply for coverage in order for his or her qualified relatives to be able to apply for coverage. For example, the parents of an employee may submit applications even if the employee decides not to apply. OPM wants each qualified relative to have maximum flexibility and unrestricted opportunity to apply for and select the coverage or cost that works best for him or her.

OPM does not plan to have regularly scheduled open seasons. There may be open seasons with abbreviated underwriting requirements for some eligible groups when OPM determines it is in the best interest of the FLTCIP. OPM will specify open season beginning and ending dates, as well as the requirements for applicants during the open season, in **Federal Register** Notices.

The FLTCIP Carrier will accept applications for coverage at any time. Any workforce member or qualified relative may apply, subject to full underwriting requirements. (OPM may or may not reduce underwriting requirements during an open season.)

In order to prevent adverse selection and thus keep the FLTCIP viable, OPM must require full underwriting outside of an open season even for Federal civilian and Postal employees and members of the uniformed services. Adverse selection occurs when someone enrolls only when it is apparent that he or she will need access to benefits. By deferring enrollment until benefits are needed, such individuals likely would not pay their fair share of overall premiums.

OPM will announce effective dates of coverage for open season enrollments in a **Federal Register** Notice. The effective date will be different for each open season. At any time outside of an open season, an applicant's coverage effective date is the first day of the month after the approval date of the application. For example, if an application is approved on November 1, then the coverage effective date is the first day of the next month, December 1.

There are some situations in addition to open season in which Federal civilian and Postal employees and members of the uniformed services will be eligible for abbreviated underwriting, such as when they become newly eligible for FLTCIP (see § 875.206). In such situations, the applicant must also be actively at work on the coverage effective date for coverage to actually go into effect. This requirement protects FLTCIP's stability. With abbreviated underwriting, only a few questions are

asked about the applicant's health status. If an employee is actively at work, he or she is less likely to go into claims status shortly. As discussed previously, it is important to protect the FLTCIP against adverse selection.

If an applicant is not actively at work on the coverage effective date, he or she must inform the Carrier. He or she will get a revised coverage effective date, which will be the first day of the month after his or her return to active work. But, he or she must also be actively at work on the revised coverage effective date for coverage to take effect. If that is not the case, then the applicant must inform the Carrier, and the process of issuing a revised effective date will begin again.

A newly married spouse of a Federal civilian or Postal employee or member of the uniformed services may apply for coverage within 60 days of marriage with the same underwriting requirements provided to this group during the most recent open season. However, if the employee or member of the uniformed services is not already enrolled, and wants to apply for coverage at the same time, then he or she must apply with full underwriting. This person already had the opportunity to apply with abbreviated underwriting and does not get another opportunity outside of an open season.

The regulations specify that an enrollee may upgrade coverage at any time, with full underwriting. An enrollee may also upgrade coverage during an open season with the underwriting requirements and coverage rules specified for that open season.

If an enrollee upgrades coverage by adding to the daily benefit amount other than through the automatic compound inflation option, he or she will then pay a ''blended'' premium, where the premium for that amount of increased daily benefit is based on his or her age and premium rates at the time of the purchase of the increased benefit (also called the attained age), while the premium for the base insurance purchased is still based on the enrollee's age and rates when the base insurance was purchased. For example, if an enrollee chose at age 55 a $125 daily benefit amount, he or she can decide at age 65 to increase that coverage to $150. He or she will pay age 65-based premiums for the additional $25 in coverage, but will continue to pay age 55-based premiums for the initial $125 coverage. For other types of coverage upgrades, premiums will be based on the enrollee's attained age and the prevailing rate at the time of purchase.

An enrollee may also decrease or cancel coverage at any time. There will be no refund of premiums paid for the portion of insurance cancelled, unless he or she cancels during the ''free look'' period specified in the benefit booklet. Any increase or decrease is subject to the Program options available at the time of the change.

The Carrier will make insurability decisions for all applicants, and these decisions are not appealable to OPM. This rule is identical to the FEGLI Program rule, which vests all insurability decisions with the Carrier. This requirement has worked very well for many years in the FEGLI Program, and OPM expects the same outcome for the FLTCIP.

A standard feature of life and long term care insurance policies is an incontestability clause, which allows for erroneous enrollments to remain in effect under certain conditions. The FEGLI Program regulations contain such a clause, and OPM is providing similar protections under the FLTCIP.

However, it will be important for each applicant to complete the enrollment application accurately and thoroughly. If the Carrier finds that the applicant omitted, misstated, or misrepresented information on the application, the Carrier may rescind coverage. This provision is meant to protect the integrity of the FLTCIP, in terms of both premium sufficiency and fairness to all applicants.

An enrollee must authorize the release of his or her medical information within 3 weeks of the Carrier's request (4 weeks if he or she is outside the United States). It is in an enrollee's best interest to get the authorization to the Carrier as quickly as possible. Without access to medical records, the Carrier cannot determine whether an enrollee is eligible for benefits. If the enrollee does not provide the authorization within this time period, the Carrier has the right to deny claims for benefits or, as a last resort, void coverage.

The FLTCIP law provides for portability of coverage. Federal civilian or Postal employees and members of the uniformed services and their qualified relatives may maintain coverage if the employee or member of the uniformed services transfers, retires, or separates from service, so long as the Carrier continues to receive the premiums. The premiums do not change because of these events. Once the employee or member of the uniformed services leaves active service, however, he or she is no longer eligible for any abbreviated underwriting provided during an open season or other qualifying event. The portability feature of the FLTCIP also extends to other individuals who separate under the FERS MRA+10 provision. Enrolled qualified relatives may also keep FLTCIP coverage when they lose qualified relative status, such as upon divorce.

Coverage will terminate when the enrollee exhausts the benefits available, does not timely pay the required premiums, or dies. If an enrollee does not pay a premium on time, he or she will have a grace period of 30 days in which he or she can bring payments up to date before the Carrier may terminate coverage.

If an enrollee's coverage ends because he or she did not pay the required premium, the Carrier will reinstate coverage if the Carrier receives proof within 6 months of the date coverage ended that the enrollee suffered a cognitive impairment such as Alzheimer's disease or loss of functional capacity before the premium payment grace period ended. In such an instance, the enrollee does not need to submit to any further underwriting to restore the earlier coverage.

The Carrier may reinstate an enrollee's coverage for other reasons within 12 months from the date coverage terminated. This provision applies when an enrollee voluntarily cancels coverage or does not pay the required premium. However, the enrollee must submit to full underwriting and the Carrier will determine whether he or she is still insurable. Coverage will be reinstated retroactively to the termination date and he or she must pay back premiums for that period. The enrollee's premium will be the same as it was prior to termination.

Lastly, FLTCIP benefits will be coordinated, according to National Association of Insurance Commissioners (NAIC) guidelines, with other government programs, group medical benefits, and other employer-sponsored long term care insurance coverage so that benefit payments are not duplicated. Coordination of benefits is a standard feature of health and long term care insurance policies, and helps to keep costs down by ensuring that payments do not exceed 100 percent of charges.

E.O. 12866, Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Order 12866.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because it affects only Federal employees, annuitants, members of the uniformed services, retired members of

the uniformed services, their qualified relatives, and the FLTCIP Carrier(s).

List of Subjects in 5 CFR Part 875

Administrative practices and procedures, Government contracts, Government employees, Employee benefit plans, Health insurance, Military personnel, Organization and functions, Retirement.

Office of Personnel Management.

Kay Coles James,

Director.

For the reasons stated in the preamble, the Office of Personnel Management amends title 5, Code of Federal Regulations, by adding part 875 as follows:

PART 875—FEDERAL LONG TERM CARE INSURANCE PROGRAM

Subpart A—Administration and General Provisions

Sec.
875.101 Definitions.
875.102 Where do I send benefit claims?
875.103 Do I need to authorize release of my medical records when I file a claim?
875.104 What are the steps required to resolve a dispute involving benefit eligibility or payment of a claim?
875.105 May OPM correct errors?
875.106 What responsibilities do agencies have under this Program?
875.107 What are OPM's responsibilities as regulator under this Program?
875.108 If the Carrier approves my application, will I get a certificate of insurance?
875.109 Is there a delegation of authority for resolving contract disputes between OPM and the Carrier?

Subpart B—Eligibility

Sec.
875.201 Am I eligible as a Federal civilian or Postal employee?
875.202 Am I eligible as a Federal annuitant?
875.203 Am I eligible if I separated under the FERS MRA+10 provision?
875.204 Am I eligible as a member of the uniformed services?
875.205 Am I eligible as a retired member of the uniformed services?
875.206 As a new Federal civilian or Postal employee or member of the uniformed services, when may I apply?
875.207 What happens if I am in nonpay status during an open season?
875.208 May I apply as a qualified relative if the person on whom I am basing my eligibility status has died?
875.209 How do I demonstrate that I am eligible to apply for coverage?
875.210 What happens if I become ineligible after I submit an application?
875.211 What happens if my eligibility status changes after I submit an application?
875.212 Is there a minimum application age?

Subpart C—Cost

Sec.
875.301 Is there a Government contribution toward premiums?
875.302 What are the options for making premium payments?
875.303 How are premium payment errors corrected?
875.304 How does the Carrier account for FLTCIP funds?

Subpart D—Coverage

Sec.
875.401 How do I apply for coverage?
875.402 When will open seasons be held?
875.403 May I apply for coverage outside of an open season?
875.404 What is the effective date of coverage?
875.405 If I marry, may my new spouse apply for coverage?
875.406 May I change my coverage?
875.407 Who makes insurability decisions?
875.408 What is the significance of incontestability?
875.409 Must I provide an authorization to release medical information?
875.410 May I continue my coverage when I leave Federal or military service?
875.411 May I continue my coverage when I am no longer a qualified relative?
875.412 When will my coverage terminate?
875.413 Is it possible to have coverage reinstated?
875.414 Will benefits be coordinated with other coverage?

Authority: 5 U.S.C. 9008.

Subpart A—Administration and General Provisions

§ 875.101 Definitions.

This part is written as if the reader were an applicant or enrollee. Accordingly, the terms ''you,'' ''your,'' etc., refer, as appropriate, to the applicant or enrollee.

In this part, the terms *annuitant, employee, member of the uniformed services, retired member of the uniformed services*, and *qualified relative* have the meanings set forth in section 9001 of title 5, United States Code, and supplement the following definitions:

Abbreviated underwriting is a type of underwriting that asks fewer questions about your health status than with full underwriting to enable the Carrier to determine whether your application for coverage will be approved. The Carrier may also require review of your medical records, a phone interview, or an in-home interview.

Actively at work means:

(1) For a Federal civilian or Postal employee, that you meet all of the following conditions:

(i) You are reporting for work at your usual place of employment or other location to which Government business requires you to travel;

(ii) You are able to perform all the usual and customary duties of your employment on your regular work-schedule; and

(iii) You are not absent from work due to sickness, injury, annual leave, sick leave or any other leave. (You are not considered to be on leave on your alternate work schedule's scheduled day off.)

(2) For a member of the uniformed services, that you are on active duty and are physically able to perform the duties of your position.

Carrier means a qualified carrier as defined in section 9001 of title 5, United States Code, with which OPM has contracted to provide long term care insurance coverage under this section. A Carrier may designate 1 or more administrators to perform some of its obligations.

Eligible individual means an annuitant, Federal civilian or Postal employee, member of the uniformed services, retired member of the uniformed services or qualified relative, as defined in section 9001 of title 5, United States Code.

Enrollee means an eligible individual whose application for coverage the Carrier has approved and whose coverage is in effect.

FLTCIP means the Federal Long Term Care Insurance Program.

Free look means that within 30 days after you receive the Benefit Booklet, you may cancel your coverage if you are not satisfied with it and receive a refund of any premium you paid. It will be as if the coverage was never issued.

Full underwriting is the more comprehensive type of underwriting under the FLTCIP, which requires that you answer many questions about your health status to enable the Carrier to determine whether your application for coverage will be approved. The Carrier may also require review of your medical records, a phone interview, or an in-home interview.

Stepparent means any person, other than your mother or father, who is currently married to one of your parents, or, if one of your parents is dead, a person who was married to that parent at the time of that parent's death.

Underwriting requirements means the information about your current health status and history and other information that you must provide to the Carrier with your application for coverage to enable the Carrier to determine your insurability.

Workforce member means a Federal civilian or Postal employee, member of the uniformed services, Federal annuitant, or a retired member of the uniformed services, as defined in

section 9001 of title 5, United States Code.

§ 875.102 Where do I send benefit claims?

You must submit your benefit claims to the FLTCIP Carrier or its designee.

§ 875.103 Do I need to authorize release of my medical records when I file a claim?

Yes, if you file a claim for benefits, the Carrier needs to have a valid authorization from you to release your medical records.

§ 875.104 What are the steps required to resolve a dispute involving benefit eligibility or payment of a claim?

(a) If you dispute the Carrier's denial of your eligibility for benefits or your claim for payment of benefits, you must first send a written request for reconsideration to the Carrier no later than 60 days from the date of its decision.

(b) The Carrier must provide you with written notice of its review decision no later than 60 days after the date it receives your reconsideration request.

(c) If the Carrier upholds its denial (or does not respond within 60 days), you have the right to appeal its reconsideration decision. You must make this appeal in writing within 60 days from the date of the Carrier's notice upholding its decision. You will be notified of the decision on your appeal in writing no later than 60 days from receipt of your appeal request.

(d) If a denial of your eligibility for benefits or a denial of your claim is upheld upon appeal due to the evaluation of your medical condition/functional capacity, the Carrier will inform you that you may request that an independent third party, mutually agreed to by OPM and the Carrier, review the decision. You must make this request in writing within 60 days from the date of the notice informing you of the appeal decision. The independent third party must notify you in writing of its decision no later than 60 days from the Carrier's or its designee's receipt of your request for appeal to the third party. This is the final administrative remedy available to you. The decision of the independent third party is final and binding on the Carrier.

(e) You may seek judicial review of the final administrative denial of a claim. Such action may not be brought prior to exhaustion of the administrative process provided in this section. To pursue such judicial review, you must bring legal action against the Carrier in an appropriate United States district court within 2 years from the date of the final decision. You may not sue OPM, the independent reviewer, or any other entity. If you prevail in court, your recovery is limited to the amount of benefits payable under your benefit booklet and schedule of benefits.

§ 875.105 May OPM correct errors?

OPM may order correction of administrative errors after reviewing evidence and finding that it would be against equity and good conscience not to do so.

§ 875.106 What responsibilities do agencies have under this Program?

Federal agencies and uniformed services establishments are responsible for:

(a) Providing access to information about the FLTCIP to eligible individuals;

(b) Responding to questions from the Carrier, including questions on the employment status of an applicant or enrollee;

(c) Providing reports as OPM requires;

(d) Complying with Benefits Administration Letters and other OPM issuances/instructions; and

(e) Deducting premiums as authorized by a workforce member and as requested by the Carrier, when possible.

§ 875.107 What are OPM's responsibilities as regulator under this Program?

Consistent with the authority and discretion given to OPM by the FLTCIP law, OPM's responsibilities include those functions typically associated with, and preemptive of, State insurance regulatory authorities such as:

(a) Reviewing and approving the content and format of materials associated with the FLTCIP pursuant to section 9008(d) of title 5, United States Code;

(b) Reviewing and approving rates, forms, and marketing materials; and

(c) Determining the qualifications of enrollment personnel and the Program administrator(s).

§ 875.108 If the Carrier approves my application, will I get a certificate of insurance?

If the Carrier approves your application for coverage, OPM and/or the Carrier will make available to you a benefit booklet and schedule of benefits with complete coverage information, which will serve as your proof of insurance. You will also get a copy of your approved application for coverage.

§ 875.109 Is there a delegation of authority for resolving contract disputes between OPM and the Carrier?

For the purpose of making findings of fact and to the extent that conclusions of law may be required under any proceeding conducted in accordance with the provisions of the disputes clause included in the FLTCIP master contract, OPM delegates this function to the Armed Services Board of Contract Appeals.

Subpart B—Eligibility

§ 875.201 Am I eligible as a Federal civilian or Postal employee?

(a) If you are a Federal civilian or Postal employee whose current position conveys eligibility for Federal Employees Health Benefits under part 890 of this chapter, you are also eligible to apply for coverage, with the following exceptions:

(1) If you are a District of Columbia employee or retiree, you are not eligible to apply for coverage, regardless of whether you are eligible for Federal Employees Health Benefits coverage.

(2) If you are a Tennessee Valley Authority employee or retiree, you are eligible to apply for coverage, even though you may not be eligible for Federal Employees Health Benefits coverage.

(b) If you are a Federal civilian or Postal employee whose current position is excluded from Federal Employees Health Benefits eligibility under § 890.102 of this chapter, you are excluded from applying for coverage unless paragraph (a)(2) of this section applies.

(c) If you are an annuitant reemployed by the Federal Government, you may apply for coverage as an employee.

§ 875.202 Am I eligible as a Federal annuitant?

If you are a Federal annuitant, including a survivor annuitant, a deferred annuitant, or a compensationer, you are eligible to apply for coverage. If you are a deferred annuitant, you may apply for coverage only after you begin receiving your annuity.

§ 875.203 Am I eligible if I separated under the FERS MRA+10 provision?

If you have separated from service under the FERS Minimum Retirement Age and 10 years of service (MRA+10) provision of 5 U.S.C. 8412(g), and have postponed receiving an annuity under that provision, you are eligible to apply for coverage under this part. For underwriting purposes, you will be considered an annuitant.

§ 875.204 Am I eligible as a member of the uniformed services?

(a) You are eligible to apply for coverage if you are on active duty or full-time National Guard duty for more than a 30-day period.

(b) You are eligible to apply for coverage if you are a member of the Selected Reserve, which consists of:

(1) Drilling Reservists and Guardsmembers assigned to Reserve Component Units;

(2) Individual Mobilization Augmentees who are Reservists assigned to Reserve Component billets in Active Component units (you may be performing duty in a pay or non-pay status); and

(3) Active Guard and Reserve members who are full-time Reserve members on full-time National Guard duty or active duty in support of the National Guard or Reserves.

(c) You are not eligible to apply for coverage if you belong to the Individual Ready Reserve. The Individual Ready Reserves includes Reservists who are assigned to a Voluntary Training Unit in the Naval Reserve and Category E in the Air Force Reserve.

§ 875.205 Am I eligible as a retired member of the uniformed services?

(a) You are eligible to apply for coverage if you are a retired member of the uniformed services entitled to retired or retainer pay (including disability retirement pay).

(b) You are eligible to apply for coverage if you are a retired reservist who is currently receiving retirement pay.

§ 875.206 As a new Federal civilian or Postal employee or member of the uniformed services, when may I apply?

(a) As a new, newly eligible, or returning Federal civilian or Postal employee or member of the uniformed services, you may apply as follows:

(1) If you are a new Federal civilian or Postal employee or member of the uniformed services entering a position that conveys eligibility, you may apply for coverage within 60 days after becoming eligible.

(2) If you are entering a position that conveys eligibility as a Federal civilian or Postal employee or member of the uniformed services from a position that did not convey eligibility, you may apply for coverage within 60 days after becoming eligible.

(3) If you return to Federal civilian or Postal service or the uniformed services after a break in service of 180 days or more to a position that conveys eligibility, you may apply for coverage within 60 days after becoming eligible.

(b) Your spouse may also apply during that 60-day period after you become eligible.

(c) The underwriting requirements that will be applicable will be those required of Federal civilian and Postal employees and members of the uniformed services and their spouses during the last open season for enrollment before the date of your application.

(d) After the 60-day period ends, you may still apply for coverage, as may your spouse, but full underwriting requirements will apply.

(e) If your employing office determines that you were unable, for a cause beyond your control, to submit an application during the initial 60-day period, you may submit an application within 60 days after your employing office advises you of that determination. Similarly, your employing office may make this determination if your spouse is unable to submit an application during the same time period for a cause beyond his/her control. This employing office authority only applies within 6 months after the beginning date of the initial eligibility period. The underwriting requirements will be as specified in paragraph (c) of this section.

(f) Your other qualified relatives may apply for coverage at any time. They will be subject to full underwriting requirements.

§ 875.207 What happens if I am in nonpay status during an open season?

(a) If you return to a pay status from nonpay status during the open season, you have 60 days from the date of your return, or until the end of the open season, whichever gives you more time, to apply for coverage pursuant to the open season underwriting requirements for Federal civilian or Postal employees and members of the uniformed services.

(b) If you return to pay status from nonpay status after the open season, you have 60 days from the date of your return to apply for coverage pursuant to the underwriting requirements specified for Federal civilian or Postal employees and members of the uniformed services in the immediately preceding open season.

(c) Paragraphs (a) and (b) of this section apply only when you have been in nonpay status for more than one-half of an open season, unless you went into nonpay status for a reason beyond your control.

§ 875.208 May I apply as a qualified relative if the person on whom I am basing my eligibility status has died?

You may not apply as a qualified relative if the workforce member on whom you are basing your qualified relative status died prior to the time you apply for coverage, unless you are receiving a survivor annuity as the spouse of a deceased workforce member.

§ 875.209 How do I demonstrate that I am eligible to apply for coverage?

(a) When you submit your application for coverage, you must make known your status as a member of an eligible group.

(b) If the Carrier finds that you misrepresented your eligibility status, the Carrier has the right to void your coverage and return to you any premiums you paid, without interest. The incontestability provisions in § 875.409 do not apply to this section.

§ 875.210 What happens if I become ineligible after I submit an application?

(a) You must be eligible at the time of your application and at the time your coverage is scheduled to go into effect. Except as noted in paragraph (b) of this section, if you lose your status as part of an eligible group before your coverage goes into effect, you are no longer eligible for FLTCIP coverage. You are required to inform the Carrier that you are no longer eligible.

(b) In two instances, you will continue to be eligible for coverage even if you lose your status as part of an eligible group after you submit an application for coverage, but before your coverage becomes effective. The two instances are:

(1) When you are involuntarily separated from Federal civilian service (except for misconduct) or from the uniformed services (except for a dishonorable discharge). In either of these events, your qualified relatives will continue to be eligible.

(2) When you are the qualified relative of a workforce member who dies.

§ 875.211 What happens if my eligibility status changes after I submit an application?

(a) If you applied as a Federal civilian or Postal employee or member of the uniformed services, and separate from service under the MRA+10 provisions of 5 U.S.C. 8412(g), or retire after you submit an application for coverage, but before your coverage becomes effective, you must reapply as an annuitant and submit to full underwriting requirements.

(b) If you applied as a Federal civilian or Postal employee or member of the uniformed services, and otherwise separate from service, but you are a qualified relative of another workforce member, you must reapply based on the additional underwriting requirements specified for that type of qualified relative.

§ 875.212 Is there a minimum application age?

Yes, there is a minimum application age. You must be at least 18 years old at the time you submit an application for coverage.

Subpart C—Cost

§ 875.301 Is there a Government contribution toward premiums?

There is no Government premium contribution toward the cost of long term care insurance.

§ 875.302 What are the options for making premium payments?

(a) Premium payments may be made by Federal payroll or annuity deduction, uniformed services retirement pay deduction, by pre-authorized debit, or by direct billing.

(b) You must continue to make premium payments when they are due for your coverage to stay in effect.

§ 875.303 How are premium payment errors corrected?

(a) If the Carrier finds that you have underpaid the premium rate for your age and/or level of coverage, you must pay retroactive premiums to the Carrier for the amount due. If you fail to pay back premiums within the time provided by the Carrier to correct the error, the Carrier may terminate your coverage.

(b) If the Carrier finds that you have overpaid premiums, the Carrier will either reimburse you or reduce a future premium payment(s) by the amount of the overpayment.

(c) If you die while you have coverage, any premiums paid for the period beyond the date of your death will be refunded to your estate or to an alternate payee. If there is no estate, the Carrier will determine whether to pay the refund to an alternate payee. If you cancel your coverage, any premiums paid in advance for the period following the effective date of your cancellation will be refunded to you.

(d) Any premiums you paid will be returned if you cancel coverage within the ''free look'' period specified in the benefit booklet.

§ 875.304 How does the Carrier account for FLTCIP funds?

The Carrier must keep account of all funds received under this section separate from all other funds. The Carrier may use FLTCIP funds only for purposes specifically related to the FLTCIP.

Subpart D—Coverage

§ 875.401 How do I apply for coverage?

(a) To apply for coverage, you must complete the application in a form appropriate for your eligibility status as prescribed by the Carrier and approved by OPM.

(b) If you are the qualified relative of a workforce member, you may apply for coverage even if the workforce member does not apply for coverage.

§ 875.402 When will open seasons be held?

(a) The first open season for enrollment under this section began July 1, 2002, as described in a **Federal Register** Notice (67 FR 43691, June 28, 2002), including the open season ending date(s) and which eligible individuals may apply based on abbreviated underwriting.

(b) There are no regularly scheduled open seasons for long term care insurance. OPM will announce any subsequent open seasons via a **Federal Register** Notice. The Notice will include the requirements for applicants during the open season.

§ 875.403 May I apply for coverage outside of an open season?

If you are eligible for coverage, you may submit an application at any time outside of an open season. You will be subject to full underwriting requirements.

§ 875.404 What is the effective date of coverage?

(a) The effective dates of coverage under open season enrollments will be announced in a **Federal Register** Notice that announces open season dates.

(b)(1) If you enroll at any time outside of an open season, your coverage effective date is the 1st day of the month after the date your application is approved.

(2) If you are a Federal civilian or Postal employee or member of the uniformed services and you are applying for coverage under abbreviated underwriting, you also must be actively at work on your coverage effective date for your coverage to become effective. If your coverage effective date falls on a weekend or holiday, you must be actively at work on the last workday before that date for coverage to become effective. You must inform the Carrier if you are not actively at work on your coverage effective date. In that event, the Carrier will issue you a revised effective date, which will be the 1st day of the month after the date you return to being actively at work. You also must be actively at work on any revised effective date for coverage to become effective, or you will be issued another revised effective date in the same manner.

§ 875.405 If I marry, may my new spouse apply for coverage?

(a)(1) If you are a Federal civilian or Postal employee or member of the uniformed services and you have married, your spouse is eligible to submit an application for coverage under this section within 60 days from the date of your marriage, and will be subject to the underwriting requirements in force for the spouses of civilian employees and members of the uniformed services during the most recent open season. You, however, are not eligible for abbreviated underwriting because of your marriage. You may apply for coverage along with your spouse, but full underwriting will be required for you.

(2) After 60 days, your spouse may still apply for coverage but will be subject to full underwriting. Your new qualified relatives (such as parents-in-law) may apply for coverage with full underwriting at any time following the marriage.

(b) The new spouse and other qualified relatives of an annuitant or retired member of the uniformed services may apply for coverage with full underwriting at any time following the marriage.

§ 875.406 May I change my coverage?

(a) You may make the following changes to your coverage:

(1) You may apply to increase your coverage at any time. Full underwriting is required, except when an open season allows abbreviated underwriting.

(2) If you increase your coverage by adding to your daily benefit amount, the premiums for the additional coverage will be based on your age, prevailing premium rates, and coverage rules in effect at the time you purchase the additional coverage.

(3) For other types of coverage increases, your entire premium will be based on your age, prevailing premium rates, and coverage rules in effect at the time you purchase the increased coverage. Any increase in coverage will take effect on the 1st day of the month following the date the Carrier approves your request for an increase.

(b) You may decrease your coverage at any time, although any decrease will be subject to coverage rules at the time of the decrease. Decreased coverage takes effect on the 1st day of the month after the Carrier receives your request. You will not receive any refund of premiums paid for coverage you held before the decrease; however, your subsequent

premiums will be reduced based on your new, lower level of coverage. The Carrier will refund or credit any portion of premium paid in advance for the period following the date on which you decrease your coverage.

(c) You may cancel your coverage at any time.

(1) If you cancel during the free look period, your premiums will be refunded to you.

(2) If you cancel your coverage at any time other than during the free look period, cancellation will take effect on your requested cancellation date or at the end of the period covered by your last premium payment, whichever occurs first. You will not receive any refund of premiums paid, other than any premiums paid in advance for the period following the effective date of your cancellation of coverage, and you will not have to pay any more premiums unless you owed retroactive premiums.

§ 875.407 Who makes insurability decisions?

The Carrier determines the insurability of all applicants. The Carrier's decision may not be appealed to OPM.

§ 875.408 What is the significance of incontestability?

(a) *Incontestability* means coverage issued based on an erroneous application may remain in effect. Such coverage will not remain in effect, and your claim may be denied, under any of the following conditions:

(1) If your coverage has been in force for less than 6 months, the Carrier may void your coverage or deny a claim upon a showing that information on your signed application that was material to your approval for coverage is different than what is shown in your medical records.

(2) If your coverage has been in force for at least 6 months but less than 2 years, the Carrier may void your coverage or deny a claim upon a showing that information on your signed application that was material to your approval for coverage is different than what is shown in your medical records, and pertains to the condition for which benefits are sought.

(3) After your coverage has been in effect for 2 years, the Carrier may void your coverage only upon a showing that you knowingly and intentionally made a false or misleading statement or omitted information in your signed application for coverage regarding your health status.

(b) Your coverage can be contested at any time when the Carrier finds that you were not an eligible individual at the time you applied and were approved for coverage.

(c) If the Carrier voids coverage after it has paid benefits, it cannot recover the benefits already paid.

(d) Incontestability does not apply when you have not paid your premiums on a timely basis.

§ 875.409 Must I provide an authorization to release medical information?

You must provide the Carrier with an authorization to release medical information when requested. The Carrier may deny a claim for benefits or void your coverage if the Carrier does not receive an authorization to release medical information within 3 weeks after its request (4 weeks for those outside the United States).

§ 875.410 May I continue my coverage when I leave Federal or military service?

If you are a Federal civilian or Postal employee or member of the uniformed services, your coverage will automatically continue when you leave active service, as long as the Carrier continues to receive the required premium when due. However, once you leave active service, you are no longer eligible for any abbreviated underwriting provided during any future open season.

§ 875.411 May I continue my coverage when I am no longer a qualified relative?

If you are already enrolled as a qualified relative, you may continue your FLTCIP coverage if you subsequently lose qualified relative status (such as upon divorce), as long as the Carrier receives the required premium when due.

§ 875.412 When will my coverage terminate?

Your coverage will terminate on the earliest of the following dates:

(a) The date you specify to the Carrier that you wish your coverage to end;

(b) The date of your death;

(c) The end of the period covered by your last premium payment if you do not pay the required premiums when due, after a grace period of 30 days; or

(d) The date you have exhausted your maximum lifetime benefit. (However, in this event, care coordination services will continue.)

§ 875.413 Is it possible to have coverage reinstated?

(a) Under certain circumstances, your coverage can be reinstated. The Carrier will reinstate your coverage if it receives proof satisfactory to it, within 6 months from the termination date, that you suffered from a cognitive impairment or loss of functional capacity, before the grace period ended, that caused you to miss making premium payments. In that event, you will not be required to submit to underwriting. Your coverage will be reinstated retroactively to the termination date but you must pay back premiums for that period. The premium will be the same as it was prior to termination.

(b) If your coverage has terminated because you did not pay premiums or because you requested cancellation, the Carrier may reinstate your coverage within 12 months from the termination date at your request. You will be required to reapply based on full underwriting, and the Carrier will determine whether you are still insurable. If you are insurable, your coverage will be reinstated retroactively to the termination date and you must pay back premiums for that period. The premium will be the same as it was prior to termination.

§ 875.414 Will benefits be coordinated with other coverage?

Yes, benefits will be coordinated with other plans, following the coordination of benefits (COB) guidelines set by the National Association of Insurance Commissioners. The total benefits from all plans that pay a long term care benefit to you should not exceed the actual costs you incur. The other plans that are considered for COB purposes include government programs, group medical benefits, and other employer-sponsored long term care insurance plans. Medicaid, individual insurance policies, and association group insurance policies are not taken into consideration under this provision.

[FR Doc. 03–2463 Filed 2–3–03; 8:45 am]

BILLING CODE 6325–50–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 23

[Docket No. CE194, Special Condition 23–134–SC]

Special Conditions; Cirrus Design Corporation SR22; Protection of Systems for High Intensity Radiated Fields (HIRF)

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special conditions; request for comments.

SUMMARY: These special conditions are issued to Cirrus Design Corporation, 4515 Taylor Circle, Duluth, Minnesota 55811, for a Type Design Change for the