other forces that have shaped the practice of telemarketing over the past two decades. The report will also look forward, assessing emerging trends for the future. The Commission will publish a separate **Federal Register** notice shortly to solicit comments and opinions in connection with both the rule review and the broader report on the telemarketing industry. In addition to requesting written comments and academic studies, the Commission plans to hold a series of public forums to afford staff and interested parties an opportunity to explore relevant issues.

The first forum in this series will address the ''do-not-call'' issue. By devoting an entire forum to this single topic, the Commission staff expects that interested parties will have sufficient time to explore the many facets of this important topic. This forum will be held in advance of the deadline for submitting written comments in the overall rule review so that participants will be able to use the ''do-not-call'' discussion to advance alternative approaches, to gain deeper insight into the forces motivating the various interested parties, and to make their subsequent written comments more focused than they might otherwise be.

After analyzing the complete record of the rule review, which will include the information provided at all the forums as well as all written comments and academic studies, the Commission will determine whether to propose amendments to the ''do-not-call'' provision or any of the other Rule provisions. The Commission will also use the information gathered during the review process in its report on telemarketing.

Section B. Public Forum

The FTC staff will conduct a public forum to discuss the issues raised by the ''do-not-call'' requirement set forth in § 310.4(b)(1)(ii) of the Telemarketing Sales Rule. The purpose of the forum is to facilitate a discussion among members of industry, consumer groups, state regulators, and law enforcement agencies about issues raised by this provision, and possible solutions to any concerns raised in the forum.

Section C. Request To Participate

The FTC invites members of the public, industry, and other interested parties to participate in the forum. To be eligible to participate, you must file a request to participate by December 10, 1999. If the number of parties who request to participate in the forum is so large that including all requesters would inhibit effective discussion among participants, FTC staff will select as participants a limited number of parties to represent the relevant interests. Selection will be based on the following criteria:

1. The party submitted a request to participate by December 10, 1999.

2. The party's participation would promote the representation of a balance of interests at the forum.

3. The party's participation would promote the consideration and discussion of the issues to be presented in the forum.

4. The party has expertise in issues to be raised in the forum.

5. The party adequately reflects the views of the affected interest(s) which it purports to represent.

If it is necessary to limit the number of participants, those who requested to participate but were not selected will be afforded an opportunity, if at all possible, to present statements during a limited time period at the end of the session. The time allotted for these statements will be based on the amount of time necessary for discussion of the issues by the selected parties, and on the number of persons who wish to make statements.

Requesters will be notified as soon as possible after December 10, 1999, whether they have been selected to participate.

By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. 99–30700 Filed 11–23–99; 8:45 am]

BILLING CODE 6750–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DoD 6010.8–R]

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); TRICARE Family Member Dental Plan

AGENCY: Office of the Secretary, DoD.

ACTION: Proposed rule.

SUMMARY: This proposed rule revises the comprehensive CHAMPUS regulation pertaining to the Expanded Active Duty Dependents Benefit Plan. The new plan, and this proposed rule: places the responsibility for TRICARE Family Member Dental Plan (TFMDP) enrollment and a large portion of the appeals program on the dental plan contractor; allows the dental plan contractor to bill eligible dependents for plan premiums in certain circumstances; reduces the enrollment period from 24 to 12 months; excludes Reserve component members ordered to active duty in support of a contingency operation from the mandatory 12 month enrollment; simplifies enrollment types and exceptions; reduces cost-shares for certain enlisted grades; adds anesthesia as a covered benefit; incorporates legislative authority for calculating the method by which premiums may be raised and allowing premium reductions for certain enlisted grades; and reduces administrative burden by reducing redundant language, referencing language appearing in other CFR sections and removing language more appropriate to the actual contract. These improvements will provide Uniformed Service families with numerous quality of life benefits that will improve participation in the plan, significantly reduce enrollment errors and positively effect utilization of this important dental plan.

DATES: Comments must be received by December 27, 1999.

ADDRESSES: Address all comments concerning this proposed rule to TRICARE Management Activity/Special Contract Operations Branch, 16401 East Centretech Parkway, Aurora, CO 80011–9043.

FOR FURTHER INFORMATION CONTACT: Lt Col Brian W. Grassi, 303–676–3496.

SUPPLEMENTARY INFORMATION:

I. Background and Legislative Changes

The Basic Active Duty Dependents Dental Benefit Plan was implemented on August 1, 1987, allowing military personnel to voluntarily enroll their dependents in a basic dental health care plan. Under this plan, DoD shared the cost of the premium with the active duty service member. Although the plan was viewed as a major step in benefit enhancement for military families, there were still complaints that the enabling legislation was too restrictive in scope and that there should be expansion of services to better meet the dental needs of the Uniformed Service family.

Congress responded to these concerns by authorizing the Secretary of Defense to develop and implement an Expanded Active Duty Dependents Dental Benefit Plan (the Defense Authorization Act, Public Law 102–484, sec. 701). The provisions of this Act specified the expended benefit structure, as well as maximum monthly premiums for enrollees. Cost-sharing levels for the expanded benefits were left up to the discretion of the Secretary of Defense after consultation with the other Administering Secretaries. The provisions of this Act were implemented on April 1, 1993.

Thereafter, Congress granted legislative authority to allow the Secretary of Defense to expand the dental plan outside the United States and to provide one year of continued dental coverage for enrolled beneficiaries to service members who die while on active duty (The Defense Authorization Act, Public Law 103–337, sec. 703). In addition, the Congress granted subsequent legislative authority to allow the Secretary of Defense to waive or reduce the cost-shares in overseas locations (The Defense Authorization Act, Public Law 105–85, sec. 732).

In Fiscal Year 1999, the Congress authorized a methodology by which the enrollee's share of the premium could be increased. This methodology is tied to the lesser of the percent increase in the basic pay of active duty service members or the basic pay for statutory pay systems plus one-half percent. In authorizing language, the Secretary of Defense could apply this premium increase methodology as if it had been in place continuously since December 31, 1993. To allow for an expanded and more comprehensive benefit, the Department will apply this premium increase methodology as authorized. The language further instructed the Secretary of Defense to advise the Congress of any plans to reduce dental plan benefits and to wait one year, after notification, before any benefits could be reduced (The Defense Authorization Act, Public Law 105–261, sec. 701).

The legislative provisions have been codified in 10 U.S.C. Chapter 55, sec. 1076a, Dependents Dental Program, and are reflected in the regulatory provisions of this rule.

II. Programmatic Improvements

The below programmatic improvements will be effective once the follow-on TFMDP contract has been awarded and the performance period has begun. At the present time, the performance period is expected to begin on February 1, 2001.

A. Contractor Enrollment

Since the plan began, the Uniformed Services have administered the dental plan enrollment, disenrollment and eligibility determination functions. The complexities of the dental plan combined with a high turnover rate of relatively inexperienced Service personnel and other competing responsibilities, separate Service procedures, databases and data transfer processes, high cost and lengthy delays in software modifications, and Uniformed Service personnel downsizing, created the need for a centralized and uniform enrollment process. This can be best achieved by an experienced dental plan contractor and will allow active duty service members to contact one organization to enroll, disenroll, re-enroll and discuss other TFMDP benefit and claims adjudication issues. By allowing the contractor to administer the enrollment function across all of the Uniformed Services, enrollment becomes portable whereas the current system does not allow an active duty member from one Service to enroll through a separate Service. Contractor enrollment will also simplify the payroll deduction and eligibility determination process and reduce the possibility of waste and abuse at the local level. In addition, it maintains a stable, trained work force at the front end of the TFMDP and greatly improves customer service.

An added benefit to contractor enrollment will be the elimination of the current required Uniformed Service enrollment forms. The complex DD Form 2494, Active Duty Dependent Dental Plan Enrollment Form, and the DD Form 2494–1, Supplemental Active Duty Dependent Dental Plan Enrollment Form, will no longer be needed and will be replaced by a standard, simplified contractor enrollment form as well as telephonic and fax enrollment options.

Contractor enrollment has proven to be a success with the TRICARE Managed Care Support contractors as well as with contracted enrollment via the TRICARE Selected Reserve Dental Program and the Tricare Retiree Dental Program. The Uniformed Services will continue, as with the former dental plan and current TRICARE/CHAMPUS programs, to determine eligibility for the dental plan and process any changes regarding eligibility through the Defense Enrollment Eligibility Reporting System (DEERS).

B. Contractor Direct Billing

The dental plan is financed through premiums jointly paid by the Government and the active duty service member. The active duty service member's share of the premiums is deducted from their payroll accounts. In certain situations, otherwise eligible dependents are precluded from enrolling in the dental plan if their sponsor does not have an active payroll account nor has insufficient funds in that account. These eligible dependents include dependents of incarcerated sponsors and survivors. By allowing the contractor to directly bill these dependents for their premium share, dependents previously excluded from enrollment can now receive coverage. This improvement eliminates a previous enrollment termination provision in the regulation where eligibility for basic pay was a deciding criterion for continued enrollment in the dental plan.

C. Reduction in Mandatory Enrollment Period

A mandatory enrollment period is an essential factor behind Government and contractor actuarial estimates in developing the TFMDP premium and provides a guarantee to the contracting community that they will collect a certain amount of premiums for the potential benefit payout. The proposed regulation reduces the previous longstanding 24-month mandatory enrollment period to 12 months since this 24-month period precluded numerous, otherwise eligible, dependents from enrolling in the dental plan. These eligible dependents include those that are near the end of their active service and have new eligible dependents, enlisted service members who are outside of their re-enlistment window of opportunity, and Reserve/Guard personnel called to active duty for less than 24 months (such as Reserve/Guard personnel on active duty for training and special assignments). Reduction to a 12-month enrollment period for the TFMDP has a precedent with other TRICARE plans, to include the TRICARE Managed Care Prime option and the Tricare Selected Reserve Dental Program. By introducing this more liberal enrollment period, the proposed regulation also calls for a 12-month ''lock-out'' if the active duty service member disenrolls before completing the 12-month enrollment period or if the active duty service member fails to pay their premiums. A 12-month lock-out period also applies to a Reserve component member who disenrolls before completing the special mandatory enrollment period for Reserve component members ordered to active duty in support of a contingency operation. This ''lock-out'' period has a precedent with other commercial dental insurance plans as well as the TRICARE Managed Care Prime option, the TRICARE Selected Reserve Dental Program and the TRICARE Retiree Dental Program. ''Lock-out'' periods also discourage potential beneficiaries from enrolling in an insurance plan, receiving all of their benefit in a few months and then disenrolling without paying a full 12 months' worth of premiums.

Beneficiaries enrolled in the current dental plan at the time when TFMDP coverage begins must complete their two (2) year enrollment period established under that superceded plan except if one of the conditions for valid disenrollment applies. Once this

original two (2) year enrollment period is met, the active duty member may continue TFMDP enrollment on a month-to-month basis. A new one (1) year enrollment period will only be incurred if the active duty member disenrolls and attempts to re-enroll in the TFMDP at a later date.

D. Enrollment Period for Certain Reserve Component Sponsors

The proposed regulation provides that the 12-month enrollment period shall not apply to eligible dependents of Reserve component sponsors ordered to active duty for more than 30 days but less than 12 months (other than for training) in support of a contingency operation as defined in 10 U.S.C. sec. 101(a)(13). Orders may be issued under statutory authorities for recalling Reserve component members to active duty, but must specify that the member is serving in support of a specific contingency operation under the statutory definition. This disparate treatment for certain Reserve component members is necessary because of the involuntary nature of their call to active duty and statutory limitations on their periods of active duty.

By contrast, active duty members are enlisted, reenlisted or commissioned for periods of active duty longer than one year. The active duty member has the option to enroll eligible dependents at any time during that period of active duty prior to the last 12 months of service, and at a relatively constant premium cost. Similarly, other Reserve component members generally volunteer for call to active duty and serve for at least one year; therefore they will have the option to enroll family members at any time other than in the last 12 months of that service.

However Reserve component members ordered to active duty in support of a contingency operation are normally limited by statute to a period of active duty of 9 months or less. While 38 U.S.C. Chapter 43 provides that a Reserve component member who has coverage under a civilian employer sponsored dental program may elect to continue that coverage during a period of active duty, for up to 18 months; if serving for more than 30 days, the member may be required to pay the full premium cost with employer cost-sharing no longer required. Upon release from active duty, 38 U.S.C. Chapter 43, provides that the Reserve component member may be reinstated in his or her civilian employer sponsored program without a waiting period. Without an exception to the mandatory 12 month enrollment period for TFMDP, members who cannot afford to pay the full premium for continuing their civilian plan would be unable to provide dental insurance coverage for their family members while on active duty. This exclusion to the 12-month enrollment period is therefore necessary to preclude such prejudicial treatment of Reserve component members ordered to active duty for less than 12 months to support a contingency operation. In its place, a separate enrollment period is created for the Reserve component member.

E. Reduction in Cost-Shares for Certain Enlisted Pay Grades

Although certain cost-shares are mandated by law, the Secretary of Defense has the prerogative to adjust cost-shares for certain types of dental procedures. Available data shows that our lower-paid enlisted families are reluctant to pursue specialized dental care because of the amount of their cost-share. To allow greater participation and dental benefit utilization among our younger enlisted families, this proposed regulation would have a two-tiered maximum cost-share dependent on the active duty service member's pay grade. With the rates below, this reduction for enlisted service members does not have a measurable effect on the overall premium.

[In percent]

Covered services	Cost-share for pay grades E–1, E–2, E–3 and E–4	Cost-share for all other pay grades
Diagnostic	0	0
Preventive, except Sealants	0	0
Emergency Services	0	0
Sealants	20	20
Professional Consultations	20	20
Professional Visits	20	20
Post Surgical Services	20	20
Basic Restorative (example: amalgams, resins, stainless steel crowns)	20	20
Endodontic	30	40
Periodontic	30	40
Oral and Maxillofacial Surgery	30	40
General Anesthesia	40	40
Intravenous Sedation	50	50
Other Restorative (example: crowns, onlays, casts)	50	50
Prosthodontic	50	50
Medications	50	50
Orthodontic	50	50
Miscellaneous Services	50	50

A reduction in cost shares has been chosen over a reduction in premium rates for enlisted service members in these pay grades because the premium rates have traditionally been affordable as compared to similar dental benefits programs administered by commercial dental insurance plans and given the fact that the Government pays 60 percent of the total premium. As such, the greatest effect on participation and utilization can best be achieved through a reduction in cost-shares.

F. Simplification on Enrollment Options

Under the proposed rule, TFMDP enrollment options have been simplified to assist the beneficiary, Government, provider of care and the dental plan contractor. Under the prior dental plan, dependents were asked to choose from several different enrollment options

depending on whether they had children under the age of 4. With the advances in pediatric dentistry (pedodontics), dental care for children between the ages of 1 and 4 is highly recommended. As such, the dental plan contractor will offer sponsors the opportunity to enroll these particular dependents when eligibility information indicates a dependent is 1 year of age or older. Although there will continue to be two separate premiums, a ''single'' premium for one covered life and a ''family'' premium for more than one covered life, providing additional exceptions to this rule based on age will advance pediatric care among our beneficiary population, simplify enrollment processing by the dental plan contractor and promote greater understanding of enrollment options by all parties.

G. Addition of Anesthesia Services

Local anesthesia, in conjunction with other covered dental procedures, is considered integral to the procedure itself and has been covered for several years. Other anesthesia services were historically excluded due to their high cost. The proposed regulation allows the Department to add other types of anesthesia services to the TFMDP benefit package.

H. Appeals Plan

Under the TFMDP, the Department wishes to procure a responsive, simple, and two (or greater) tiered appeals program within the dental plan contractor's operation. We have had similar success with this approach under the TRICARE Selected Reserve Dental Program and the TRICARE Retiree Dental Program, where the contractors administer the first two levels of the appeals program, which are termed the initial determination and the reconsideration. Under the TFMDP, the appealing parties would appeal adverse decisions through the contractor's established appeal process where separate parties would perform the initial determination and reconsideration reviews (whether internal or external to the organization). the final level of review would be, as before, to the Department, subscribing to guidelines under the Formal Review and Hearing procedures listed in 32 CFR 199.10.

I. Plan Transition

The programmatic improvements are scheduled to take effect when the follow-on TFMDP contract to the current Expanded Active Duty Dependents Dental Plan contract is awarded and the performance period begins. Considering the magnitude of the planned improvements, the Department plans to ''phase-out'' operations under the former contractor and method of operation to accommodate late claims processing and to allow the Uniformed Services time to process retroactive enrollment and coverage information to assist our beneficiaries. This ''phase-out'' schedule will be jointly determined between the Department and the outgoing and incoming dental plan contractors.

III. Administrative Changes

The proposed regulation incorporates several administrative changes. There is revised language on Federal preemption of State and local laws that conforms the dental regulation language to reflect the Department's previous exercise of statutory authority in this area. Other changes include: widespread publication of premium rates; allowing the Department to modify the benefit package based on developments in common dental care practices and standard dental insurance plans; permitting the dental plan contractor to pay ''by report'' procedures by providing an additional allowance to the primary covered procedure; removing detailed descriptions of types of authorized providers in favor of more general language; updating dental terminology to be consistent with the American Dental Association's Council on Dental Care Program's Code on Dental Procedures and Nomenclature; and, reorganizing and adding language on the maximum amount payable by the TFMDP.

The proposed regulation incorporates plan name and other changes to reflect current terminology, such as outdated references to the former TRICARE Management Activity address, ''Active Duty Dependent Dental Plan'' and superceded regulations. It also reduces redundant language and reduces the overall size of the regulation through cross-references to applicable language appearing in other CFR sections. This includes references to appeals, fraud and abuse, eligibility, and adjunctive dental care as well as information on the former dental plans. Items that are more appropriate for inclusion in the actual contract statement of work have also been removed and transferred to that document. This includes equality of benefit processing, coordination of benefits, participating provider lists, Government review of billing practices, and how a Dental Explanation of Benefits should be structured. Finally, the regulation has been reorganized for better flow, ease of reading and understanding.

IV. Costs

The changes in the proposed regulation coincide with the upcoming recompetition of the TFMDP contract. As such, the Department plans to include these requirements in the request for proposal. By relaxing or eliminating some current contractual requirements and adding a greater number of eligible dependents, we anticipate that costs for the programmatic improvements can be met through contractor internal efficiencies and the competitive nature of the bid process and will result in affordable premiums comparable to what dental plan enrollees presently pay.

V. Regulatory Procedures

Executive Order 12866 requires certain regulatory assessments for any ''significant regulatory action'' defined as one that would result in an annual effect on the economy of $100 million or more, or have other substantial impacts. The Regulatory Flexibility Act (RFA) requires that each federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities.

This proposed rule is not a significant regulatory action under Executive Order 12866. The changes set forth in this proposed rule are minor revisions to the existing regulation. Since this proposed rule does not impose information collection requirements, it does not need to be reviewed by the Executive Office of Management and Budget under authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

List of Subjects in 32 CFR Part 199

Administrative practice and procedure, Claims, Dental health, Fraud, Health care, Health insurance, Individuals with disabilities, Military personnel.

Accordingly, 32 CFR part 199 is amended as follows:

PART 199—[AMENDED]

1. The authority citation for part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55.

2. Section 199.13 is revised to read as follows:

§ 199.13 TRICARE Family Member Dental Plan.

(a) *General provisions*—(1) *Purpose.* This section prescribes guidelines and policies for the delivery and administration of the TRICARE Family Member Dental Plan (TFMDP) of the Uniformed Service of the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the U.S. Public Health Service (USPHS) and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA). The TFMDP is a premium based indemnity dental insurance coverage plan that is available to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services and their voluntary decision to accept enrollment in the plan and cost share (when applicable) with the Government in the premium cost of the benefits. The TFMDP is authorized by 10 U.S.C. 1076a, Dependents' Dental Program, and this section was previously titled the ''Active Duty Dependents Dental Plan''.

(2) *Applicability*—(i) *Geographic scope.* (A) The TFMDP is applicable geographically within the 50 States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands. These areas are collectively referred to as the ''CONUS (or Continental United States) service area''.

(B) *Extension of the TFMDP to areas outside the CONUS service area.* In accordance with the authority cited in 10 U.S.C. 1076a(h), the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) may extend the TFMDP to areas other than those areas specified in paragraph (a)(2)(i)(A) of this section for the eligible dependents of active duty members of the Uniformed Services. These areas are collectively referred to as the ''OCONUS (or outside the Continental United States) service area''. In extending the TFMDP outside the CONUS service area, the ASD(HA), or designee, is authorized to establish program elements, methods of administration and payment rates and procedures to providers that are different from those in effect for the CONUS service area to the extent the ASD(HA), or designee, determines necessary for the effective and efficient operation of the TFMDP. This includes provisions for preauthorization of care if the needed services are not available in a Uniformed Service overseas dental treatment facility and payment by the Department of certain cost-shares (or co-payments) and other portions of a provider's billed charges. Other difference may occur based on limitations in the availability and capabilities of the Uniformed Service overseas dental treatment facility and a particular nation's civilian sector providers in certain areas. These differences include varying licensure and certification requirements of OCONUS providers, Uniformed Service provider selection criteria and local results of provider selection, referral, beneficiary pre-authorization and marketing procedures, and care for beneficiaries residing in distant areas. The Director, Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) shall issue guidance, as necessary, to implement the provisions of this paragraph (a)(2)(i)(B). Beneficiaries will be eligible for the same TFMDP benefits in the OCONUS service area although services may not be available or accessible in all OCONUS countries.

(ii) *Agency.* The provisions of this section apply throughout the Department of Defense (DoD), the United States Coast Guard, the USPHS and NOAA.

(iii) *Exclusion of benefit services performed in military dental care facilities.* Except for emergency treatment, dental care provided outside the United States, and services incidental to noncovered services, beneficiaries enrolled in the TFMDP may not obtain those services that are benefits of the TFMDP in military dental care facilities, as long as those covered benefits are available for cost-sharing under the TFMDP. Enrolled beneficiaries may continue to obtain noncovered services from military dental care facilities subject to the provisions for space available care.

(3) *Authority and responsibility*—(i) *Legislative authority*— (A) *Joint regulations.* 10 U.S.C. 1076a authorizes the Secretary of Defense, in consultation with the Secretary of Health and Human Services, and the Secretary of Transportation, to prescribe regulations for the administration of the TFMDP.

(B) *Administration.* 10 U.S.C. 1073 authorizes the Secretary of Defense to administer the TFMDP for the Army, Navy, Air Force, and Marine Corps under DoD jurisdiction, the Secretary of Transportation to administer the TFMDP for the Coast Guard, when the Coast Guard is not operating as a service in the Navy, and the Secretary of Health and Human Services to administer the TFMDP for the Commissioned Corps of the NOAA and the USPHS.

(ii) *Organizational delegations and assignments*—(A) *Assistant Secretary of Defense (Health Affairs) (ASD(HA)).* The Secretary of Defense, by 32 CFR part 367, delegated authority to the ASD(HA) to provide policy guidance, management control, and coordination as required for all DoD health and medical resources and functional areas including health benefit programs. Implementing authority is contained in 32 CFR part 367. For additional implementing authority see § 199.1. Any guidelines or policy necessary for implementation of this § 199.13 shall be issued by the Director, OCHAMPUS.

(B) *Evidence of eligibility.* DoD, through the Defense Enrollment Eligibility Reporting System (DEERS), is responsible for establishing and maintaining a listing of persons eligible to receive benefits under the TFMDP.

(4) *Preemption of State and local laws.* (i) Pursuant to 10 U.S.C. 1103 and section 8025 (fourth proviso) of the Department of Defense Appropriations Act, 1994, DoD has determined that, in the administration of 10 U.S.C. chapter 55, preemption of State and local laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods is necessary to achieve important Federal interests, including, but not limited to, the assurance of uniform national health programs for military families and the operation of such programs at the lowest possible cost to DoD, that have a direct and substantial effect on the conduct of military affairs and national security policy of the United States. This determination is applicable to the dental services contracts that implement this section.

(ii) Based on the determination set forth in paragraph (a)(4)(i) of this section, any State or local law relating to health or dental insurance, prepaid health or dental plans, or other health or dental care delivery or financing methods is preempted and does not apply in connection with the TFMDP contract. Any such law, or regulation pursuant to such law, is without any force or effect, and State or local governments have no legal authority to enforce them in relation to the TFMDP contract. (However, DoD may, by contract, establish legal obligations on the part of the dental plan contractor to conform with requirements similar or identical to requirements of State or local laws or regulations.)

(iii) The preemption of State and local laws set forth in paragraph (a)(4)(ii) of this section includes State and local laws imposing premium taxes on health or dental insurance carriers or underwriters or other plan managers, or similar taxes on such entities. Such laws are laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods,

within the meaning of the statutes identified in paragraph (a)(4)(i) of this section. Preemption, however, does not apply to taxes, fees, or other payments on net income or profit realized by such entities in the conduct of business relating to DoD health services contracts, if those taxes, fees, or other payments are applicable to a broad range of business activity. For purposes of assessing the effect of Federal preemption of State and local taxes and fees in connection with DoD health and dental services contracts, interpretations shall be consistent with those applicable to the Federal Employees Health Benefits Program under 5 U.S.C. 8909(f).

(5) *Plan funds.*—(i) *Funding sources.* The funds used by the TFMDP are appropriated funds furnished by the Congress through the annual appropriation acts for DoD, the Department of Health and Human Services and the Department of Transportation and funds collected by the Uniformed Services or contractor through payroll deductions or through direct billing as premium shares from enrolled beneficiaries.

(ii) *Disposition of funds.* TFMDP funds are paid by the Government (or in the case of direct billing, by the beneficiary) as premiums to an insurer, service, or prepaid dental care organization under a contract negotiated by the Director, OCHAMPUS, or a designee, under the provisions of the Federal Acquisition Regulation (FAR) (48 CFR chapter 1).

(iii) *Plan.* The Director, OCHAMPUS, or designee provides an insurance policy, service plan, or prepaid contract of benefits in accordance with those prescribed by law and regulation; as interpreted and adjudicated in accord with the policy, service plan, or contract and a dental benefits brochure; and as prescribed by requirements of the dental plan contractor's contract with the Government.

(iv) *Contracting out.* The method of delivery of the TFMDP is through a competitively procured contract. The Director, OCHAMPUS, or a designee, is responsible for negotiating, under provisions of the FAR, a contract for dental benefits insurance or prepayment that includes responsibility for:

(A) Development, publication, and enforcement of benefit policy, exclusions, and limitations in compliance with the law, regulation, and the contract provisions;

(B) Adjudicating and processing claims; and conducting related supporting activities, such as enrollment, disenrollment, collection of premiums, eligibility verification, provider relations, and beneficiary communications.

(6) *Role of Health Benefits Advisor (HBA).* The HBA is appointed (generally by the commander of an Uniformed Services medical treatment facility) to serve as an advisor to patients and staff in matters involving the TFMPD. The HBA may assist beneficiaries in applying for benefits, in the preparation of claims, and in their relations with OCHAMPUS and the dental plan contractor. However, the HBA is not responsible for the TFMPD's policies and procedures and has no authority to make benefit determinations or obligate the TFMPD's funds. Advice given to beneficiaries by HBAs as to determination of benefits or level of payment is not binding on OCHAMPUS or the dental plan contractor.

(7) *Right to information.* As a condition precedent to the provision of benefits hereunder, the Director, OCHAMPUS, or designee, shall be entitled to receive information from an authorized provider or other person, institution, or organization (including a local, State, or United States Government agency) providing services or supplies to the beneficiary for which claims for benefits are submitted. While establishing enrollment and eligibility, benefits, and benefit utilization and performance reporting information standards, the Government has established and does maintain a system of records for dental information under the TFMDP. By contract, the Government audits the adequacy and accuracy of the dental plan contractor's system of records and requires access to information and records to meet plan accountabilities, to assist in contractor surveillance and program integrity investigations and to audit OCONUS financial transactions where the Department has a financial stake. Such information and records may relate to attendance, testing, monitoring, examination, or diagnosis of dental disease or conditions; or treatment rendered; or services and supplies furnished to a beneficiary; and shall be necessary for the accurate and efficient administration and payment of benefits under this plan. To assist in claims adjudication, grievance and fraud investigations, and the appeals process, and before an interim or final determination can be made on a claim of benefits, a beneficiary or active duty service member must provide particular additional information relevant to the requested determination, when necessary. Failure to provide the requested information may result in denial of the claim and inability to effectively investigate the grievance or fraud or process the appeal. The recipient of such information shall in every case hold such records confidential except when:

(i) Disclosure of such information is necessary to the determination by a provider or the dental plan contractor of beneficiary enrollment or eligibility for coverage of specific services;

(ii) Disclosure of such information is authorized specifically by the beneficiary;

(iii) Disclosure is necessary to permit authorized Government officials to investigate and prosecute criminal actions;

(iv) Disclosure constitutes a routine use of a record which is compatible with the purpose for which it was collected. This includes a standard and acceptable business practice commonly used among dental insurers which is consistent with the principle of preserving confidentiality of personal information and detailed clinical data. For example, the release of utilization information for the purpose of determining eligibility for certain services, such as the number of dental prophylaxis procedures performed for a beneficiary, is authorized;

(v) Disclosure is pursuant to an order form a court of competent jurisdiction; or

(vi) Disclosure by the Director, OCHAMPUS, or designee, is for the purpose of determining the applicability of, and implementing the provisions of, other dental benefits coverage or entitlement.

(8) *Utilization review and quality assurance.* Claims submitted for benefits under the TFMDP are subject to review by the Director, OCHAMPUS, or designee, for quality of care and appropriate utilization. The Director, OCHAMPUS, or designee, is responsible for appropriate utilization review and quality assurance standards, norms, and criteria consistent with the level of benefits.

(b) *Definitions.* For most definitions applicable to the provisions of this section, refer to 199.2. The following definitions apply only to his section:

(1) *Assignment of benefits.* Acceptance by a nonparticipating provider of payment directly from the insurer while reserving the right to charge the beneficiary or active duty service member for any remaining amount of the fees for services which exceeds the prevailing fee allowance of the insurer.

(2) *Authoried provider.* A dentist, dental hygienist, or certified and licensed anesthetist specifically authorized to provide benefits under the TFMPD in paragraph (f) of this section.

(3) *Beneficiary.* A dependent of an active duty member who has been enrolled in the TFMDP, and has been determined to be eligible for benefits, as set forth in paragraph (c) of this section.

(4) *Beneficiary liability.* The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of dental care or treatment received. Specifically, for the purposes of services and supplies covered by the TFMDP, beneficiary liability includes cost-sharing amounts or any amount above the prevailing fee determination by the insurer where the provider selected by the beneficiary is not a participating provider or a provider within an approved alternative delivery system. In cases where a nonparticipating provider does not accept assignment of benefits, beneficiaries may have to pay the nonparticipating provider in full at the time of treatment and seek reimbursement directly from the insurer for all or a portion of the nonparticipating provider's fee. Beneficiary liability also includes any expenses for services and supplies not covered by the TFMDP, less any available discount provided as a part of the insurer's agreement with an approved alternative delivery system.

(5) *By report.* Dental procedures which are authorized as benefits only in unusual circumstances requiring justification of exceptional conditions related to otherwise authorized procedures. These services are further defined in paragraph (e) of this section.

(6) *Contingency operation.* Defined in 10 U.S.C. 101(a)(13) as a military operation designated as a contingency operation by the Secretary of Defense or a military operation that results in the exercise of authorities for ordering Reserve component members to active duty without their consent and is therefore automatically a contingency operation.

(7) *Cost-share.* The amount of money for which the beneficiary (or active duty service member) is responsible in connection with otherwise covered dental services (other than disallowed amounts) as set forth in paragraph (e) of this section. A cost-share may also be referred to as a ''co-payment.''

(8) *Defense Enrollment Eligibility reporting System (DEERS).* The automated system that is composed of two phases:

(i) Enrolling all active duty and retired service members, their dependents, and the dependents of deceased service members; and

(ii) Verifying their eligibility for health care benefits in the direct care facilities and through the TFMDP.

(9) *Dental hygienist.* Practitioner in rendering complete oral prophylaxis services, applying medication, performing dental radiography, and providing dental education services with a certificate, associate degree, or bachelor's degree in the field, and licensed by an appropriate authority.

(10) *Dentist.* Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

(11) *Diagnostic services.* Category of dental services including:

(i) Clinical oral examinations;

(ii) Radiographic examinations; and

(iii) Diagnostic laboratory tests and examinations provided in connection with other dental procedures authorized as benefits of the TFMDP and further defined in paragraph (e) of this section.

(12) *Endodontics.* The etiology, prevention, diagnosis, and treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue as further defined in paragraph (e) of this section.

(13) *Initial determination.* A formal written decision on a TFMDP claim, a request for TFMDP benefit [pre-determination, a request by a provider for approval as an authorized provider, or a decision suspending, excluding or terminating a provider as an authorized provider under the TFMFDP. Rejection of a claim or pre-determination, or of a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding TFMDP benefits are not initial determinations.

(14) *Nonparticipating provider.* A dentist or dental hygienist that furnished dental services to a TFMDP beneficiary, but who has not agreed to participate or to accept the insurer's fee allowances and applicable cost share as the total charge for the services. A nonparticipating provider looks to the beneficiary or active duty member for final responsibility for payment of his or her charge, but may accept payment (assignment of benefits) directly from the insurer or assist the beneficiary in filing the claim for reimbursement by the dental plan contractor. Where the nonparticipating provider does not accept payment directly from the insurer, the insurer pays the beneficiary or active duty member, not the provider.

(15) *Oral and maxillofacial surgery.* Surgical procedures performed in the oral cavity as further defined in paragraph (e) of this section.

(16) *Orthodontics.* The supervision, guidance, and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex as further defined in paragraph (e) of this section.

(17) *Participating provider.* A dentist or dental hygienist who has agreed to accept the insurer's reasonable fee allowances or other fee arrangements as the total charge (even though less than the actual billed amount), including provision for payment to the provider by the beneficiary (or active duty member) of any cost-share for covered services.

(18) *Party to the initial determination.* Includes the TFMDP, a beneficiary of the TFMDP and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized TFMDP provider is a party to that initial determination, as is a provider who is suspended, excluded or terminated as an authorized provider, unless the provider is excluded under another federal or federally funded program.

(19) *Periodontics.* The examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth as further defined in paragraph (e) of this section.

(20) *Preventive services.* Traditional prophylaxis including scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth as further defined in paragraph (e) of this section.

(21) *Prosthodontics.* The diagnosis, planning, making, insertion, adjustment, relinement, and repair of artificial devices intended for the replacement of missing teeth and associated tissues as further defined in paragraph (e) of this section.

(22) *Provider.* A dentist or dental hygienist as specified in paragraph (f) of this section. This term, when used in relation to OCONUS service area providers, may include other recognized professions authorized to furnish care under laws of that particular country.

(23) *Restorative services.* Restoration of teeth including those procedures commonly described as amalgam restorations, resin restorations, pin retention, and stainless steel crowns for primary teeth as further defined in paragraph (e) of this section.

(24) *Sealants.* A material designed for application on specified teeth to seal the surface irregularities to prevent ingress of oral fluids, food, and debris in order to prevent tooth decay.

(c) *Eligibility and enrollment*—(1) *General.* 10 U.S.C. 1076a, 1072(2)(A), (D), or (I) and 1072(6) set forth those persons who are eligible for voluntary enrollment in the TFMDP. A determination that a person is eligible for voluntary enrollment does not automatically entitle that person to benefit payments. The person must be enrolled in accordance with the provisions set forth in this section and meet any additional eligibility requirements in this part in order for dental benefits to be extended.

(2) *Eligibility.*—(i) *Person eligible (dependent).* A person who bears one of the following relationships to an active duty member (under a call or order that does not specify a period of thirty (30) days of less):

(A) *Spouse.* A lawful husband or wife, regardless of whether or not dependent upon the active duty member.

(B) *Child.* To be eligible, the child must be unmarried and meet the requirements set forth in § 199.3(b)(2)(iv)(A) and § 199.3(b)(2)(iv)(C).

(ii) *Determination of eligibility status and evidence of eligibility.*—(A) *Eligibility determination responsibility of the Uniformed Services.* Determination of a person's eligibility for the TFMDP is the responsibility of the active duty member's Uniformed Service. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, OCHAMPUS, or designee, review the eligibility status. In such cases, a report on the result of the review and any action taken will be submitted to the Director, OCHAMPUS, or designee.

(B) *Procedures for determination of eligibility.* Uniformed Services identification cards do not distinguish eligibility for the TFMDP. Procedures for the determination of eligibility are identified in § 199.3(f)(2), except that Uniformed Services identification cards do not provide evidence of eligibility for the TFMDP. Although OCHAMPUS and the dental plan contractor must make determinations concerning a dependent's eligibility in order to ensure proper enrollment and proper disbursement of appropriated funds, ultimate responsibility for resolving a dependent's eligibility rests with the Uniformed Services.

(C) *Evidence of eligibility required.* Eligibility and enrollment in the TFMDP will be verified through the DEERS. Eligibility and enrollment information established and maintained in the DEERS file is the only acceptable evidence of TFMDP eligibility and enrollment. It is the responsibility of the active duty member or TFMDP beneficiary, parent, or legal representative, when appropriate, to provide adequate evidence for entry into the DEERS file to establish eligibility for the TFMDP, and to ensure that all changes in status that may effect eligibility are reported immediately to the appropriate Uniformed Service for action. Ineligibility for benefits is presumed in the absence of prescribed eligibility evidence in the DEERS file.

(3) *Enrollment—Previous plans*—(A) *Basic active duty dependents dental benefit plan.* The Basic Active Duty Dependents Dental Plan was effective from August 1, 1987, up to the date of implementation of the Expanded Active Duty Dependents Dental Benefit Plan. The Basic Active Duty Dependents Dental Benefit Plan terminated upon implementation of the expanded plan.

(B) *Expanded active duty dependents dental benefit plan.* The Expanded Active Duty Dependents Dental Benefit Plan was effective from August 1, 1993, up to the date of implementation of the TFMDP. The Expanded Active Duty Dependents Dental Benefit Plan terminates upon implementation of the TFMDP.

(ii) *TRICARE Family Member Dental Plan (TFMDP)*—(A) *Election of coverage.* (*1*) Except as provided in paragraph (c)(3)(ii)(A) (*2*) of this section, active duty members may voluntarily elect to enroll their eligible dependents following implementation of the TFMDP. In order to obtain TFMDP coverage, written or telephonic election by the active duty member must be made and will be accomplished by submission or telephonic completion of an application to the dental plan contractor. This election can also be accomplished via electronic means.

(*2*) Eligible dependents of active duty members enrolled in the Expanded Active Duty Dependents Dental Benefit Plan at the time of implementation of TFMDP will automatically be enrolled in TFMDP. No election to enroll in TFMDP will be required by the active duty member.

(B) *Premiums.* (*1*) Enrollment will be by either single or family premium as defined as follows:

(*i*) *Single premium.* One (1) covered eligible dependent.

(*ii*) *Family premium.* Two (2) or more covered eligible dependents. Under the family premium, all eligible dependents of the active duty member are enrolled.

(*2*) *Exceptions.* (*i*) An active duty member may elect to enroll only those eligible dependents residing in one location when the active duty member has eligible dependents residing in two or more geographically separate locations (*e.g.,* children living with a divorced spouse; a child attending college).

(*ii*) Instances where a dependent requires a hospital or special treatment environment (due to a medical, physical handicap, or mental condition) for dental care otherwise covered by the TFMDP, the dependent may be excluded from TFMDP enrollment and may continue to receive care from a military treatment facility.

(C) *Enrollment period*—(*1*) *General.* Enrollment of beneficiaries is for a period of one (1) year followed by month-to-month enrollment as long as the active duty member chooses to continue enrollment. Active duty members may enroll their family members in the TFMDP provided there is an intent to remain on active duty for a period of not less than one (1) year by the active duty member and the parent Uniformed Service. Family members enrolled in the TFMDP must remain enrolled for a minimum period of one (1) year unless one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met.

(*2*) *Reserve component members ordered to active duty in support of contingency operations.* The mandatory 12 month enrollment period does not apply to Reserve component members ordered to active duty (other than for training) in support of a contingency operation as designated by the Secretary of Defense. Affected Reserve component members may enroll in the TFMDP only if their orders specify that they are ordered to active duty in support of a contingency operation, as defined by 10 U.S.C., for a period of thirty-one (31) days or more. An affected Reserve component member must elect to enroll in TFMDP and complete the enrollment application within 30 days following entry on active duty. following enrollment, family members must remain enrolled, with the member paying premiums, until the end of the member's active duty period in support of the contingency operation or 12 months, whichever occurs first unless one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met.

(*3*) *Continuation of enrollment from Expanded Active Duty Dependents Dental Benefit Plan.* Beneficiaries enrolled in the Expanded Active Duty Dependents Dental Benefit Plan at the time when TFMDP coverage begins

must complete their two (2) year enrollment period established under this former plan except if one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met. Once this original two (2) year enrollment period is met, the active duty member may continue TFMDP enrollment on a month-to-month basis. A new one (1) year enrollment period will only be incurred if the active duty member disenrolls and attempts to re-enroll in the TFMDP at a later date.

(D) *Beginning dates of eligibility.* The beginning date of eligibility for TFMDP benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and the enrollment and premium is received by the dental plan contractor, subject to a predetermined and publicized dental plan contractor monthly cut-off date. This includes any changes between single and family member premium coverage and coverage of newly eligible or enrolled dependents.

(E) *Changes in and termination of enrollment—(1) Changes in status of active duty member.* When the active duty member is separated, discharged, or retired, his or her dependents lose eligibility as of 11:59 p.m. on the last day of the month in which the change in status takes place. Eligible dependents of an active duty member serving a sentence of confinement in conjunction with a sentence of punitive discharge are still eligible for the TFMDP until such time as the active duty member's discharge is executed.

(*2*) *Continuation of eligibility for dependents of active duty members who die on active duty.* Eligible dependents of active duty members who die on or after October 1, 1993, while on active duty for a period of more than thirty (30) days and who are enrolled in the TFMDP on the date of the death of the active duty member shall be eligible for continued enrollment in the TFMDP for up to one (1) year from the date of the active duty member's death.

(*3*) *Changes in status of dependent.*—(*i*) *Divorce.* A spouse separated from an active duty member by a final divorce decree loses all eligibility based on his or her former marital relationship as of 11:59 p.m. of the last day of the month in which the divorce becomes final. The eligibility of the active duty member's own children (including adopted and eligible illegitimate children) is unaffected by the divorce. An unadopted stepchild, however, loses eligibility with the termination of the marriage, also as of 11:59 p.m. of the last day of the month in which the divorce becomes final.

(*ii*) *Annulment.* A spouse whose marriage to an active duty member is dissolved by annulment loses eligibility as of 11:59 p.m. of the last day of the month in which the court grants the annulment order. The fact that the annulment legally declares the entire marriage void from its inception does not affect the termination date of eligibility. When there are children, the eligibility of the active duty member's own children (including adopted and eligible illegitimate children) is unaffected by the annulment. An unadopted stepchild, however, loses eligibility with the annulment of the marriage, also as of 11:59 p.m. of the last day of the month in which the court grants the annulment order.

(*iii*) *Adoption.* A child of an active duty member who is adopted by a person, other than a person whose dependents are eligible for TFMDP benefits while the active duty member is living, thereby severing the legal relationship between the child and the active duty member, loses eligibility as of 11:59 p.m. of the last day of the month in which the adoption becomes final.

(*iv*) *Marriage of child.* A child of an active duty member who marries a person whose dependents are not eligible for the TFMDP, loses eligibility as of 11:59 p.m. on the last day of the month in which the marriage takes place. However, should the marriage be terminated by death, divorce, or annulment before the child is 21 years old, the child again becomes eligible for enrollment as a dependent as of 12:00 a.m. of the first day of the month following the month in which the occurrence takes place that terminates the marriage and continues up to age 21 if the child does not remarry before that time. If the marriage terminates after the child's 21st birthday, there is no reinstatement of eligibility.

(*v*) *Disabling illness or injury of child age 21 or 22 who has eligibility based on his or her student status.* A child 21 or 22 years old who is pursuing a full-time course of higher education and who, either during the school year or between semesters, suffers a disabling illness or injury with resultant inability to resume attendance at the institution remains eligible for the TFMDP for six (6) months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, the TFMDP can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child 21 or 22 years old in full-time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child 21 or 22 years old in student status does not have eligibility related to mental or physical incapacity as described in § 199.3(b)(2)(iv)(C)(*2*).

(*4*) *Other.*—(*1*) *Disenrollment because of no eligible beneficiaries.* When an active duty member ceases to have any eligible beneficiaries, enrollment is terminated.

(*ii*) *Option to disenroll as a result of a change in active duty station.* When an active duty member transfers with beneficiaries to a duty station where space-available dental care for the beneficiaries is readily available at the local Uniformed Service dental treatment facility or to locations within the OCONUS service area, the active duty member may elect, within ninety (90) calendar days of the transfer, to disenroll from the TFMDP. If the active duty member is later transferred to a duty station where dental care for the dependents is not available in the local Uniformed Service dental treatment facility, the active duty member may re-enroll his or her dependents in the TFMDP *provided* the member, as of the date of reenrollment, otherwise meets the requirements for enrollment, including the intent to remain on active duty for a period of not less than one (1) year.

(*iii*) *Option to disenroll after an initial one (1) year enrollment.* When an active duty member's enrollment has been in effect for a continuous period of one (1) year, the active duty member may disenroll at any time following procedures as set up by the dental plan contractor. Subsequent to the disenrollment, the active duty member may reenroll for another minimum period of one (1) year. If, during any one (1) year enrollment period, the active duty member disenrolls for reasons other than those listed in this paragraph (c)(3)(ii)(E) or fails to make premium payments, the active duty member and beneficiaries will be subject to a lock-out period of twelve (12) months. Following this period of time, active duty members will be able to reenroll if they so choose. The twelve (12) month lock-out period applies to a Reserve component member who disenrolls for reasons other than those listed in this paragraph (c)(3)(ii)(E) or fails to make premium payments after the member has enrolled pursuant to paragraph (c)(3)(ii)(C) of this section.

(d) *Premium sharing*—(1) *General.* Active duty members enrolling in the TFMDP shall be required to pay a

portion of the premium cost for their dependents.

(2) *Proportion of active duty member's premium share.* The proportion of premium share to be paid by the active duty member is established by the ASD (HA), or designee, at not more than forty (40) percent of the total premium.

(3) *Provision for increases in active duty member's premium share.* (i) Although previously capped at $20 per month, the law has been amended to authorize the cap on active duty members' premiums to rise, effective as of January 1 of each year, by the percent equal to the lesser of:

(A) The percent by which the rates of basic pay of active duty members are increased on such date; or

(B) The sum of one-half percent and the percent computed under 5 U.S.C. 5303(a) for the increase in rates of basic pay for statutory pay systems for pay periods beginning on or after such date.

(ii) Under the legislation authorizing an increase in the monthly premium cap, the methodology for determining the active duty member's TFMDP premium will be applied as if the methodology had been in continuous use since December 31, 1993.

(4) *Reduction of premium share or cost-shares for enlisted members.* For enlisted members in pay grades E–1 through E–4, the ASD (HA) or designee, may reduce the monthly premium and/or cost-shares these active duty members pay for selected benefits as specified in paragraph (e)(3)(i) of this section.

(5) *Premium payment method.* The active duty member's premium share shall be deducted from the active duty member's basic pay, if sufficient pay is available. For dependents who are otherwise eligible for TFMDP benefits and whose sponsors do not receive such pay, or if sufficient pay is available, the premium payment may be collected pursuant to procedures established by the Director, OCHAMPUS, or designee.

(6) *Annual notification of premium rates.* TFMDP premium rates will be determined as part of the competitive contracting process. Information on the premium rates will be widely distributed by the dental plan contractor and the Government.

(e) *Plan benefits.*—(1) *General.*—(i) *Scope of benefits.* The TFMDP provides coverage for diagnostic and preventive services, sealants, restorative services, endodontics, periodontics, prosthodontics, orthodontics and oral and maxillofacial surgery.

(ii) *Authority to act for the plan.* The authority to make benefit determinations and authorize plan payments under the TFMDP rests primarily with the insurance, service plan, or prepayment dental plan contractor, subject to compliance with Federal law and regulation and Government contract provisions. The Director, OCHAMPUS, or designee, provides required benefit policy decisions resulting from changes in Federal law and regulation and appeal decisions. No other persons or agents (such as dentists or Uniformed Services HBAs) have such authority.

(iii) *Dental benefits brochure.*—(A) *Content.* The Director, OCHAMPUS, or designee, shall establish a comprehensive dental benefits brochure explaining the benefits of the plan in common lay terminology. The brochure shall include the limitations and exclusions and other benefit determination rules for administering the benefits in accordance with the law and this part. The brochure shall include the rules for adjudication and payment of claims, appealable issues, and appeal procedures in sufficient detail to serve as a common basis for interpretation and understanding of the rules by providers, beneficiaries, claims examiners, correspondence specialists, employees and representatives of other Government bodies, HBAs, and other interested parties. Any conflict, which may occur between the dental benefits brochure and law or regulation, shall be resolved in favor of law and regulation.

(b) *Distribution.* The dental benefits brochure will be available through the dental plan contractor and will be distributed with the assistance of the Uniformed Service HBAs and major personnel centers at Uniformed Service installations to all members enrolling their dependents.

(iv) *Alternative course of treatment policy.* The Director, OCHAMPUS, or designee, may establish, in accordance with generally accepted dental benefit practices, alternative course of treatment policy which provides reimbursement in instances where the dentist and beneficiary select a more expensive service, procedure, or course of treatment than is customarily provided. The alternative course of treatment policy must meet the following conditions:

(A) The service, procedure, or course of treatment must be consistent with sound professional standards of dental practice for the dental practice for the dental condition concerned.

(B) The service, procedure, or course of treatment must be a generally accepted alternative for a service or procedure covered by the TFMDP for the dental condition.

(C) Payment for the alternative service or procedure may not exceed the lower of the prevailing limits fro the alternative procedure, the prevailing limits or dental plan contractor's scheduled allowance for the otherwise authorized benefit procedure for which the alternative is substituted, or the actual charge for the alternative procedure.

(2) *Benefits.* The following benefits are defined (subject to the TFMDP's exclusions, limitations, and benefit determination rules approved by OCHAMPUS) using the American Dental Association's Council on Dental Care Program's Code on Dental Procedures and Nomenclature. The Director, OCHAMPUS, or designee, may modify these services, to the extent determined appropriate based on developments in common dental care practices and standard dental insurance programs.

(i) *Diagnostic and preventive services.* Benefits may be extended for those dental services described as oral examination, diagnostic, and preventive services defined as traditional prophylaxis (*i.e.*, scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth) when performed directly by dentists and dental hygienists as authorized under paragraph (f) of this section. These include the following categories of service:

(A) *Diagnostic services.* (*1*) Clinical oral examinations.

(*2*) Radiographs and diagnostic imaging.

(*3*) Tests and laboratory examinations.

(B) *Preventive services.* (*1*) Dental prophylaxis.

(*2*) Topical fluoride treatment (office procedure).

(*3*) Other preventive services.

(*4*) Space maintenance (passive appliances).

(ii) *General services and services ''by report''.* The following categories of services are authorized when performed directly by dentists or dental hygienists, as authorized under paragraph (f) of this section, only in unusual circumstances requiring justification of exceptional conditions directly related to otherwise authorized procedures. Use of the procedures may not result in the fragmentation of services normally included in a single procedure. The dental plan contractor may recognize a ''by report'' condition by providing additional allowance to the primary covered procedure instead of recognizing or permitting a distinct billing for the ''by report'' service. These include the following categories of general services:

(A) Unclassified treatment.

(B) Anesthesia.

(C) Professional consultation.
(D) Professional visits.
(E) Drugs.
(F) Miscellaneous services.

(iii) *Restorative services.* Benefits may be extended for restorative services when performed directly by dentists or dental hygienists, or under orders and supervision by dentists, as authorized under paragraph (f) of this section. These include the following categories of restorative services:

(A) Amalgam restorations.
(B) Resin restorations.
(C) Inlay and onlay restorations.
(D) Crowns.
(E) Other restorative services.

(iv) *Endodontic services.* Benefits may be extended for those dental services involved in treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of endodontic services:

(A) Pulp capping.
(B) Pulpotomy and pulpectomy.
(C) Endodontic therapy.
(D) Apexification and recalcification procedures.
(E) Apicoectomy and periradicular services.
(F) Other endodontic procedures.

(v) *Periodontic services.* Benefits may be extended for those dental services involved in prevention and treatment of diseases affecting the supporting structures of the teeth to include periodontal prophylaxis, gingivectomy or gingivoplasty, gingival curettage, etc., when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of periodontic services:

(A) Surgical services.
(B) Periodontal services.
(C) Other periodontal services.

(vi) *Prosthodontic services.* Benefits may be extended for those dental services involved in fabrication, insertion, adjustment, relinement, and repair of artificial teeth and associated tissues to include removal of complete and partial dentures, fixed crowns and bridges when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of prosthodontic services:

(A) *Prosthodontics (removable).*
(*1*) Complete and partial dentures.
(*2*) Adjustment to dentures.
(*3*) Repairs to complete and partial dentures.
(*4*) Denture rebase procedures.
(*5*) Denture reline procedures.
(*6*) Other removable prosthetic services.

(B) *Prosthodontics (fixed).*
(*1*) Fixed partial denture pontics.
(*2*) Fixed partial denture retainers.
(*3*) Other partial denture services.

(vii) *Orthodontic services.* Benefits may be extended for the supervision, guidance, and correction of growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations through the use of orthodontic procedures and devices when performed directly by dentists as authorized under paragraph (f) of this section to include in-process orthodontics. These include the following categories of orthodontic services:

(A) Limited orthodontic treatment.
(B) Minor treatment to control harmful habits.
(C) Interceptive orthodontic treatment.
(D) Comprehensive orthodontic treatment.
(E) Other orthodontic services.

(viii) *Oral and maxillofacial surgery services.* Benefits may be extended for basic surgical procedure of the extraction, reimplantation, stabilization and repositioning of teeth, alveoloplasties, incision and drainage of abscesses, suturing of wounds, biopsies, etc., when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of oral and maxillofacial surgery services:

(A) Extractions.
(B) Surgical extractions.
(C) Other surgical procedures.
(D) Alveoloplasty—surgical preparation of ridge for denture.
(E) Surgical incision.
(F) Repair of traumatic wounds.
(G) Complicated suturing.
(H) Other repair procedures.

(ix) *Exclusion of adjunctive dental care.* Adjunctive dental care benefits are excluded under the TFMP. For further information on adjunctive dental care benefits under TRICARE/CAMPUS, see § 199.4(e)(10).

(x) *Benefit limitations and exclusions.* The Director, OCHAMPUS, or designee, may establish such exclusions and limitations as are consistent with those established by dental insurance and prepayment plans to control utilization and quality of care for the services and items covered by the TFMDP.

(xi) *Limitation on reduction of benefits.* If a reduction in benefits is planned, the Secretary of Defense, or designee, may not reduce TFMDP benefits without notifying the appropriate Congressional committees. If a reduction is approved, the Secretary of Defense, or designee, must wait one year from the date of notice before a benefit reduction can be implemented.

(3) *Cost-shares, liability and maximum coverage.* (i) *Cost-shares.* The following table lists maximum active duty member cost shares for covered services for participating and nonparticipating providers of care. These are percentages of the dental plan contractor's determined allowable amount that the active duty member or beneficiary must pay to these providers:

[In percent]

Covered services	Cost-share for pay grades E–1, E–2, E–3 and E–4	Cost-share for all other pay grades
Diagnostic	0	0
Preventive, except Sealants	0	0
Emergency Services	0	0
Sealants	20	20
Professional Consultations	20	20
Professional Visits	20	20
Post Surgical Services	20	20
Basic Restorative (example: amalgams, resins, stainless steel crowns)	20	20
Endodontic	30	40
Periodontic	30	40
Oral and Maxillofacial Surgery	30	40
General Anesthesia	40	40

[In percent]

Covered services	Cost-share for pay grades E–1, E–2, E–3 and E–4	Cost-share for all other pay grades
Intravenous Sedation	50	50
Other Restorative (example: crowns, onlays, casts)	50	50
Prostodontic	50	50
Medications	50	50
Orthodontic	50	50
Miscellaneous Services	50	50

(ii) *Dental plan contractor liability.* Where the dental program contractor is unable to identify a participating provider of care (*i.e.,* a general dentist) within thirty five (35) miles of the beneficiary's place of residence with appointment availability within twenty one (21) calendar days, the dental program contractor will reimburse the beneficiary, or active duty member, or the nonparticipating provider selected by the beneficiary within thirty five (35) miles of the beneficiary's place of residence at the level of the provider's usual fees less the applicable beneficiary cost share, if any.

(iii) *Maximum coverage amounts.* Beneficiaries are subject to an annual maximum coverage amount for non-orthodontic dental benefits and a lifetime maximum coverage amount for orthodontics as established by the ASD (HA) or designee.

(f) *Authorized providers*—(1) *General.* Enrolled beneficiaries may seek covered services from any provider who is fully licensed and approved to provide dental care or covered anesthesia benefits in the state where the provider is located. This includes licensed dental hygienists, practicing within the scope of their licensure, subject to any restriction a state licensure or legislative body imposes regarding their status as independent providers of care.

(2) *Authorized provider status does not guarantee payment of benefits.* The fact that a provider is ''authorized'' is not to be construed to mean that the TFMDP will automatically pay a claim for services or supplies provided by such a provider. The Director, OCHAMPUS, or designee, also must determine if the patient is an eligible beneficiary, whether the services or supplies billed are authorized and medically necessary, and whether any of the authorized exclusions of otherwise qualified providers presented in this section apply.

(3) *Utlization review and quality assurance.* Services and supplies furnished by providers of care shall be subject to utilization review and quality assurance standards, norms, and criteria established under the TFMDP. Utilization review and quality assurance assessments shall be performed under the TFMDP. Utilization review and quality assurance assessments shall be performed under the TFMDP consistent with the nature and level of benefits of the plan, and shall include analysis of the data and findings by the dental plan contractor from other dental accounts.

(4) *Provider required.* In order to be considered benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a TFMDP authorized provide practicing within the scope of his or her license.

(5) *Participating provider.* An authorized provider may elect to participate for all TFMDP beneficiaries and accept the fee or charge determinations as established and made known to the provider by the dental plan contractor. The fee or charge determinations are binding upon the provider in accordance with the dental plan contractor's procedures for participation. The authorized provider may not participate on a claim-by-claim basis. The participating provider must agree to accept, within one day of a request for appointment, beneficiaries in need of emergency palliative treatment. Payment to the participating provider is based on the lower of the actual charge or the dental plan contractor's determination of the allowable charge; however, payments to participating providers shall be in accordance with the methodology specified in paragraph (g)(2)(ii) of this section. Payment is made directly to the participating provider, and the participating provider may only charge the beneficiary the percent cost-share of the dental plan contractor's allowable charge for those benefit categories as specified in paragraph (e) of this section, in addition to the full charges for any services not authorized as benefits.

(6) *Nonparticipating provider.* An authorized provider may elect to not participate for all TFMDP beneficiaries and request the beneficiary or active duty member to pay any amount of the provider's billed charge in excess of the dental plan contractor's determination of allowable charges (to include the appropriate cost share). Neither the Government nor the dental plan contractor shall have any responsibility for any amounts over the allowable charges as determined by the dental plan contractor, except where the dental plan contractor is unable to identify a participating provider of care within thirty five (35) miles of the beneficiary's place of residence with appointment availabiltiy within twenty one (21) calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within thirty five (35) miles of the beneficiary's place of residence shall be paid his or her usual fees (either by the beneficiary or the dental plan contractor if the beneficiary elected assignment of benefits), less the percent cost-share as specified in paragraph (e)(i) of this section.

(i) *Assignment of benefits.* A nonparticipating provider may accept assignment of benefits for claims (for beneficiaries certifying their wilingness to make such assignment of benefits) by filing the claims completed with the assistance of the beneficiary or active duty member for direct payment by the dental plan contractor to the provider.

(ii) *No assignment of benefits.* A nonparticipating provider for all beneficiaries may request that the beneficiary or active duty member file the claim directly with the dental plan contractor, making arrangements with the beneficiary or active duty member for direct payment by the beneficiary or active duty member.

(7) *Alternative delivery system*—(i) *General.* Alternative delivery systems may be established by the Director, OCHAMPUS, or designee, as authorized providers. Only dentists, dental hygienists and licensed anesthetists shall be authorized to provide or direct the provision of authorized services and supplies in an approved alternative delivery system.

(ii) *Defined.* An alternative delivery system may be any approved

arrangement for a preferred provider organization, capitation plan, dental health maintenance or clinic organization, or other contracted arrangement which is approved by OCHAMPUS in accordance with requirements and guidelines.

(iii) *Elective or exclusive arrangement.* Alternative delivery systems may be established by contract or other arrangement on either and elective or exclusive basis for beneficiary selection of participating and authorized providers in accordance with contractual requirements and guidelines.

(iv) *Provider election of participation.* Otherwise authorized providers must be provided with the opportunity of applying for participation in an alternative delivery system and of achieving participation status based on reasonable criteria for timeliness of application, quality of care, cost containment, geographic location, patient availability, and acceptance of reimbursement allowance.

(v) *Limitation on authorized providers.* Where exclusive alternative delivery systems are established, only providers participating in the alternative delivery system are authorized providers of care. In such instances, the TFMDP shall continue to pay beneficiary claims for services rendered by otherwise authorized providers in accordance with established rules for reimbursement of nonparticipating providers where the beneficiary has established a patient relationship with the nonparticipating provider prior to the TFMDP's proposal to subcontract with the alternative delivery system.

(vi) *Charge agreements.* Where the alternative delivery system employs a discounted fee-for-service reimbursement methodology or schedule of charges or rates which includes all or most dental services and procedures recognized by the American Dental Association's Council on Dental Care Program's Code on Dental Procedures and Nomenclature, the discounts or schedule of charges or rates for all dental services and procedures shall be extended by its participating providers to beneficiaries of the TFMDP as and incentive for beneficiary participation in the alternative delivery system.

(g) *Benefit payment.*—(1) *General.* TFMDP benefit payments are made either directly to the provider or to the beneficiary or active duty member, depending on the manner in which the claim is submitted or the terms of the subcontract of an alternative delivery system with the dental plan contractor.

(2) *Benefit payment.* Beneficiaries are not required to utilize participating providers. For beneficiaries who do use these participating providers, however, these providers shall not balance bill any amount in excess of the maximum payment allowed by the dental plan contractor for covered services. Beneficiaries using nonparticipating providers may be balance-billed amounts in excess of allowable charges. The following general requirements for the TFMDP benefit payment methodology shall be met, subject to modifications and exceptions approved by the Director, OCHAMPUS, or designee:

(i) Nonparticipating providers (or the beneficiaries or active duty members of unassigned claims) shall be reimbursed at the equivalent of not less than the 50th percentile of prevailing charges made for similar services in the same locality (region) or state, or the provider's actual charge, whichever is lower, subject to the exception listed in paragraph (e)(3)(ii) of this section, less any cost-share amount due for authorized services.

(ii) Participating providers shall be reimbursed at the equivalent of a percentile of prevailing charges sufficiently above the 50th percentile of prevailing charges made for similar services in the same locality (region) or state as to constitute a significant financial incentive for participation, or the provider's actual charge, whichever is lower, less any cost-share amount due for authorized services.

(3) *Fraud, abuse, and conflict of interest.* The provisions of § 199.9 shall apply except for § 199.9(e). All references to ''CHAMPUS contractors'', ''CHAMPUS beneficiaries'' and ''CHAMPUS providers'' in § 199.9 shall be construed to mean the ''dental plan contractor'', ''TFDP beneficiaries'' and ''TFMDP providers'' respectively for the purposes of this section. Examples of fraud include situations in which ineligible persons not enrolled in the TFMDP obtain care and file claims for benefits under the name and identification of an enrolled beneficiary; or when providers submit claims for services and supplies not rendered to beneficiaries; or when a participating provider bills the beneficiary for amounts over the dental plan contractors's determination of allowable charges; or when a provider fails to collect the specified patient cost-share amount.

(h) *Appeal and hearing procedures.* The provisions of § 199.10 shall apply except where noted in this section. All references to ''CHAMPUS contractors'', ''CHAMPUS beneficiaries'', ''CHAMPUS participating providers'' and ''CHAMPUS Explanation of Benefits'' in § 199.10 shall be construed to mean the ''dental plan contractor'', ''TFMDP beneficiaries'', ''TFMDP participating providers'' and ''Dental Explanation of Benefits of DEOB'' respectively for the purposes of this section. References to ''OCAMPUSEUR'' in § 199.10 are not applicable to the TFMDP or this section.

(1) *General.* See § 199.10(a).

(i) *Initial determination*—(A) *Notice of initial determination and right to appeal.* See § 199.10(a)(1)(i).

(B) *Effect of initial determination.* See § 199.10(a)(1)(ii).

(B) *Participation in an appeal.* Participating in an appeal is limited to any party to the initial determination, including OCHAMPUS, the dental plan contractor, and authorized representatives of the parties. Any party to the initial determination, except OCHAMPUS and the dental plan contractor, may appeal an adverse determination. The appealing party is the party who actually files the appeal.

(A) *Parties to the initial determination.* See § 199.10(a)(2)(i) and § 199.10(a)(2)(i)(A), (B), (C) and (E). In addition, a third party other than the dental plan contractor, such as an insurance company, is not a party to the initial determination and is not entitled to appeal, even though it may have an indirect interest in the initial determination.

(B) *Representative.* See § 199.10(a)(2)(ii).

(iii) *Burden of proof.* See § 199.10(a)(3).

(iv) *Evidence in appeal and hearing cases.* See § 199.10(a)(4).

(v) *Late filing.* If a request for reconsideration, formal review, or hearing is filed after the time permitted in this section, written notice shall be issued denying the request. Late filing may be permitted only if the appealing party reasonably can demonstrate to the satisfaction of the dental plan contractor, or the Director, OCHAMPUS, or designee, that timely filing of the request was not feasible due to extraordinary circumstances over which the appealing party had no practical control. Each request for an exception to the filing requirement will be considered on its own merits. The decision of the Director, OCHAMPUS, or a designee, on the request for an exception to the filing requirement shall be final.

(vi) *Appealable issue.* See § 199.10(a)(6), § 199.10(a)(6)(i), § 199.10(a)(6)(iv), including § 199.10(a)(6)(iv) (A) and (C), and § 199.10(a)(6)(v) for an explanation and examples of nonappealable issues.

Other examples of issues that are not appealable under this section include:

(A) The amount of the dental plan contractor-determined allowable charge since the methodology constitutes a limitation on benefits under the provisions of this section.

(B) Certain other issues on the basis that the authority for the initial determination is not vested in OCHAMPUS. Such issues include but are not limited to the following examples:

(*1*) A determination of a person's enrollment in the TFMDP is the responsibility of the dental plan contractor and ultimate responsibility for resolving a beneficiary's enrollment rests with the dental plan contractor. Accordingly, a disputed question of fact concerning a beneficiary's enrollment will not be considered an appealable issue under the provisions of this section, but shall be resolved in accordance with paragraph (c) of this section and the dental plan contractor's enrollment policies and procedures.

(*2*) Decisions relating to the issuance of a nonavailability statement (NAS) in each case are made by the Uniformed Services. Disputes over the need for an NAS or a refusal to issue an NAS are not appealable under this section. The one exception is when a dispute arises over whether the facts of the case demonstrate a dental emergency for which an NAS is not required. Denial of payment in this one situation is an appealable issue.

(*3*) Any decision or action on the part of the dental plan contractor to include a provider in their network or to designate a provider as participating is not appealable under this section. Similarly, any decision or action on the part of the dental plan contractor to exclude a provider from their network or to deny participating provider status is not appealable under this section.

(vii) *Amount in dispute.* (A) *General.* An amount in dispute is required for an adverse determination to be appealed under the provisions of this section, except as set forth or further explained in § 199.10(a)(7)(ii), (iii) and (iv).

(B) *Calculated amount.* The amount in dispute is calculated as the amount of money the dental plan contractor would pay if the services involved in the dispute were determined to be authorized benefits of the TFMDP. Examples of amounts of money that are excluded by this section from payments for authorized benefits include, but are not limited to:

(*1*) Amounts in excess of the dental plan contractor's-determined allowable charge.

(*2*) The beneficiary's cost-share amounts.

(*3*) Amounts that the beneficiary, or parent, guardian, or other responsible person has no legal obligation to pay.

(*4*) Amounts excluded under the provisions of § 199.8 of this part.

(viii) *Levels of appeal.* See § 199.10(a)(8)(i). Initials determinations involving the sanctioning (exclusion, suspension, or termination) of TFMDP providers shall be appealed directly to the hearing level.

(ix) *Appeal decision.* See § 199.10(a)(9).

(2) *Reconsideration.* See § 199.10(b).

(3) *Formal review.* See § 199.10(c).

(4) *Hearing.*—(i) *General.* See § 199.10(d) and § 199.10(d)(1) through (d)(5) and (d)(7) through (d)(12) for information on the hearing process.

(ii) *Authority of the hearing officer.* The hearing officer, in exercising the authority to conduct a hearing under this part, will be bound by 10 U.S.C., chapter 55, and this part. The hearing officer in addressing substantive, appealable issues shall be bound by the dental benefits brochure, policies, procedures, instructions and other guidelines issued by the ASD(HA), or a designee, or by the Director, OCHAMPUS, or a designee, in effect for the period in which the matter in dispute arose. A hearing officer may not establish or amend the dental benefits brochure, policy, procedures, instructions, or guidelines. However, the hearing officer may recommend reconsideration of the policy, procedures, instructions or guidelines by the ASD(HA), or a designee, when the final decision is issued in the case.

(5) *Final decision.* See § 199.10(e)(1) and § 199.10(e)(1)(i) for information on final decisions in the appeal and hearing process, with the exception that no recommended decision shall be referred for review by ASD(HA).

Dated: November 12, 1999.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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LIBRARY OF CONGRESS

Copyright Office

37 CFR Part 201

[Docket No. RM 99–7]

Exemption to Prohibition on Circumvention of Copyright Protection Systems for Access Control Technologies

AGENCY: Copyright Office, Library of Congress.

ACTION: Notice of inquiry.

SUMMARY: The Copyright Office of the Library of Congress is preparing to conduct proceedings to make recommendations in accordance with section 1201(a)(1) of the Copyright Act, 17 U.S.C. 1201(a)(1), which was added by the Digital Millennium Copyright Act and which provides that the Librarian of Congress may exempt certain classes of works from the prohibition against circumventing a technological measure that controls access to a copyrighted work. The purpose of this rulemaking proceeding is to determine whether there are classes of works as to which users are, or are likely to be, adversely affected in their ability to make noninfringing uses if they are prohibited from circumventing such technological measures. This notice requests written comments from all interested parties, including representatives of copyright owners, educational institutions, libraries and archives, scholars, researchers and members of the public, in order to elicit information and views on whether noninfringing uses of certain classes of works are, or are likely to be, adversely affected by such prohibition.

DATES: Written comments are due by February 10, 2000. Reply comments are due by March 13, 2000.

ADDRESSES: Submissions by electronic mail should be made to ''1201@loc.gov''; see **SUPPLEMENTARY INFORMATION** section for file formats and other information about electronic filing. If delivered by hand, comments should be delivered to the Office of the General Counsel, Copyright Office, LM–403, James Madison Memorial Building, 101 Independence Avenue, SE., Washington DC. If delivered by mail, comments should be addressed to David O. Carson, General Counsel, Copyright GC/I&R, PO Box 70400, Southwest Station, Washington, DC 20024. See **SUPPLEMENTARY INFORMATION** section for information about formats of submissions.

FOR FURTHER INFORMATION CONTACT: David O. Carson, General Counsel, or