state and local interests. In adherence to fundamental federalism principles, NCUA, an independent regulatory agency as defined in 44 U.S.C. 3502(5), voluntarily complies with the executive order. The executive order states that: ''National action limiting the policymaking discretion of the states shall be taken only where there is constitutional and statutory authority for the action and the national activity is appropriate in light of the presence of a problem of national significance.'' The risk of loss to federally insured credit unions and the NCUSIF caused by the establishment of foreign branches is a concern of national scope. The final rule helps assure that proper safeguards are in place to ensure the safety and soundness of federally insured credit unions that establish branches in foreign countries.

The final rule applies to all federally insured credit unions. NCUA believes that the protection of those credit unions, and ultimately the NCUSIF, warrants application of the final rule to all federally insured credit unions. The final rule does not impose additional costs or burdens on the states or affect the states' ability to discharge traditional state government functions. NCUA has determined that this rule may have an occasional direct effect on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government. The potential risk to the NCUSIF without the rule justifies this action.

The Treasury and General Government Appropriations Act, 1999—-Assessment of Federal Regulations and Policies on Families

The NCUA has determined that this final rule will not affect family well-being within the meaning of section 654 of the Treasury and General Government Appropriations Act, 1999, Pub. L. 105–277, 112 Stat. 2681 (1998).

Small Business Regulatory Enforcement Fairness Act

The Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121) provides generally for congressional review of agency rules. A reporting requirement is triggered in instances where NCUA issues a final rule as defined by Section 551 of the Administrative Procedures Act. 5 U.S.C. 551. The Office of Management and Budget has determined that this is not a major rule.

List of Subjects in 12 CFR Part 741

Bank deposit insurance, Credit unions.

By the National Credit Union Administration Board on April 24, 2003.

Becky Baker,

Secretary of the Board.

■ For the reasons set forth in the pre-amble, the National Credit Union Administration amends 12 CFR part 741 as follows:

PART 741—REQUIREMENTS FOR INSURANCE

■ 1. The authority citation for part 741 continues to read as follows:

Authority: 12 U.S.C. 1757, 1766(a), and 1781–1790; Pub. L. 101–73.

■ 2. Add §741.11 to subpart A to read as follows:

§ 741.11 Foreign branching.

(a) *Application and Prior NCUA Approval Required.* Any credit union insured under Title II of the Act must apply for and receive approval from the regional director before establishing a credit union branch outside the United States unless the foreign branch is located on a United States military instillation or embassy outside the United States. The regional director will have 60 days to approve or deny the request.

(b) *Contents of Application.* The application must include a business plan, written approval by the state supervisory agency if the applicant is a state-chartered credit union, and documentation evidencing written permission from the host country to establish the branch that explicitly recognizes NCUA's authority to examine and take any enforcement action, including conservatorship and liquidation actions.

(c) *Contents of Business Plan.* The written business plan must address the following:

(1) Analysis of market conditions in the area where the branch is to be established;

(2) The credit union's plan for addressing foreign currency risk;

(3) Operating facilities, including office space/equipment and supplies;

(4) Safeguarding of assets, bond coverage, insurance coverage, and records preservation;

(5) Written policies regarding the branch (shares, lending, capital, charge-offs, collections);

(6) The field of membership or portion of the field of membership to be served through the foreign branch and the financial needs of the members to be served and services and products to be provided;

(7) Detailed *pro forma* financial statements for branch operations (balance sheet and income and expense projections) for the first and second year including assumptions;

(8) Internal controls including cash disbursal procedures for shares and loans at the branch;

(9) Accounting procedures used to identify branch activity and performance; and

(10) Foreign income taxation and employment law.

(d) *Revocation of Approval.* A state regulator that revokes approval of the branch office must notify NCUA of the action once it issues the notice of revocation. The regional director may revoke approval of the branch office for failure to follow the business plan in a material respect or for substantive and documented safety and soundness reasons. If the regional director revokes the approval, the credit union will have six months from the date of the revocation letter to terminate the operations of the branch. The credit union can appeal this revocation directly to the NCUA Board within 30 days of the date of the revocation letter.

(e) *Insurance Coverage.* Accounts at foreign branches are insured by the NCUSIF only if denominated in U.S. dollars and only if payable, by the terms of the account agreement, at a U.S. office of the credit union. If the host country requires insurance from its own system, accounts will not be insured by the National Credit Union Share Insurance Fund.

[FR Doc. 03–10612 Filed 4–29–03; 8:45 am]

BILLING CODE 7535–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

RIN 0720–AA66

TRICARE Program; Eligibility and Payment Procedures for Civilian Health and Medical Program of the Uniformed Services Beneficiaries Age 65 and Over

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: This final rule implements section 712 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001. Section 712 extends TRICARE eligibility to beneficiaries age 65 and over who would otherwise have lost their TRICARE eligibility due to attainment of entitlement to hospital

insurance benefits under Part A of Medicare.

DATES: This rule was effective October 1, 2001.

FOR FURTHER INFORMATION CONTACT: Stephen E. Isaacson, Medical Benefits and Reimbursement Systems, TMA, telephone (303) 676–3572.

SUPPLEMENTARY INFORMATION:

I. Summary of Final Rule Provisions

This fine rule implements section 712 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (Pub. L. 106–398, 114 Stat. 1654), and was effective October 1, 2001. It extends TRICARE eligibility to beneficiaries age 65 and over. This beneficiary group previously lost TRICARE eligibility due to attaining entitlement to hospital insurance benefits under Part A of Medicare. In order for these individuals to retain their TRICARE eligibility, they must be enrolled in the supplementary medical insurance program under Part B of Medicare. In general, in the case of medical or dental care provided to these individuals for which payment may be made under both Medicare and TRICARE, Medicare is the primary payer and TRICARE will normally pay the actual out-of-pocket costs incurred by the person. This rule prescribes TRICARE payment procedures and makes revisions to TRICARE rules to accommodate Medicare-eligible CHAMPUS beneficiaries.

The reader should refer to the interim final rule that was published on August 3, 2001, (66 FR 40601) for detailed information regarding eligibility requirements, the scope of the benefit, and other aspects of this significant expansion of the Military Health System.

We also want to clarify an erroneous statement in the preamble to the interim final rule. Since the error was in the preamble and not in the regulatory language, it does not actually affect this final rule, but we want to ensure the TRICARE policy is understood. In section C. of the supplementary information on page 40603, we stated in two places that if a TRICARE-required preauthorization is not obtained, TRICARE will make no payment. This is not correct. If a required preauthorization is not obtained, TRICARE will still pay for any covered services, but the TRICARE payment will be reduced by not less than 10 percent.

II. Public Comments

We issued this rule as an interim final rule, with comment period, as an exception to our standard practice of soliciting public comments prior to issuance. The Assistant Secretary of Defense (Health Affairs) determined that following the standard practice would have been impracticable, unnecessary, and contrary to public interest. This determination was based on the fact that this change directly implemented a statutory entitlement enacted by Congress expressly for this purpose, with a statutory effective date of October 1, 2001. Public comments were invited, though, and we received comments from one individual.

Comment—Individuals who are over age 65, are currently employees of the U.S. Government, are retired from the military, and meet all eligibility requirements for TFL, should be able to drop their coverage under the Federal Employees Health Benefits Program (FEHBP) and subsequently re-enroll in the FEHBP during any open season with no penalty.

Response—This is permitted.

Comment—TRICARE should pay any premium and deductible costs for employer-provided insurance for individuals eligible for TFL and who are employed. Alternatively, any such costs paid by individuals eligible for TFL should be applied to that individual's catastrophic cap.

Response—TRICARE has statutory authority only to pay for medically necessary services and supplies. We have no authority to pay for the type of costs identified in this comment. Therefore, this type of change goes beyond the regulatory process and would require a legislative change.

Comment—An individual who is eligible for TFL and is also enrolled in employer-provided health insurance should not have to file the paperwork, *i.e.*, submit claims. Providers should be required to submit all claims.

Response—We cannot, through the regulatory process, require providers to submit claims to employer-provided health insurance plans that are primary to TRICARE. Nevertheless, we recognize that having to submit claims can present a significant burden to our beneficiaries, but there are several things that mitigate this burden. Under current procedures for both TRICARE and Medicare, providers are required to submit the claim in the vast majority of cases. More importantly, we have gone to great efforts to establish a process under TFL so that after the Medicare contractors process a claim, they send the claims directly to the appropriate TRICARE contractor with no beneficiary action required. As a result, there are almost no instances where beneficiaries have had to submit their claim to TRICARE.

III. Changes in the Final Rule

The only change we have made to the language in the interim final rule is to clarify certain provisions in § 199.17 regarding TRICARE Standard. In the interim final rule there were a number of areas where enrollment in TRICARE Standard was explicitly stated or implied. TRICARE Standard is the default coverage under TRICARE, and there is no enrollment action required of beneficiaries to be covered under Standard. We have, therefore, reworded various places in § 199.17 to ensure that this is clear. These changes have no substantive effect on the policies or procedures contained in either the interim final rule or this final rule.

IV. Regulatory Procedures

This final rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511).

Executive Order 12866 requires certain regulatory assessments for any significant regulatory action, defined as one which 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 final rule is an economically significant regulatory action under Executive Order 12866, as it implements a statutory program that has added about $1.7 billion for DoD in annual healthcare benefit and administrative costs based on cost data collected for October 1, 2001, through September 30, 2002. These costs exclude pharmacy benefits that are addressed in the rulemaking for the TRICARE Senior Pharmacy Program. The benefits of this final rule include an increased level of health care for Medicare-eligible beneficiaries of the Department of Defense military health system. It has been determined to be major under the Congressional Review Act. However, this rule does not require a regulatory flexibility analysis, as it is not economically significant and will not significantly affect a substantial number of small entities. This rule has been designated as significant and has been reviewed by the Office of Management and Budget as required under the provisions of E.O. 12866.

List of Subjects in 32 CFR Part 199

Claims, Handicapped, Health insurance, Military personnel.

■ Accordingly, 32 CFR part 199 is amended to read as follows:

PART 199—[AMENDED]

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

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

■ 2. Section 199.2(b) is amended by adding at the appropriate place in alphabetical order the following definition:

§ 199.2 Definitions.

* * * * *

(b) * * *

Director, TRICARE Management Activity. This term includes the Director, TRICARE Management Activity, the official sometimes referred to in this part as the Director, Office of CHAMPUS (or OCHAMPUS), or any designee of the Director, TRICARE Management Activity or the Assistant Secretary of Defense for Health Affairs who is designated for purposes of an action under this part.

■ 3. Section 199.3 is amended by revising paragraphs (b)(2)(i)(D), (f)(3)(vi), and (f)(3)(vii) and the note following paragraph (f)(3)(vii) to read as follows:

§ 199.3 Eligibility.

* * * * *

(b) * * *

(2) * * *

(i) * * *

(D) Must not be eligible for Part A of Title XVIII of the Social Security Act (Medicare) except as provided in paragraphs (f)(3)(vii), (f)(3)(viii), and (f)(3)(ix) of this section; and

* * * * *

(f) * * *

(3) * * *

(vi) Attainment of entitlement to hospital insurance benefits (Part A) under Medicare except as provided in paragraphs (f)(3)(vii), (f)(3)(viii), and (f)(3)(ix) of this section. (This also applies to individuals living outside the United States where Medicare benefits are not paid.)

(vii) Attainment of age 65, except for dependents of active duty members, beneficiaries not entitled to part A of Medicare, and beneficiaries entitled to Part A of Medicare who have enrolled in Part B of Medicare. For those who do not retain CHAMPUS, CHAMPUS eligibility is lost at 12:01 a.m. on the first day of the month in which the beneficiary becomes entitled to Medicare.

Note: If the person is not eligible for Part A of Medicare, he or she must file a Social Security Administration ''Notice of Disallowance'' certifying to that fact with the Uniformed Service responsible for the issuance of his or her identification card so a new card showing CHAMPUS eligibility can be issued. Individuals entitled only to supplementary medical insurance (Part B) of Medicare, but no Part A, or Part A through the Premium HI provisions (provided for under the 1972 Amendments to the Social Security Act) retain eligibility under CHAMPUS (refer to § 199.8 for additional information when a double coverage situation is involved).

* * * * *

■ 4. Section 199.8 is amended by redesignating paragraph (c)(5) as (c)(6) and the second paragraph (c)(4) as (c)(5) and by revising paragraph (d)(1) to read as follows:

§ 199.8 Double Coverage.

* * * * *

(d) *Special consideration.*—(1) *CHAMPUS and Medicare.*—(i) *General rule.* In any case in which a beneficiary eligible for both Medicare and CHAMPUS receives medical or dental care for which payment may be made under Medicare and CHAMPUS, Medicare is always the primary payer. For dependents of active duty members, payment will be determined in accordance to paragraph(c) of this section. For all other beneficiaries eligible for Medicare, the amount payable by CHAMPUS shall be the amount of the actual out-of-pocket costs incurred by the beneficiary for that care over the sum of the amount paid for that care under Medicare and the total of all amounts paid or payable by third party payers other than Medicare.

(ii) *Payment limit.* The total CHAMPUS amount payable for care under paragraph (d)(1)(i) of this section may not exceed the total amount that would be paid under CHAMPUS if payment for that care were made solely under CHAMPUS.

(iii) *Application of general rule.* In applying the general rule under paragraph (d)(1)(i) of this section, the first determination will be whether payment may be made under Medicare. For this purpose, Medicare exclusions, conditions, and limitations will be the basis for the determination.

(A) For items or services or portions or segments of items or services for which payment may be made under Medicare, the CHAMPUS payment will be the amount of the beneficiary's actual out of pocket liability, minus the amount payable by Medicare, also minus amount payable by other third party payers, subject to the limit under paragraph (d)(1)(ii) of this section.

(B) For items or services or segments of items or services for which no payment may be made under Medicare, the CHAMPUS payment will be the same as it would be for a CHAMPUS eligible retiree, dependent, or survivor beneficiary who is not Medicare eligible.

(iv) *Examples of applications of general rule.* The following examples are illustrative. They are not all-inclusive.

(A) In the case of a Medicare-eligible beneficiary receiving typical physician office visit services, Medicare payment generally will be made. CHAMPUS payment will be determined consistent with paragraph (d)(1)(iii)(A) of this section.

(B) In the case of a Medicare-eligible beneficiary residing and receiving medical care overseas, Medicare payment generally may be made. CHAMPUS payment will be determined consistent with paragraph (d)(1)(iii)(B) of this section.

(C) In the case of a Medicare-eligible beneficiary receiving skilled nursing facility services a portion of which is payable by Medicare (such as during the first 100 days) and a portion of which is not payable by Medicare (such as after 100 days), CHAMPUS payment for the first portion will be determined consistent with paragraph (d)(1)(iii)(A) of this section and for the second portion consistent with paragraph (d)(1)(iii)(B) of this section.

(v) *Application of catastrophic cap.* Only in cases in which CHAMPUS payment is determined consistent with paragraph (d)(1)(iii)(B) of this section, actual beneficiary out of pocket liability remaining after CHAMPUS payments will be counted for purposes of the annual catastrophic loss protection, set forth under § 199.4(f)(10). When a family has met the cap, CHAMPUS will pay allowable amounts for remaining covered services through the end of that fiscal year.

(vi) *Effect of enrollment in Medicare+Choice plan.* In the case of a beneficiary enrolled in a Medicare+Choice plan who receives items or services for which payment may be made under both the Medicare+Choice plan and CHAMPUS, a claim for the beneficiary's normal out-of-pocket costs under the Medicare+Choice plan may be submitted for CHAMPUS payment. However, consistent with paragraph (c)(4) of this section, out-of-pocket costs do not include costs associated with unauthorized out-of-system care or care otherwise obtained under circumstances that result in a denial or limitation of coverage for care that would have been

covered or fully covered had the beneficiary met applicable requirements and procedures. In such cases, the CHAMPUS amount payable is limited to the amount that would have been paid if the beneficiary had received care covered by the Medicare+Choice plan.

(vii) *Effect of other double coverage plans, including medigap plans.* CHAMPUS is second payer to other third-party payers of health insurance, including Medicare supplemental plans.

(viii) *Effect of employer-provided insurance.* In the case of individuals with health insurance due to their current employment status, the employer insurance plan shall be first payer, Medicare shall be the second payer, and CHAMPUS shall be the tertiary payer.

* * * * *

■ 5. Section 199.10 is amended by revising paragraph (a)(1)(ii) to read as follows:

§ 199.10 Appeal and hearing procedures.

(a) * * *

(1) * * *

(ii) *Effect of initial determination.* (A) The initial determination is final unless appealed in accordance with this chapter, or unless the initial determination is reopened by the TRICARE Management Activity, the CHAMPUS contractor, or the CHAMPUS peer review organization.

(B) An initial determination involving a CHAMPUS beneficiary entitled to Medicare Part A, who is enrolled in Medicare Part B, may be appealed by the beneficiary or their provider under this section of this Part only when the claimed services or supplies are payable by CHAMPUS and are not payable under Medicare. Both Medicare and CHAMPUS offer an appeal process when a claim for healthcare services or supplies is denied and most healthcare services and supplies are a benefit payable under both Medicare and CHAMPUS. In order to avoid confusion on the part of beneficiaries and providers and to expedite the appeal process, services and supplies denied payment by Medicare will not be considered for coverage by CHAMPUS if the Medicare denial of payment is appealable under Medicare. Because such claims are not considered for payment by CHAMPUS, there can be no CHAMPUS appeal. If, however, a Medicare claim or appeal results in some payment by Medicare, the services and supplies paid by Medicare will be considered for payment by CHAMPUS. In that situation, any decision to deny CHAMPUS appealable issues involving Medicare-eligible CHAMPUS beneficiaries are illustrative; they are not all-inclusive:

(*1*) If Medicare processes a claim for a healthcare service or supply that is a Medicare benefit and the claim is denied by Medicare for a patient-specific reason, the claim is appealable through the Medicare appeal process. The Medicare decision will be final if the claim is denied by Medicare. The claimed services or supplied will not be considered for CHAMPUS payment and there is not CHAMPUS appeal of the CHAMPUS decision denying the claim.

(*2*) If Medicare processes a claim for a healthcare service or supply that is a Medicare benefit and the claim is paid, either on initial submission or as a result of a Medicare appeal decision, the claim will be submitted to CHAMPUS for processing as a second payer to Medicare. If CHAMPUS denies payment of the claim, the Medicare-eligible beneficiary or their provider have the same appeal rights as other CHAMPUS beneficiaries and their providers under this section.

(*3*) If Medicare processes a claim and the claim is denied by Medicare because it is not a healthcare service or supply that is a benefit under Medicare, the claim is submitted to CHAMPUS. CHAMPUS will process the claim under this Part 199 as primary payer (or as secondary payer if another double coverage plan exists). If any part of the claim is denied, the Medicare-eligible beneficiary and their provider will have the same appeal rights as other CHAMPUS beneficiaries and their providers under this section.

* * * * *

■ 6. Section 199.15 is amended by revising paragraph (a)(6) to read as follows:

§ 199.15 Quality and Utilization Review Peer Review Organization Program.

(a) * * *

(6) *Medicare rules used as model.* The CHAMPUS Quality and Utilization Review Peer Review Organization program, based on specific statutory authority, follows many of the quality and utilization review requirements and procedures in effect for the Medicare Peer Review Organization program, subject to adaptations appropriate for the CHAMPUS program. In recognition of the similarity of purpose and design between the Medicare and CHAMPUS PRO programs, and to avoid unnecessary duplication of effort, the CHAMPUS Quality and Utilization Review Peer Review Organization program will have special procedures applicable to supplies and services furnished to Medicare-eligible CHAMPUS beneficiaries. These procedures will enable CHAMPUS normally to rely upon Medicare determinations of medical necessity and appropriateness in the processing of CHAMPUS claims as a second payer to Medicare. As a general rule, only in cases involving Medicare-eligible CHAMPUS beneficiaries where Medicare payment for services and supplies is denied for reasons other than medical necessity and appropriateness will the CHAMPUS claim be subject to review for quality of care and appropriate utilization under the CHAMPUS PRO program. TRICARE will continue to perform a medical necessity and appropriateness review for quality of care and appropriate utilization under the CHAMPUS PRO program where required by statute, such as inpatient mental health services in excess of 30 days in any year.

* * * * *

■ 7. Section 199.17 is amended by revising paragraphs (a) introductory text, (a)(6) introductory text, (a)(6)(i), (a)(6)(ii), (b) introductory text, (b)(1), (c) introductory text, (c)(3), (c)(4), and (v) to read as follows:

§ 199.17 TRICARE program.

(a) *Establishment.* The TRICARE program is established for the purpose of implementing a comprehensive managed health care program for the delivery and financing of health care services in the Military Health System.

* * * * *

(6) *Major features of the TRICARE program.* The major features of the TRICARE program, described in this section, include the following:

(i) Comprehensive enrollment system. Under the TRICARE program, all health care beneficiaries become classified into one of four categories:

(A) Active duty members, all of whom are automatically enrolled in TRICARE Prime;

(B) TRICARE Prime enrollees;

(C) TRICARE Standard participants, who are all CHAMPUS eligible beneficiaries who are not enrolled in TRICARE Prime;

(D) Non-CHAMPUS beneficiaries, who are beneficiaries eligible for health care services in military treatment facilities, but not eligible for CHAMPUS;

(ii) Establishment of a triple option benefit. A second major feature of TRICARE is the establishment of three options for receiving health care:

(A) ''TRICARE Prime,'' which is a health maintenance organization (HMO)-like program. It generally features use of military treatment facilities and substantially reduced out-

of-pocket costs for CHAMPUS care. Beneficiaries generally agree to use military treatment facilities and designated civilian provider networks and to follow certain managed care rules and procedures.

(B) ''TRICARE Extra,'' which is a preferred provider organization (PPO) program. It allows TRICARE Standard beneficiaries to use the TRICARE provider network, including both military facilities and the civilian network, with reduced out-of-pocket costs. These beneficiaries also continue to be eligible for military medical treatment facility care on a space-available basis.

(C) ''TRICARE Standard'' which is the basic CHAMPUS program. All eligible beneficiaries are automatically included in Standard unless they have enrolled in Prime. It preserves broad freedom of choice of civilian providers, but does not offer reduced out-of-pocket costs. These beneficiaries continue to be eligible to receive care in military medical treatment facilities on a space-available basis.

* * * * *

(b) *Triple option benefit in general.* Where the TRICARE program is fully implemented, eligible beneficiaries are given the option of enrolling in TRICARE Prime (also referred to as ''Prime'') or remaining in TRICARE Standard (also referred to as ''Standard''). In the absence of an enrollment in Prime, coverage under Standard is automatic.

(1) *Choice voluntary.* With the exception of active duty members, the choice of whether to enroll in Prime is voluntary for all eligible beneficiaries. For dependents who are minors, the choice will be exercised by a parent or guardian.

* * * * *

(c) *Eligibility for enrollment.* Where the TRICARE program is fully implemented, all CHAMPUS-eligible beneficiaries who are not Medicare eligible on basis of age are eligible to enroll in Prime or to remain covered under Standard. CHAMPUS beneficiaries who are eligible for Medicare on basis of age (and are enrolled in Medicare Part B) are automatically covered under TRICARE Standard. Further, some rules and procedures are different for dependents of active duty members and retirees, dependents, and survivors. In addition, where the TRICARE program is implemented, a military medical treatment facility commander or other authorized individual may establish priorities, consistent with paragraph (c) of this section, based on availability or other operational requirements, for when and whether to offer enrollment in Prime.

* * * * *

(3) *Retired members, dependents of retired members, and survivors.* (i) Where TRICARE is fully implemented, all CHAMPUS-eligible retired members, dependents of retired members, and survivors who are not eligible for Medicare on the basis of age are eligible to enroll in Prime. After all active duty members are enrolled and availability of enrollment is assured for all active duty dependents wishing to enroll, this category of beneficiaries will have third priority for enrollment.

(ii) If all eligible retired members, dependents of retired members, and survivors within the area concerned cannot be accepted for enrollment in Prime at the same time, the MTF Commander (or other authorized individual) may allow enrollment within this beneficiary group category on a first come, first served basis.

(4) *Coverage under Standard.* All CHAMPUS-eligible beneficiaries who do not enroll in Prime will remain in Standard.

* * * * *

(v) *Administrative procedures.* The Assistant Secretary of Defense (Health Affairs), the Director, TRICARE Management Activity, and MTF Commanders (or other authorized officials) are authorized to establish administrative requirements and procedures, consistent with this section, this part, and other applicable DoD Directives or Instructions, for the implementation and operation of the TRICARE program.

Dated: April 17, 2003.

L.M. Bynum,

Alternate OSD Federal Register, Liaison Officer, Department of Defense.

[FR Doc. 03–10092 Filed 4–29–03; 8:45 am]

BILLING CODE 5001–08–M

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[CGD05–03–037]

RIN 1625–AA09

Drawbridge Operation Regulations; Elizabeth River Southern Branch, AICWW, Virginia

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, Fifth Coast Guard District, has approved a temporary deviation from the regulations governing the operation of the Dominion (Steel) Bridge across the Elizabeth River (Southern Branch) Atlantic Intracoastal Waterway (AICWW) mile 8.8, at Chesapeake, Virginia to allow the bridge owner to conduct needed mechanical work. The work will be performed at night. The closure periods to navigation are from 8 p.m. to 7 a.m., on Fridays and Saturdays, and from 8 p.m. to 5 a.m., on Sundays to Mondays.

DATES: This deviation is effective from 8 p.m. on May 2, 2003, to 5 a.m. on June 9, 2003.

FOR FURTHER INFORMATION CONTACT: Bill Brazier, Bridge Management Specialist, Fifth Coast Guard District, at (757) 398–6422.

SUPPLEMENTARY INFORMATION: The City of Chesapeake has requested a temporary deviation from the current operating regulation set out in 33 CFR 117.997(f) which requires the drawbridge to open on signal, except that, from 7 a.m. to 9 a.m. and from 4 p.m. to 6 p.m., Monday through Friday except Federal holidays, the draw need not open for the passage of recreational vessels. The City of Chesapeake has requested the temporary deviation to allow necessary repairs to the drawbridge in a critical time sensitive manner.

The work involves the replacement of bent sections of the nose and tail locks on the moveable span of the bridge. To facilitate the replacement, the bascule span will be locked in the closed position to vessels at night for up to 11 hours on each Friday and Saturday from 8 p.m. to 7 a.m., and up to nine hours each Sunday to Monday, from 8 p.m. to 5 a.m., from May 2–5, May 9–12, May 16–19, May 30—June 2, and June 6–9, 2003. During this period, the work requires completely immobilizing the operation of the bascule span in the closed position to vessels. At all other times, the bridge will operate in accordance with the current operating regulations outlined in 33 CFR 117.997(f). Calling the project superintendent at (757) 672–4829 will provide for emergency opening requests.

The Coast Guard has informed the known users of the waterway of the closure periods for the bridge so that these vessels can arrange their transits to minimize any impact caused by the temporary deviation.

The District Commander has granted temporary deviation from the operating requirements listed in 33 CFR 117.35 for the purpose of repair completion of the