§ 157.208 Construction, acquisition, operation, replacement, and miscellaneous rearrangement of facilities.

* * * * *

(d) * * *

TABLE I

Year	Limit	
	Auto. proj. cost limit (Col.1)	Prior notice proj. cost limit (Col.2)
1982	$4,200,000	$12,000,000
1983	4,500,000	12,800,000
1984	4,700,000	13,300,000
1985	4,900,000	13,800,000
1986	5,100,000	14,300,000
1987	5,200,000	14,700,000
1988	5,400,000	15,100,000
1989	5,600,000	15,600,000
1990	5,800,000	16,000,000
1991	6,000,000	16,700,000
1992	6,200,000	17,300,000
1993	6,400,000	17,700,000
1994	6,600,000	18,100,000
1995	6,700,000	18,400,000
1996	6,900,000	18,800,000
1997	7,000,000	19,200,000
1998	7,100,000	19,600,000
1999	7,200,000	19,800,000
2000	7,300,000	20,200,000
2001	7,400,000	20,600,000
2002	7,500,000	21,000,000
2003	7,600,000	21,200,000
2004	7,800,000	21,600,000
2005	8,000,000	22,000,000
2006	9,600,000	27,400,000
2007	9,900,000	28,200,000
2008	10,200,000	29,000,000
2009	10,400,000	29,600,000
2010	10,500,000	29,900,000
2011	10,600,000	30,200,000

* * * * *

■ 3. Table II in § 157.215(a)(5) is revised to read as follows:

§ 157.215 Underground storage testing and development.

(a) * * *

(5) * * *

TABLE II

Year	Limit
1982	$2,700,000
1983	2,900,000
1984	3,000,000
1985	3,100,000
1986	3,200,000
1987	3,300,000
1988	3,400,000
1989	3,500,000
1990	3,600,000
1991	3,800,000
1992	3,900,000
1993	4,000,000
1994	4,100,000
1995	4,200,000
1996	4,300,000
1997	4,400,000
1998	4,500,000
1999	4,550,000
2000	4,650,000
2001	4,750,000
2002	4,850,000
2003	4,900,000
2004	5,000,000
2005	5,100,000
2006	5,250,000
2007	5,400,000
2008	5,550,000
2009	5,600,000
2010	5,700,000
2011	5,750,000

* * * * *

[FR Doc. 2011–3190 Filed 2–11–11; 8:45 am]

BILLING CODE P

DEPARTMENT OF HOMELAND SECURITY

U. S. Customs and Border Protection

19 CFR Part 141

[USCBP–2008–0062; CBP Dec. 10–34]

RIN 1515–AD61 (Formerly 1505–AB96)

Technical Correction: Completion of Entry and Entry Summary—Declaration of Value; Correction

AGENCY: Customs and Border Protection, Department of Homeland Security.

ACTION: Final rule; correction.

SUMMARY: Customs and Border Protection (CBP) published in the **Federal Register** of December 30, 2010, a document concerning technical corrections to part 141 of title 19 of the CBP Regulations (19 CFR part 141). Inadvertently, an erroneous CBP Decision Number was listed in the heading of that document. This document corrects the December 30, 2010 document to reflect that the correct CBP Decision Number is 10–34 as set forth above.

DATES: The final rule is effective February 14, 2011.

FOR FURTHER INFORMATION CONTACT: Michele J. Snavely, Regulations and Rulings, Office of International Trade, (202) 325–0354.

Correction

In rule document 2010–32912 beginning on page 82241 in the issue of Thursday, December 30, 2010, make the following correction in the third column:

Remove in the heading of the document "CBP Dec. 10–33" and add in its place "CBP Dec. 10–34".

Dated: February 9, 2011.

Harold M. Singer,

Director, Regulations and Disclosure Law Division, U.S. Customs and Border Protection.

[FR Doc. 2011–3265 Filed 2–11–11; 8:45 am]

BILLING CODE 9111–14–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DOD–2008–HA–0057]

RIN 0720–AB24

TRICARE Program; Surgery for Morbid Obesity

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: This final rule adds a definition of Bariatric Surgery, amends the definition of Morbid Obesity, and revises the language relating to the treatment of morbid obesity to allow benefit consideration for newer bariatric surgical procedures that are considered appropriate medical care. The final rule removes language that specifically limits the types of surgical procedures to treat co-morbid conditions associated with morbid obesity and retains the TRICARE Program exclusion of non-surgical interventions related to morbid obesity, obesity and/or weight reduction. This final rule is necessary to allow coverage for other surgical procedures that reduce or resolve co-morbid conditions associated with morbid obesity and the use of the Body Mass Index (BMI), which is the more accurate measure for excess weight to estimate relative risk of disease. As new technologies or procedures evolve from investigational into generally accepted norms for medical practice, the statutes and regulations governing the TRICARE Program allow the Department to offer beneficiaries these new benefits. These changes are required in order to allow the Department to provide these newer technologies and procedures for the treatment of morbid obesity as they evolve.

DATES: *Effective Date:* This rule is effective March 16, 2011.

ADDRESSES: TRICARE Management Activity, Medical Benefits and Reimbursement Branch, 16401 East Centretech Parkway, Aurora, CO 80011–9066.

FOR FURTHER INFORMATION CONTACT: Gail L. Jones, Medical Benefits and Reimbursement Branch, TRICARE Management Activity, telephone (303) 676–3401.

SUPPLEMENTARY INFORMATION:

I. Background

On December 27, 1982, the Department of Defense (DoD) published a final rule in the **Federal Register** (47 FR 57491–57493) that restricted surgical intervention for morbid obesity to gastric bypass, gastric stapling, or gastroplasty method (excluding all other types) when the primary purpose of surgery is to treat a severe related medical illness or medical condition. The severe medical conditions or illness associated with morbid obesity included diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian Syndrome (and other severe respiratory disease), hypothalamic disorders, and severe arthritis of the weight-bearing joints. The DoD also limited program payments to two categories of patients: (1) Those who weighed 100 pounds over their ideal weight with a specific severe medical condition; and (2) those who were 200 percent or more over their ideal weight with no medical complications required. Program payment was made available as well in cases in which a patient, who originally met the criteria, received an intestinal bypass, or other surgery for obesity and, because of complications, required a second surgery. Payment was allowed even though the patient's condition may not have technically met the definition of morbid obesity because of the weight that was already lost following the initial surgery. All other surgeries including non-surgical treatment related to morbid obesity, obesity, and/or weight reduction were excluded.

The DoD used the definition of morbid obesity, which was based on the Metropolitan Life Table and used then by other major health care plans, as well as reflected the 1982 general opinion regarding which cases justify surgical intervention. The DoD decided, at the time, that it was necessary to be very specific in benefit parameters due to fiscal responsibility and to ensure that Program beneficiaries were not being exposed to less than fully developed medical technology or procedures.

At the time the current regulation was written in 1982, gastric bypass, gastric stapling, and gastroplasty methods were the recognized surgeries for morbid obesity. However, in recent years, other bariatric surgical procedures have evolved and some have a substantial body of literature to support their safety and efficacy. Unlike the original rule that listed the specific surgical procedures and the clinical conditions for which coverage may be extended; this final rule authorizes benefit consideration for those bariatric surgical procedures that have moved from the unproven status to the position of nationally accepted medical practice, as determined by the Program standard of reliable evidence.

Also in 1982 during development of the current regulation for morbid obesity, overweight and obesity were typically measured with height-weight tables (such as the Metropolitan Life Table). The 1982 regulation restricted eligibility for bariatric surgery to individuals who exceed their ideal weight for height by 100 pounds with an associated severe medical condition, or 200 percent or more over their ideal body weight with no associated medical condition required.

This final rule changes the Program definition of morbid obesity to reflect the current nationally accepted medical use of the BMI, rather than the typical assessed height-weight table (*i.e.,* the Metropolitan Life Table), to determine an individual's eligibility for bariatric surgical treatment. The BMI is the more accurate measure for excess weight to estimate relative risk of disease. Since there now are more than 30 major diseases associated with obesity, the final rule requires the Director, TMA, to issue specific criteria for co-morbid conditions exacerbated or caused by (morbid) obesity, as determined by the Program standard of reliable evidence.

This final rule does not expand the TRICARE benefit for morbid obesity surgery. However, it does make the specific procedures that are covered, as well as the clinical conditions for which coverage may be extended, a matter of policy. In other words, new bariatric surgery procedures may be added to the TRICARE benefit structure as such procedures are proven safe and effective and are established as nationally accepted medical practice as determined by the Program standard of reliable evidence.

II. Public Comments

On October 29, 2009 (74 FR 55792–55794), the Office of the Secretary of Defense published a proposed rule and provided the public the opportunity to comment on implementing changes to surgery for morbid obesity. The comment period closed on December 28, 2009. As result of publication of the proposed rule, DoD received 18 comments. Thirteen commenters expressed support and approval. We appreciate all expressions of support and approval for the proposed guidelines. We do not discuss the majority these comments which were favorable to the proposed rule and thus with which the Agency generally agrees. However, several people made comments with specific suggestions and questions and we have responded to each of these comments below.

Comment: One commenter objected to the provisions of the proposed rule in the belief the coverage is inappropriate for the selected group of patients.

Response: We disagree. As discussed in the proposed rule, TRICARE allows coverage for surgical procedures that may reduce or resolve co-morbid conditions associated with morbid obesity. This is because a component of the effective treatment of the co-morbidity condition for those who fit the morbid obesity criteria set forth in this rule is weight loss. Thus while the Department does not pay for general weight loss programs, it may pay for these bariatric surgical procedures as a component of the treatment of the co-morbidity condition. Title 10, United States Code Section 1079(a)(13) is sometimes referred to as the Department's "medical necessity" provision. It prohibits the Department from providing any service or supply, which is not medically, or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury, or bodily malfunction as assessed or diagnosed by a physician or other authorized provider. Because the Department has found this type of treatment for the co-morbidity condition to be medically necessary, the type of health care services in the proposed rule are the type of health care services authorized by statute and may be provided by the TRICARE program.

Comment: Another commenter asked if there is anything being done to help employees cope with their obesity, and whether there are any preventative programs in place to educate people and help them to avoid obesity.

Response: There is a focus on health and wellness for active duty members, DoD civilians, retired members, contractors, reservists, and beneficiaries to help encourage healthy lifestyles. Each of the armed services has developed programs to promote fitness and health. The Army has the *MOVE* Program, which is a personalized online weight management program that comprises up to 13 one-hour sessions. The Navy *Shipshape* Program is designed to move military personnel and their families toward healthier food choices, fitness habits and lifestyles. The Air Force *Fit to Fight* Program encourages unit fitness programs, encourages units to exercise together, and offers nutrition and fitness counseling to those with borderline fitness test scores. These wellness programs are designed to provide individuals with tools to improve their

overall health and lifestyles and address everything from smoking to obesity.

Comment: One professional organization affirmed the purpose and scope of the rule acknowledging the need to use body mass index (BMI) criteria instead of the Metropolitan Life Tables accurately to classify the degree of morbid obesity. The commenter recommends that DoD provide coverage for other standard accepted bariatric surgical procedures as recognized by the American College of Surgeons (ACS), Bariatric Surgery Center Network (BSCN) and American Society for Metabolic and Bariatric Surgery (ASMBS). Another professional commenter points out that gastric sleeve resection has been established and recognized by the ASMBS as having an important role, as an intermediate intervention regarding both risk and efficacy of weight loss between bypass and adjustable gastric banding.

Response: Before the Department may offer any treatment or procedure to its beneficiaries, the regulations in this part require that the treatment or procedure must be "proven care". This is done as outlined in § 199.4(g)(15) of this part using the hierarchy of established reliable evidence as defined in § 199.2 of this part. A procedure must meet this standard in order for the Department to ensure safe, quality health care for its beneficiaries and to avoid arbitrary administration of TRICARE benefit decisions.

Comment: Another commenter agrees with the changes as well but recommends that the list of obesity-associated co-morbidities be a complete, inclusive list to prevent inappropriate denial of service. The commenter goes on to state that covered procedures should include the laparoscopic vertical sleeve gastrectomy and duodenal switch procedures.

Response: We appreciate the suggestion that morbid obesity multiple co-morbidities be a complete, inclusive list and will consider it as one of many recommendations in revising the benefit policy. We disagree with the commenter's suggestion that vertical sleeve gastrectomy (VSG) and biliopancreatic diversion with duodenal switch (BPD/DS) should be covered under the TRICARE Program. The evidence evaluating the safety and efficacy of BPD/DS and VSG do not meet the program specific standards of reliable evidence. Existing data does suggest the use of these procedures is a possible benefit to some patients but there is incomplete information to predict the effect of long-term outcomes. This lack of information relating to the long-term outcomes is a matter of concern to the Department. Medical literature indicates as well that well-controlled trials are needed to determine both short-term and long-term safety and efficacy of BPD/DS and long-term (> 5 years) weight loss and co-morbidity resolution data for VSG. The Agency will continue to monitor the development of the literature and the status of ongoing well-controlled clinical trials regarding the effectiveness of the laparoscopic VSG and BPD/DS procedures. At such time when the reliable evidence demonstrates that these bariatric surgical procedures have proven medical effectiveness, the Director, TMA will initiate action to cover these procedures.

Comment: This same commenter asks that DoD consider improving reimbursement for bariatric surgical procedure to a level that increases access for patients. The commenter goes on to state that current reimbursement levels are so low that many surgeons will not accept these patients because TRICARE rates are tied to Medicare fee schedule, and rates have declined over 10% in the last two years despite increasing practice overhead expenses.

Response: In section 707 the National Defense Authorization Act of Fiscal Year 2002, Congress amended the statutory authorization (in 10 U.S.C. 1079(j)(2)) to a mandate that TRICARE payment methods shall be determined in accordance with Medicare payment rules to the extent practicable. In the same way under 10 U.S.C. 1079(h), the amount to be paid to health care professional and other non-institutional health care providers "shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules used by Medicare"

Comment: One commenter asked if the proposed guidelines apply to active duty service members as well.

Response: TRICARE covers most health care deemed medically necessary for active and retired military and their dependent family. However, bariatric surgery primarily represents a major and permanent change to the digestive system and requires a strict adherence to a dietary regimen, which interferes with operational deployment of active duty service members (ADSMs). Because of this, ADSMs are not permitted to have bariatric surgery. ADSMs have an obligation to maintain themselves in a state of high physical readiness and the Services have weight and fitness screening programs to assure compliance with Service standards, and each Service offers evidence-based, multidisciplinary weight and fitness programs for individuals who are unable to meet those standards.

Comment: Another commenter expresses his company's support for the proposal rule to add new bariatric surgical procedures to the TRICARE benefit structure when such procedures are proven safe, effective, and established as nationally accepted medical practice, as determined by the TRICARE definition of reliable evidence. The commenter also noted that the proposed rule did not clearly state that the definition of reliable evidence applies to the determination that a procedure is established as nationally accepted medical practice; and therefore, recommend paragraph (e)(15) of this section be modify.

Response: We appreciate the commenter's support and concerns regarding the application of TRICARE definition of reliable evidence and have modified paragraph (e)(15) of this section to include a reference to § 199.2 of this part for the procedures used in determining if a medical treatment or procedure is unproven.

Comment: This same commenter recommends coverage for laparoscopic adjustable gastric band (LAGB) and medically necessary adjustment of LAGB systems. The commenter also recommends that DoD revise the proposed rule to add coverage for post-surgical follow-up and band adjustments. The commenter also recommends that DoD not specify any minimum duration of weight loss management as a precondition for the bariatric surgery and that type 2 diabetes mellitus be specified as a high-risk co-morbidity exacerbated or caused by morbid obesity.

Response: The laparoscopic adjustable gastric banding surgical procedure (including post-surgical follow-up and band adjustments) became a TRICARE benefit effective February 1, 2007. TRICARE also provides coverage for follow-up care to include band adjustments and any unfortunate sequelae resulting from the adjustment for those patients who underwent the LAP-Band surgery before the effective date of coverage. Coverage, however, is contingent upon the patient meeting TRICARE morbid obesity policy criteria at the time of his or her surgery. We appreciate the suggestion that DoD not specify any minimum duration of weight loss management as a precondition for the bariatric surgery and that type 2 diabetes mellitus be specified as a high-risk co-morbidity and will consider these as one of many recommendations in future revisions regarding the benefit policy.

Comment: This same commenter noted that the proposed rule did not require physicians or facilities performing bariatric surgical procedures to fulfill any specific qualification requirements for coverage. The commenter states that it is the understanding that DoD intends to leave the issue of facility and surgeon qualification to the discretion of TMA or its Managed Care Support Contractors.

Response: All TRICARE authorized providers are subject to the requirements as outlined in 32 CFR 199.6. Otherwise covered services are cost shared only if the individual professional provider holds a current, valid license or certification to practice his or her profession in the jurisdiction where the service is rendered.

This final rule considered all comments received during the comment period and has responded to those comments in this final rule. Since the proposed rule was published, DoD has revised paragraph (e)(15) of this section.

Regulatory Procedures

Executive Order 12866, "*Regulatory Planning and Review*"

It has been determined that this rule is not a significant regulatory action. This rule does not:

(1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy; a section of the economy; productivity; competition; jobs; the environment; public health or safety; or State, local, or tribal governments or communities;

(2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another Agency;

(3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or

(4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.

Unfunded Mandates Reform Act (Sec. 202, Pub. L. 104–4)

It has been certified that this rule does not contain a Federal mandate that may result in the expenditure by State, local and tribal governments, in aggregate, or by the private sector, of $100 million or more in any one year.

Public Law 96–354, "*Regulatory Flexibility Act*" *(5 U.S.C. 601)*

It has been certified that this rule is not subject to the Regulatory Flexibility Act (5 U.S.C. 601) because it would not, if promulgated, have a significant economic impact on a substantial number of small entities. Set forth in the final rule are minor revisions to the existing regulation. The DoD does not anticipate a significant impact on the Program. The change from height-weight tables to the BMI should have a minimal impact on the number of beneficiaries eligible for surgery.

Public Law 96–511, "*Paperwork Reduction Act*" *(44 U.S.C. Chapter 35)*

It has been certified that this rule does not impose reporting or recordkeeping requirements under the Paperwork Reduction Act of 1995.

Executive Order 13132, Federalism

It has been certified that this rule does not have federalism implications, as set forth in Executive Order 13132. This rule does not have substantial direct effects on:

(1) The States;

(2) The relationship between the National Government and the States; or

(3) The distribution of power and responsibilities among the various levels of Government.

The final rule is consistent with the proposed rule.

List of Subjects in 32 CFR Part 199

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, 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 199.2, paragraph (b) is amended by adding the definition of "Bariatric Surgery" and revising the definition of "Morbid Obesity" to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

Bariatric Surgery. Surgical procedures performed to treat co-morbid conditions associated with morbid obesity. Bariatric surgery is based on two principles: (1) Divert food from the stomach to a lower part of the digestive tract where the normal mixing of digestive fluids and absorption of nutrients cannot occur (i.e., Malabsorptive surgical procedures); or (2) Restrict the size of the stomach and decrease intake (i.e., Restrictive surgical procedures).

* * * * *

Morbid obesity. A body mass index (BMI) equal to or greater than 40 kilograms per meter squared (kg/m^2), or a BMI equal to or greater than 35 kg/m^2 in conjunction with high-risk co-morbidities, which is based on the guidelines established by the National Heart, Lung and Blood Institute on the Identification and Management of Patients with Obesity.

Note: Body mass index is equal to weight in kilograms divided by height in meters squared.

* * * * *

■ 3. Section 199.4 is amended by revising paragraphs (e)(15) and (g)(28) to read as follows:

§ 199.4 Basic program benefits.

* * * * *

(e) * * *

(15) *Morbid obesity.* The TRICARE morbid obesity benefit is limited to those bariatric surgical procedures for which the safety and efficacy has been proven comparable or superior to conventional therapies and is consistent with the generally accepted norms for medical practice in the United States medical community. (See the definition of *reliable evidence* in § 199.2 of this part for the procedures used in determining if a medical treatment or procedure is unproven.)

(i) *Conditions for coverage.*

(A) Payment for bariatric surgical procedures is determined by the requirements specified in paragraph (g)(15) of this section, and as defined in § 199.2(b) of this part.

(B) Covered bariatric surgical procedures are payable only when the patient has completed growth (18 years of age or documentation of completion of bone growth) and has met one of the following selection criteria:

(*1*) The patient has a BMI that is equal to or exceeds 40 kg/m^2 and has previously been unsuccessful with medical treatment for obesity.

(*2*) The patient has a BMI of 35 to 39.9 kg/m^2, has at least one high-risk co-morbid condition associated with morbid obesity, and has previously been unsuccessful with medical treatment for obesity.

Note: The Director, TMA, shall issue guidelines for review of the specific high-risk co-morbid conditions, exacerbated or caused by obesity based on the Reliable Evidence Standard as defined in § 199.2 of this part.

(ii) *Treatment of complications.*

(A) Payment may be extended for repeat bariatric surgery when medically necessary to correct or treat complications from the initial covered bariatric surgery (a takedown). For instance, the surgeon in many cases will

do a gastric bypass or gastroplasty to help the patient avoid regaining the weight that was lost. In this situation, payment is authorized even though the patient's condition technically may not meet the definition of morbid obesity because of the weight that was already lost following the initial surgery.

(B) Payment is authorized for otherwise covered medical services and supplies directly related to complications of obesity when such services and supplies are an integral and necessary part of the course of treatment that was aggravated by the obesity.

(iii) *Exclusions.* CHAMPUS payment may not be extended for weight control services, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise and exercise programs, or other programs and equipment that are primarily intended to control weight or for the purpose of weight reduction, regardless of the existence of co-morbid conditions.

* * * * *

(g) * * *

(28) *Obesity, weight reduction.* Service and supplies related "solely" to obesity or weight reduction or weight control whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purpose, regardless of the circumstances under which performed (except as provided in paragraph (e)(15) of this section).

* * * * *

Dated: February 1, 2011.

Morgan F. Park,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2011–3207 Filed 2–11–11; 8:45 am]

BILLING CODE 5001–06–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R03–OAR–2010–0902; FRL–9265–6]

Approval and Promulgation of Air Quality Implementation Plans; Virginia; Revision to the Definition of Volatile Organic Compound

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: EPA is taking direct final action to approve a revision to the Virginia State Implementation Plan (SIP). The revision amends the definition of Volatile Organic Compound (VOC). EPA is approving these revisions to Virginia's definitions in accordance with the requirements of the Clean Air Act (CAA).

DATES: This rule is effective on April 15, 2011 without further notice, unless EPA receives adverse written comment by March 16, 2011. If EPA receives such comments, it will publish a timely withdrawal of the direct final rule in the **Federal Register** and inform the public that the rule will not take effect.

ADDRESSES: Submit your comments, identified by Docket ID Number EPA–R03–OAR–2010–0902 by one of the following methods:

A. *http://www.regulations.gov.* Follow the on-line instructions for submitting comments.

B. E-mail: *frankford.harold@epa.gov.*

C. Mail: EPA–R03–OAR–2010–0902, Harold A. Frankford, Air Protection Division, Mailcode 3AP00, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103.

D. Hand Delivery: At the previously-listed EPA Region III address. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–R03–OAR–2010–0902. EPA's policy is that all comments received will be included in the public docket without change, and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov,* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the electronic docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, i.e., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the State submittal are available at the Virginia Department of Environmental Quality, 629 East Main Street, Richmond, Virginia 23219.

FOR FURTHER INFORMATION CONTACT: Harold A. Frankford, (215) 814–2108, or by e-mail at *frankford.harold@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Throughout this document, whenever "we," "us," or "our" is used, we mean EPA. On September 27, 2010, the Commonwealth of Virginia submitted a formal revision to its State Implementation Plan (SIP). The SIP revision consists of the revised definition of "Volatile organic compound" (VOC) listed in 9VAC5 Chapter 10 (General Definitions), Regulation 5–10–20 (Terms defined).

II. Summary of SIP Revision

Virginia amended the definition of "Volatile organic compound" to add the organic compounds propylene carbonate and dimethyl carbonate to the list of excluded compounds. The exclusion of these compounds is consistent with the list of excluded compounds found in EPA's definition of "Volatile organic compounds (VOC)" at 40 CFR 51.100(s)(1).

III. General Information Pertaining to SIP Submittals From the Commonwealth of Virginia

In 1995, Virginia adopted legislation that provides, subject to certain conditions, for an environmental assessment (audit) "privilege" for voluntary compliance evaluations performed by a regulated entity. The legislation further addresses the relative burden of proof for parties either asserting the privilege or seeking disclosure of documents for which the