an adequate proffer to support them, the agency may properly disregard those allegations. *General Motors Corp.* v. *FERC*, 656 F.2d 791, 798 n.20 (D.C. Cir. 1981). The company failed to submit any evidence to support its assertion that requiring the label of salmonid fish fed feeds that contain astaxanthin to declare that color has been added will mislead the public or will cause consumers to believe that fish so labeled are somehow different from other fish. Thus, because it has not proffered support for its allegation, the company has not justified a hearing on this issue.

Second, under § 12.24(b)(4), this assertion would not justify a hearing even if the company had made a proper proffer because declaration of the color additive is required as a matter of law on the label of fish that have been colored with it. Under § 101.22(k), the label of a food to which any coloring has been added shall declare the presence of the coloring in the statement of ingredients. Section 101.22(k) incorporates the provisions of section 403(k) of the act (21 U.S.C. 343(k)) into FDA's regulations.

Under § 101.22(a)(4), a coloring is any ''color additive'' as defined in § 70.3(f) (21 CFR 70.3(f)). Under § 70.3(f), a legislative regulation that was adopted after notice and comment rulemaking (28 FR 6439, June 22, 1963), ''color additive'' includes an ingredient of an animal feed whose intended function is to impart, through the biological processes of the animal, a color to the meat, milk, or eggs of the animal. Thus, as matter of law, astaxanthin is a color additive whose presence in salmonid fish that have been fed feeds that contain this color additive must be declared in the label or labeling of the fish. (Sections 101.22(k)(2) and 101.100(a)(2) of FDA's regulations describe how this declaration is to be made). On this basis, FDA concludes that this objection has no legal merit and does not justify a hearing.

V. Summary and Conclusion

The agency is denying the objection and the request for a hearing on the following: (1) The specification for carotenoid content of astaxanthin under § 73.35(b) on the basis that the request is beyond the scope of the petitioned action for astaxanthin and is appropriately resolved through the submission of a petition (§ 12.24(b)(5)); and (2) the labeling requirement for astaxanthin under § 73.35(d)(3) on the basis that a hearing will not be granted based on mere allegations or general descriptions of positions and contentions (§ 12.24(b)(2)), and that, even if an appropriate proffer had been made, the objection is not determinative of the issue raised (§ 12.24(b)(4)).

The filing of the objection and request for hearings served to stay automatically the effectiveness of the two provisions of § 73.35 to which the objections were made. Section 701(e)(2) of the act states: ''Until final action upon such objections is taken by the Secretary * * *, the filing of such objections shall operate to stay the effectiveness of those provisions of the order to which the objections are made.'' Section 701(e)(3) of the act further stipulates that ''As soon as practicable * * *, the Secretary shall by order act upon such objections and make such order public.''

The agency has completed its evaluation of the objection and the request for a hearing and concludes that a continuation of the stay of the two provisions of the regulation is not warranted.

In the absence of any other objections and requests for a hearing, the agency, therefore, further concludes that this document constitutes final action on the objection and request for hearings received in response to the regulation as prescribed in section 701(e)(2) of the act. Therefore, the agency is acting to end the stay of the two provisions of the regulation by establishing a new effective date of November 1, 1995, for these provisions of the regulation of April 13, 1995, listing astaxanthin for use as a color additive in the feed of salmonid fish to enhance the color of their flesh. As announced in the Federal Register of August 14, 1995 (60 FR 41805), the effective date of the rest of the regulation was May 16, 1995.

Therefore, under the Federal Food, Drug, and Cosmetic Act (secs. 701 and 721 (21 U.S.C. 371 and 379e)) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.10), notice is given that the objection and the request for a hearing filed in response to the final rule § 73.35 that was published on April 13, 1995 (60 FR 18736), do not form a basis for further stay of the effectiveness of the specified provisions of this final rule or require amendment of the regulations. Accordingly, the stay of §§ 73.35(b) and 73.35(d)(3) that FDA announced on August 14, 1995 (60 FR 41805), is removed effective November 1, 1995. As noted previously, all other provisions of § 73.35 became effective on May 16, 1995.

Dated: October 25, 1995.

William B. Schultz,

Deputy Commissioner for Policy.

[FR Doc. 95–27033 Filed 10–31–95; 8:45 am]

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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DoD 6010.8–R]

RIN 0720–AA19

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Expanded Active Duty Dependents Dental Benefit Plan

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: The rule establishes an expanded dental program for dependents of active duty members of the Uniformed Services. The amendment specifically describes: the legislative authority for expansion of dental benefits outside the United States; the continuation of dental benefits for active duty survivors; eligibility for pre-adoptive wards; the enhanced benefit structure; enrollment and eligibility requirements; premium cost-sharing; and benefit payment levels. The provisions of this rule will provide military families with the high quality of care they desire at an affordable price.

EFFECTIVE DATE: This final rule is effective December 1, 1995.

FOR FURTHER INFORMATION CONTACT: David E. Bennett, Program Development Branch, OCHAMPUS, Aurora, Colorado 80045–6900, telephone (303) 361–1094.

SUPPLEMENTARY INFORMATION: In the Federal Register of September 16, 1993 (58 FR 48473), The Office of the Secretary of Defense published for public comment a proposed rule establishing an expanded dental program for dependents of active duty members of the Uniformed Services.

Background

The Basic Active Duty Dependents Dental Benefit Plan, was implemented on August 1, 1987, allowing military personnel to voluntarily enroll their dependents in a dental health care program that included diagnostic and preventative benefits, as well as simple restorative services. Under this program, DoD shared the cost of the premium with the military sponsor. Although the program was viewed as a major step in benefit enhancement for military families, with enrollment levels reaching as high as 60 percent, 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 military 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 for Fiscal Year 1993, Public Law 102–484, section 701, Revisions to Dependents Dental Program Under CHAMPUS). The provisions of this Act specified the expanded benefit structure, as well as maximum monthly premiums for members and their families, the application of which was not allowed until April 1, 1993. 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 section 701 of The Defense Authorization Act for Fiscal Year 1993, were implemented on April 1, 1993, while the Department proceeded with the rulemaking process required for regulations which have a substantial and direct impact on the CHAMPUS population. This interim Expanded Active Duty Dependents Dental Benefit Plan was initiated based on Congressional direction that improvements take effect April 1, 1993. Revisions were to be made as a result of the rulemaking process in establishment/implementation of a permanent Expanded Active Duty Dependents Dental Benefit Plan.

Coverage/Benefits

Under the Basic Dependents Dental Program which was in effect prior to April 1, 1993, coverage was limited to two categories of dental benefits: diagnostic, oral examination, preventive services and palliative emergency care paid at the lower of the actual charge or 100 percent of the insurer's determined allowable charge; and basic restorative services of amalgam and composite restorations and stainless steel crowns for primary teeth, and dental appliance repairs paid at 80 percent of the allowable charge. Payment to a participating provider was considered payment in full, less the 20 percent cost-share of the allowable charge for restorative services. Nonparticipating providers were paid the same amounts; however, the beneficiary was responsible for the amount of the charge for all services above the allowable charge, except when the dental plan was unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days.

Under the Expanded Active Duty Dependents Dental Benefit Plan, Congress authorizes a broad range of dental services, the payment levels of which are based on actuarial projections and budgeted program costs. The enhanced plan includes those services which were offered under the Basic Active Duty Dependents Dental Plan (examinations, x-rays, cleanings, sealants, fillings) along with the following expanded benefit categories and payment levels:

Covered benefits	Payment levels (percent)
• Sealants	80
• Endodontics (root canal treatment)	60
• Periodontics (treatment of gum disease)	60
• Oral surgery (extractions)	60
• Prosthodontics (bridges and dentures)	50
• Orthodontics (braces)	50
• Crowns and Casts	50

Preventive and diagnostic services will continue to be paid at 100 percent of the insurer's allowable charge, with the exception of sealants which will now be paid at the 80 percent level. Basic restorative services will also remain at the current level (80 percent of the allowable).

''By-report'' professional services (i.e., those services for which a dentist must explain on the claim the unusual circumstances about the case that make them necessary) will be paid at the following payment levels:

By report professional services	Payment levels (percent)
• Miscellaneous Emergency	100
• Professional Consultation	80
• Professional Visits	80
• Drugs	50
• Post-Surgical	80

The beneficiary or sponsor will be responsible for the difference between the insurer's allowable charge and the established payment level for each category of benefit. This cost-share amount will represent the beneficiary's or sponsor's total liability when dealing with participating providers. If the dentist is non-participating, the beneficiary will have to pay any difference between the insurer's allowed amount and the amount charged by the non-participating dentist.

The new benefit program will also be limited by an annual maximum amount of not less than $1000 per beneficiary for non-orthodontic dental care and not less than a $1200 lifetime limit per beneficiary for orthodontics.

Enrollment

The Basic Active Duty Dependents Dental Plan was terminated upon implementation of the interim Expanded Dependents Dental Plan. The effective date of this change was April 1, 1993. Enrollment in this interim plan was automatic for all active duty families in the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam and the U.S. Virgin Islands, whose military sponsors were known to have at least 24 months remaining in service, and for those dependents enrolled in the Basic Active Duty Dependents Dental Plan regardless of their sponsors' remaining time in service. Enrollment criteria for sponsors outside the continental United States remained unchanged.

Those who intended to remain in the service for 24 or more months and whose families were not automatically enrolled in the new plan, could have enrolled them at their military personnel office by completing DD Form 2494, Uniformed Services Active Duty Dependent Dental Plan (DDP) Enrollment Election Form. DD Form 2494–1, Supplemental Uniformed Services Active Duty Dependent Dental Plan (DDP) Enrollment Election Form, would have been used if dependents had resided in two or more physically separate locations and only the family members in one location were to be enrolled.

Service members who wanted to remove their families from the new interim Expanded Active duty Dependents Dental Benefit Plan were allowed to do so during the one-month period before the date on which the expanded plan went into effect, and for 4 months after the beginning date. They received a full refund of all premiums deducted, so long as the program had not been used following the implementation date. Use of the new plan during the disenrollment period constituted acceptance of the plan by the military sponsor and his or her family. Once the new plan was used, the family could not be disenrolled, and the premiums could not be refunded.

Premium Payments

Monthly premiums for the interim Expanded Active Duty Dependents Dental Benefit Plan were $9.65 for a single member, and $19.30 for two or more family members. Payroll deductions for the new premiums began a month prior to the starting date of the interim plan. These premium rates were

selected to maximize benefits while at the same time maintaining an approximate 60 percent government/40 percent sponsor cost-share specified in congressional reports and meet appropriated budget levels. There were no reductions in premiums for enlisted members in pay grades E–4 and below.

Monthly premiums were increased effective August 1, 1994. The increases were assessed beginning with the September 1994 payroll deduction for active-duty military sponsors. The new premiums are $10 for one enrolled active-duty family member, and $20 for active-duty sponsors with two or more enrolled family members.

Legislative Changes

The Defense Authorization Act (Pub. L. 103–337, October 5, 1994) established: authority for the Secretary of Defense to expand dental benefits outside the United States and to provide continued dental coverage for eligible dependents of service members who die on or after October 1, 1993, while on active duty for up to one year from the date of the member's death; and CHAMPUS eligibility for children placed in the custody of a service member by a court or recognized adoption agency on or after October 5, 1994, in anticipation of a legal adoption. These provisions have been codified in 10 U.S.C. Chapter 55, sections 1072(6) and 1076a—Dependent's Dental Program—and are reflected in the regulatory provisions of this rule.

Review of Comments

As a result of the publication of the proposed rule, the following comments were received from interested associations and agencies.

Comment 1. One commentor felt that all references to ''orthodontia'' should be changed to ''orthodontics'' since it was a more contemporary term and preferred by the specialty.

All references to ''orthodontia'' have been changed to ''orthodontics'' in the final rule.

Comment 2. The same commentor provided a definition which was felt to more accurately describe the scope of orthodontic practice. The commentor felt that the definition contained in the proposed rule failed to adequately address the dentofacial orthopedic aspects of orthodontic practice.

The definition of ''orthodontics'' has been changed to: ''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 the 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.''

Comment 3. Several commentors expressed concern over specific reference to American Dental Association (ADA) codes in the Regulation since they would become outdated and require continual revision. They pointed out that the ADA's Code on Dental Procedures and Nomenclature was currently under revision and that it would likely result in deletion of several existing codes and the addition of new codes. It was recommended that a general reference be made to the use of codes contained in the current edition of the ADA's Code on Dental Procedures and Nomenclature, without reference to specific codes.

Specific ADA codes have been deleted from the final rule and replaced with a general reference to the use of the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology (CDT) manual.

Comment 4. One commentor felt that ADA code 08999—Unspecified orthodontic procedures—should be included under ''Orthodontics'' [paragraph (e)(2)(vi)] if specific codes continued to be referenced in the final rule.

This is no longer an issue since specific ADA codes have been deleted from the final rule.

Comment 5. One commentor felt that the statement ''subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS'' should be deleted from the final rule since it could be used by the insurance carrier to reduce the actual benefits which would be contrary to the intent of the 1993 law.

All benefit programs must have exclusions and limitations, the intent of which are to define what is and what is not covered and the conditions under which the procedures are benefits. These limitations and exclusions are taken into consideration when determining the cost (premiums). The policies, limitations and exclusions are approved by OCHAMPUS and agreed to by contract.

Comment 6. Another commentor wanted to know how providers will be able to tell who is covered under the old plan (Basic Dependents Dental Plan) and distinguish them from those who are covered under the new plan (Expanded Dependents Dental Plan).

The Basic Active Duty Dependents Dental Benefit Plan was terminated upon implementation of the interim Expanded Active Duty Dependents Dental Benefit Plan on April 1, 1993. Enrollment in this interim plan was automatic for all active duty families in the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam and the U.S. Virgin Islands, whose military sponsors were known to have at least 24 months remaining in service, and for those dependents that were already enrolled in the Basic Active Duty Dependents Dental Benefits Plan regardless of their sponsors' remaining time in service. Implementation of the interim Expanded Active Duty Dependents Dental Benefit Plan has been addressed in the Supplementary Information section of this rule.

Comment 7. One commentor recommended that the definition of sealants be changed to remove the word ''resinous''.

The word ''resinous'' has been removed from the definition of sealants.

Comment 8. The same commentor felt that the definition of sealants should be further revised by substituting ''on tooth surface'' for ''on the occlusal surfaces.''

The suggestion was not adopted since the existing definition/specification only allows sealants on the unrestored occlusal surface. This applies even when the facial and/or lingual surfaces require a restoration. This was instituted because the previous definition resulted in denial of sealants when any surface of the tooth was carious or restored.

Comment 9. Another commentor recommended that coverage of resin restorations be extended to one to four or more surfaces.

CHAMPUS coverage of resin restorations is extended to one to four or more surfaces under the Expanded Active Duty Dependents Dental Benefit Plan. Specific ADA codes and nomenclature have been deleted from the final rule and replaced with general categories of coverage along with a reference to the use of American Dental Association's Code on Dental Procedures and Nomenclature as listed in the current Dental Terminology manual.

Comment 10. One commentor felt that an appropriate inlay code should be reported along with the onlay code under restorative services since onlays cannot be done without an inlay.

The current procedure code nomenclature and fees define the inlay in addition to the onlay. However, this is to only pay benefits for onlays if the tooth qualified on the basis of breakdown. Simple inlays (not covering cusps) are converted to a comparable

amalgam restoration. Inlays, per se, are not benefits.

Comment 11. One commentor pointed out that 03350 and 04265 were no longer valid ADA codes and should be removed.

Specific ADA codes have been deleted from the final rule and replaced with general categories of coverage along with a reference to the use of the American Dental Association's Code on Dental Procedure and Nomenclature as listed in the current Dental Terminology manual.

Comment 12. Another commentor felt that ''periodontal root planing'' should be expanded to read ''periodontal scaling and root planing.''

Although it is agreed that ''periodontal root planing'' should be expanded to read ''periodontal scaling and root planing,'' specific ADA codes and nomenclature have been deleted from the final rule and replaced with general coverage categories, along with a reference to the use of the American Dental Association's Code on Dental Procedure and Nomenclature as listed in the current Dental Terminology manual.

Comment 13. One commentor felt that ''Periodontal prophylaxis'' should be changed to read ''Periodontal maintenance procedures.''

The terminology of ''periodontal prophylaxis'' clarifies that it is considered a prophylaxis and counts toward the limitations.

Comment 14. One commentor felt that an appropriate inlay code should accompany the onlay code under prosthodontic services.

The current procedure code nomenclature and fees define the inlay in addition to the onlay. However, this is to only pay benefits for onlays if the tooth qualified on the basis of breakdown. Simple inlays (not covering cusps) are converted to a comparable amalgam restoration. Inlays are not benefits.

Comment 15. Another commentor expressed concern over the fact that active duty members could no longer disenroll because of permanent changes in duty station if dental care was available to the members' dependents under a program other than the Dependents Dental Plan. The commentor felt that the proposed regulation did not reflect the statutory right established by 10 U.S.C. Section 1076a(f) to disenroll from the program and subsequently reenroll.

The option to disenroll as a result of a change in active duty station has been reinstated with removal of the mileage restriction.

Summary of Regulatory Modifications

The following revisions were made as a result of legislative mandates, contract modifications, and suggestions received during the public comment period: established authority for expansion of dental benefits outside the United States; provided coverage for eligible dependents of services members who died on active duty for up to one year from date of member's death; established CHAMPUS eligibility for pre-adoptive wards of service members; raised the cost-share from 50 to 60 percent of the insurer's determined allowed charges for endodontics, periodontics and oral surgery; raised the lifetime orthodontic limits from $1000 to $1200; provided payment levels for ''by-report'' professional services; provided new monthly premiums which went into effect on October 1, 1994; reinstated the option to disenroll as a result of a change in active duty station; established a new definition for orthodontics; and removed specific ADA codes/nomenclature and replaced them with general coverage categories and a reference to the use of the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the current Dental Terminology manual.

Regulatory Procedures

Executive Order 12866 requires that a regulatory impact analysis be performed on any significant regulatory action, defined as one which would result in an annual effect on the national economy of $100 million or more, or which would 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 final rule is not a significant regulatory action under Executive Order 12866. The changes set forth in this final rule are minor revisions to existing regulation. In addition, this rule will have very minor impact and will not significantly affect a substantial number of small entities. In light of the above, no regulatory impact analysis is required.

This final rule does not impose information collection requirements. Therefore, 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. 3501–3520).

List of Subjects in 32 CFR Part 199

Claims, Handicapped, Health insurance, and 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 amended as follows:

a. By removing paragraph (c)(5)(vi).

b. By redesignating paragraphs (c)(2)(ii)(G) as (c)(2)(ii)(H) and (c)(5)(vii) as (c)(5)(vi).

c. By adding paragraph (a)(3)(i)(C), (c)(2)(ii)(G) and (c)(8).

d. Paragraph (b) by adding definitions ''endodontics,'' ''oral surgery,'' ''orthodontics,'' ''periodontics,'' ''Prosthodontics,'' and ''sealants'' and placing them in alphabetical order.

e. Paragraph (b) by revising the definitions for ''beneficiary liability'' and ''participating provider.''

f. By revising paragraphs (c)(1), (c)(3) and (c)(4); (c)(5)(iv) and (c)(5)(v); (e)(1)(i); (e)(2) and (e)(3); (f)(1)(ii); (f)(1)(vi) and (f)(1)(vii); (f)(6)(i) and (f)(6)(ii); (g)(2) and (g)(3) introductory text.

§ 199.13 Active duty dependents dental plan.

* * * * *

(a) * * *

(3) * * *

(i) * * *

(C) *Care outside the United States.* 10 U.S.C. 1076a authorizes the Secretary of Defense to establish basic dental benefit plans for eligible dependents of members of the uniform services accompanying the member on permanent assignments of duty outside the United States.

* * * * *

(b) * * *

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 Active Duty Dependents Dental Benefit Plan, beneficiary liability includes cost-sharing amounts and 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. Beneficiary liability also includes any expenses for services and supplies not covered by the Active

Duty Dependents Dental Benefit Plan, less any discount provided as a part of the insurer's agreement with an approved alternative delivery system.

* * * * *

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.

* * * * *

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

* * * * *

Orthodontics. The supervision, guidance, and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction or 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.

* * * * *

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 sponsor) of any cost-share for services.

* * * * *

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

* * * * *

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.

* * * * *

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

* * * * *

(c) * * *

(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 Active Duty Dependents Dental Benefit Plan. 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 other sections of this part in order for dental benefits to be extended.

* * * * *

(2) * * *

(ii) * * *

(G) A child placed in the custody of a service member by a court or recognized adoption agency on or after October 5, 1994, in anticipation of a legal adoption.

* * * * *

(3) *Enrollment.*

(i) *Basic active duty dependents dental benefit plan.* The dependent dental plan is effective from August 1, 1987, up to the date of implementation of the Expanded Active Duty Dependents Dental Benefit Plan.

(A) *Initial enrollment.* Eligible dependents of members on active duty status as of August 1, 1987 are automatically enrolled in the Active Duty Dependents Dental Plan, except where any of the following conditions apply:

(*1*) Remaining period of active duty at the time of contemplated enrollment is expected by the active duty member or the Uniformed Service to be less than two years, except that such members' dependents may be enrolled during the initial enrollment period for benefits beginning August 1, 1987 provided that the member had at least six months remaining in the initial enlistment term. Enrollment of dependents is for a period of 24 months, subject to the exceptions provided in paragraph (c)(5) of this section.

(*2*) Active duty member had completed an election to disenroll his or her dependents from the Basic Active Duty Dependents Dental Benefit Plan.

(*3*) Active duty member had only one dependent who is under four years of age as of August 1, 1987, and the member did not complete an election form to enroll the child.

(B) *Subsequent enrollment.* Eligible active duty members may elect to enroll their dependents for a period of not less than 24 months, provided there is an intent to remain on active duty for a period of not less than two years by the member and the Uniformed Service.

(C) *Inclusive family enrollment.* All eligible dependents of the active duty member must be enrolled if any were enrolled, except that a member may elect to enroll only those dependents who are remotely located from the member (e.g., a child living with a divorced spouse or a child in college).

(ii) *Expanded active duty dependents dental benefit plan.* The expanded dependents dental plan is effective on August 1, 1993. The Basic Active Duty Dependents Dental Benefit Plan terminated upon implementation of the expanded plan.

(A) *Initial enrollment.* Enrollment in the Expanded Active Duty Dependents Dental Benefit Plan is automatic for all eligible dependents of active duty members known to have at least 24 months remaining in service, and for those dependents enrolled in the Basic Dependents Dental Benefit Plan regardless of the military member's remaining time in service unless the active duty member elects to disenroll his or her dependents during the one-time disenrollment option period (one-month period before the date on which the expanded plan went into effect, and for 4 months after the beginning date). Those active duty members who intend to remain in the service for 24 months or more, whose dependents were not automatically enrolled, may enroll them at their military personnel office by completing the appropriate Uniformed Services Active Duty Dependents Dental Plan Enrollment Election Form. Use of the new plan during the one-time disenrollment option period by a dependent enrolled in the Basic Active Duty Dependents Dental Benefit Plan, constitutes acceptance of the plan by the military sponsor and his or her family. Once the new plan is used, the family cannot be disenrolled, and the premiums will not be refunded.

(B) *Subsequent enrollment.* Eligible active duty members may elect to enroll their dependents for a period of not less than 24 months, provided there is an intent to remain on active duty for a period of not less than two years by the member and the Uniformed Service.

(C) *Inclusive family enrollment.* All eligible dependents of the active duty member must be enrolled if any are enrolled, except as defined in paragraphs (c)(3)(ii)(C) (*1*) and (*2*) of this section.

(*1*) Enrollment will be by either single or family premium as defined herein:

(*i*) *Single premium.*

(*A*) Sponsors with only one family member age four (4) or older who elect to enroll that family member; or

(*B*) Sponsors who have more than one family member under age four (4) may elect to enroll one (1) family member under age four (4); or

(*C*) Sponsors who elect to enroll one (1) family member age four or older but may have any number of family members under age four (4) who are not

elected to be covered. At such time when the sponsor elects to enroll more than one (1) eligible family member, regardless of age, the sponsor must then enroll under a family premium which covers all eligible family members.

(*ii*) *Family premium.*

(*A*) Sponsors with two (2) or more eligible family members age four (4) or older must enroll under the family premium.

(*B*) Sponsors with one (1) eligible family member age four (4) or older and one (1) or more eligible family members under the age of four may elect to enroll under a family premium.

(*C*) Under the family premium, all eligible family members of the sponsor are enrolled.

(*2*) *Exceptions.*

(*i*) A sponsor may elect to enroll only those eligible family members residing in one location when the sponsor has other eligible family members residing in two or more physically separate locations (e.g., children living with a divorced spouse; children attending college).

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

(D) *Enrollment period.* Enrollment of dependents is for a period of 24 months except when:

(*1*) The dependent's enrollment is based on his or her enrollment in the Basic Active Duty Dependents Dental Benefit; or

(*2*) One of the conditions for disenrollment in paragraph (c)(5) of this section is met.

(4) *Beginning dates of eligibility.*

(i) *Basic active duty dependents dental benefit plan.*

(A) *Initial enrollment.* The beginning date of eligibility for benefits is August 1, 1987.

(B) *Subsequent enrollment.* The beginning date of eligibility for benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and received by the active duty member's Service representative, except that the date of eligibility shall not be earlier than September 1, 1987.

(ii) *Expanded active duty dependents dental benefit plan.*

(A) *Initial enrollment.* The beginning date of eligibility for benefits is April 1, 1993.

(B) *Subsequent enrollment.* The beginning date of eligibility for benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and received by the active duty member's Service representative, except that the date of eligibility shall not be earlier than the first of the month following the month of implementation of the expanded benefit.

* * * * *

(5) * * *

(iv) *Disenrollment because of no eligible dependents.* When an active duty member ceases to have any eligible dependents, the member must disenroll.

(v) *Option to disenroll as a result of a change in active duty station.* When an active duty member transfers with enrolled family members to a duty station where space-available dental care is readily available at the local military clinic, the member may elect within 90 days of the transfer to disenroll from the plan. If the member is later transferred to a duty station where dental care is not available in the local military clinic, the member may re-enroll his or her dependents in the plan.

* * * * *

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

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(i) *Scope of benefits.* The Active Duty Dependents Dental Benefit Plan provides coverage for diagnostic and preventive services, sealants, restorative services, endodontics, periodontics, prosthodontics, orthodontics and oral surgery to eligible, enrolled dependents of active duty members as set forth in paragraph (c) of this section.

* * * * *

(2) *Benefits.*

(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 or dental hygienists as authorized under paragraph (f) of this section. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules approved by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(A) *Diagnostic services.*

(*1*) Clinical Oral examinations.

(*2*) Radiographs.

(*3*) Tests and laboratory examinations.

(B) *Preventive services.*

(*1*) Dental prophylaxis.

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

(*3*) Sealants.

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

(ii) *Adjunctive general services (services ''by report'').* The following categories of services are authorized when performed directly by dentists or dental hygienists 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. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of service:

(A) Emergency oral examinations.

(B) Palliative emergency treatment of dental pain.

(C) Professional consultation.

(D) Professional visits.

(E) Drugs.

(F) Post-surgical complications.

(iii) *Restorative.* Benefits may be extended for basic 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 services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(A) *Restorative services.*

(*1*) Amalgam restorations.

(*2*) Silicate restorations.

(*3*) Resin restorations.

(*4*) Prefabricated crowns.

(*5*) Pin retention.

(B) *Other restorative services.*

(*1*) Diagnostic casts.

(*2*) Onlay restoration—metallic.
(*3*) Crowns.
(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 services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:
(A) Pulp capping—indirect.
(B) Pulpotomy.
(C) Root canal therapy.
(D) Periapical services.
(E) Hemisection.
(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 services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:
(A) Surgical services.
(B) Periodontal scaling and root planing.
(C) Unscheduled dressing change.
(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 removable complete and partial dentures, fixed crowns and bridges when performed directly by dentists as authorized under paragraph (f) of this section. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:
(A) *Prosthodontics (removable).*
(*1*) Complete/partial dentures.
(*2*) Adjustments to removable prosthesis.
(*3*) Repairs to complete/partial dentures.
(*4*) Denture rebase procedures.
(*5*) Denture reline procedures.
(*6*) Interim complete/partial dentures.
(*7*) Tissue conditioning.
(B) *Prosthodontics (fixed).*
(*1*) Bridge pontics.
(*2*) Retainers (by report).
(*3*) Bridge retainers-crowns.
(*4*) Other fixed prosthetic 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. Coverage of in-process orthodontics is limited to services rendered on or after the date of enrollment in the expanded dependents dental play. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:
(A) Minor treatment for tooth guidance.
(B) Minor treatment to control harmful habits.
(C) Interceptive orthodontic treatment.
(D) Comprehensive orthodontic treatment—transitional dentition.
(E) Comprehensive orthodontic treatment—permanent dentition.
(F) Treatment of the atypical or extended skeletal case.
(G) Post-treatment stabilization.
(viii) *Oral 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 services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:
(A) Extractions.
(B) Surgical extractions.
(C) Other surgical procedures.
(D) Alveoloplasty—surgical preparation of ridge for denture.
(E) Surgical incision and drainage of abscess—intraoral soft tissue.
(F) Repair of traumatic wounds.
(G) Complicated suturing.
(H) Excision of pericoronal gingiva.
(ix) *Exclusion of adjunctive dental care.* Under limited circumstances, benefits are available for dental services and supplies under CHAMPUS when the dental care is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition; or is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic). These benefits are excluded under the Active Duty Dependents Dental Plan. For further information on adjunctive dental care benefits under CHAMPUS, see § 199.4(e)(10).
(x) *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, dependents enrolled in the Active Duty Dependents Dental Plan may not obtain those services which are benefits of the Plan in military dental care facilities. Enrolled dependents may continue to obtain noncovered services from military dental care facilities subject to the provisions for space available care.
(xi) *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 this dental plan.
(3) *Beneficiary and sponsor liability.*
(i) *Diagnostic and preventive services.* Enrolled dependents of active duty members or their sponsors are responsible for the payment of only those amounts which are for services rendered by nonparticipating providers of care which exceed the equivalent of the statewide or regional prevailing fee levels as established by the insurer, except in the case of sealants where the dependents or their sponsors will also be responsible for payment of 20 percent of the insurer's determined allowable amount. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, the dental plan will reimburse the dependent, or sponsor, or

the nonparticipating provider selected by the dependent within 35 miles of the dependent's place of residence at the level of the provider's usual fees less 20 percent of the insurer's allowable amount for sealants.

(ii) *Restorative services.* Enrolled dependents of active duty members or their sponsors are responsible for payment of 20 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 20 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care, except in the case of crowns and casts where the dependents or their sponsors will be responsible for payment of 50 percent of the insurer's determined allowable amount. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 20 percent (50 percent in the case of crowns and casts) of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

(iii) *Endodontic, periodontic, and oral surgery services.* Enrolled dependents of active duty members or their sponsors are responsible for payment of 40 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 40 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 40 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

(iv) *Prosthodontic and orthodontic services.* Enrolled dependents of active duty members or their sponsors are responsible for payment of 50 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 50 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 50 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

(v) *Adjunctive general services (services ''by report'').* The beneficiary or sponsor liability is dependent on the particular service provided. Emergency oral examinations and palliative emergency treatment of dental pain are paid in full except for those amounts for services rendered by nonparticipating providers of care which exceed the equivalent of the statewide or regional prevailing fee levels as established by the insurer which are the responsibility of the enrolled dependents or their sponsors. Enrolled dependents or their sponsors are responsible for payment of 20 percent of the amounts determined by the insurer for professional consultations/visits and postsurgical services and 50 percent for covered medications when provided by participating providers of care, or these percentage payments plus any remaining amounts in excess of the prevailing charge limits established by the insurer for services rendered by nonparticipating providers, subject to the exceptions for dependent lack of access to participating providers as provided in paragraphs (e)(3)(i) through (e)(3)(iv) of this section. The contracting dental insurer 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.

(vi) *Amounts over the dental insurer's established allowance for charges.* It is the responsibility of the dental plan insurer to determine allowable charges for the procedures identified as benefits of this plan. All benefits of the plan are based on the insurer's determination of the allowable charges, subject to the exceptions for lack of access to participating providers as provided in paragraphs (e)(3)(i) through (e)(3)(iv) of this section.

(vii) *Maximum coverage amounts.* Enrolled dependents of active duty members 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 Secretary of Defense or designee.

(f) * * *

(1) * * *

(ii) *Conflict of interest.* See § 199.9(d).

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(vi) *Participating provider.* An authorized provider may elect to participate and accept the fee or charge determinations as established and made known to the provider by the dental plan insurer. The fee or charge determinations are binding upon the provider in accordance with the dental plan insurer'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 insurer's determination of the allowable charge. Payment is made directly to the participating provider, and the participating provider may only charge the beneficiary the percent cost-share of the insurer's allowable charge for those benefit categories as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section, in addition to the charges for any services not authorized as benefits.

(vii) *Nonparticipating provider.* An authorized provider may elect for all beneficiaries not to participate and request the beneficiary or sponsor to pay any amount of the provider's billed charge in excess of the dental plan insurer's determination of allowable charges. Neither the government nor the dental plan insurer shall have any responsibility for any amounts over the allowable charges as determined by the dental plan insurer, except where the dental plan insurer is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within 35 miles of the dependent's place of residence shall be paid his or her usual fees, less the percent cost-share as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section.

(A) *Assignment.* A nonparticipating provider may accept assignment of claims for beneficiaries certifying their willingness to make such assignment by filing the claims completed with the assistance of the beneficiary or sponsor for direct payment by the dental plan insurer to the provider.

(B) *Nonassignment.* A nonparticipating provider for all beneficiaries may request the beneficiary or sponsor to file the claim directly with the dental plan insurer, making arrangements with the beneficiary or sponsor for direct payment by the beneficiary or sponsor.

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(6) * * *

(i) Nonparticipating providers (or the dependents or sponsors for 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; less any cost-share amount due for authorized services, except where the dental plan insurer is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within 35 miles of the dependent's place of residence shall be paid his or her usual fees, less the cost-share for the 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.

(g) * * *

(2) *Benefit payments made to a participating provider.* When the authorized provider has elected to participate in accordance with the arrangement and procedures established by the dental plan insurer, payment is made based on the lower of the actual charge or the insurer's determination of the allowable charge. Payment is made directly to the participating provider as payment in full, less the percent cost-share of the insurer's allowable charge as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section.

(3) *Benefit payments made to a nonparticipating provider.* When the authorized provider has elected not to participate in accordance with the arrangement and procedures established by the dental plan, payment is made by the insurer based on the lower of the actual charge or the insurer's determination of the allowable charge. The beneficiary is responsible for payment of a percent cost-share of the insurer's allowable charge as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of a percent cost-share of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section.

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Dated: October 26, 1995.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 95–27116 Filed 10–31–95; 8:45 am]

BILLING CODE 5000–04–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Parts 100 and 165

[CGD 95–082]

Safety Zones, Security Zones, and Special Local Regulations

AGENCY: Coast Guard, DOT.

ACTION: Notice of temporary rules issued.

SUMMARY: This document provides required notice of substantive rules adopted by the Coast Guard and temporarily effective between July 1, 1995 and September 30, 1995, which were not published in the Federal Register. This quarterly notice lists temporary local regulations, security zones, and safety zones, which were of limited duration and for which timely publication in the Federal Register was not possible.

DATES: This notice lists temporary Coast Guard regulations that became effective and were terminated between July 1, 1995 and September 30, 1995, as well as several regulations which were not included in the previous quarterly list.

ADDRESSES: The complete text of these temporary regulations may be examined at, and is available on request from, Executive Secretary, Marine Safety Council (G–LRA), U.S. Coast Guard Headquarters, 2100 Second Street, SW., Washington, DC 20593–0001.

FOR FURTHER INFORMATION CONTACT: Commander Stephen J. Darmody, Executive Secretary, Marine Safety Council at (202) 267–1477 between the hours of 8 a.m. and 3 p.m., Monday though Friday.

SUPPLEMENTARY INFORMATION: District Commanders and Captains of the Port (COTP) must be immediately responsive to the safety needs of the waters within their jurisdiction; therefore District Commanders and COTPs have been delegated the authority to issue certain local regulations. Safety zones may be established for safety or environmental purposes. A safety zone may be stationary and described by fixed limits or it may be described as a zone around a vessel in motion. Security zones limit access to vessels, ports, or waterfront facilities to prevent injury or damage. Special local regulations are issued to assure the safety of participants and spectators at regattas and other marine events. Timely publication of these regulations in the Federal Register is often precluded when a regulation responds to an emergency, or when an event occurs without sufficient advance notice. However, the affected public is informed of these regulations through Local Notices to Mariners, press releases, and other means. Moreover, actual notification is provided by Coast Guard patrol vessels enforcing the restrictions imposed by the regulation.

Because mariners are notified by Coast Guard officials on-scene prior to enforcement action, Federal Register notice is not required to place the special local regulation, security zone, or safety zone in effect. However, the Coast Guard, by law, must publish in the Federal Register notice of substantive rules adopted. To discharge this legal obligation without imposing undue expense on the public, the Coast Guard periodically publishes a list of these temporary special local regulations, security zones, and safety zones. Permanent regulations are not included in this list because they are published in their entirety in the Federal Register. Temporary regulations may also be published in their entirety if sufficient time is available to do so before they are placed in effect or terminated. These safety zones, special local regulations and security zones have been exempted from review under E.O. 12866 because of their emergency nature, or limited scope and temporary effectiveness.

The following regulations were placed in effect temporarily during the period July 1, 1995 and September 30, 1995, unless otherwise indicated.

Dated: October 26, 1995.

Stephen J. Darmody,

Commander, U.S. Coast Guard, Executive Secretary, Marine Safety Council, Acting.