The second quarter 2023 interest assumptions will be 5.38 percent for the first 20 years following the valuation date and 5.09 percent thereafter. In comparison with the interest assumptions in effect for the first quarter of 2023, these interest assumptions represent no change in the select period (the period during which the select rate (the initial rate) applies), an increase of 0.52 percent in the select rate, and an increase of 0.39 percent in the ultimate rate (the final rate).

Need for Immediate Guidance

PBGC has determined that notice of, and public comment on, this rule are impracticable, unnecessary, and contrary to the public interest. PBGC routinely updates the interest assumptions in appendix B of the asset allocation regulation each quarter so that they are available to value benefits. Accordingly, PBGC finds that the public interest is best served by issuing this rule expeditiously, without an opportunity for notice and comment, and that good cause exists for making the assumptions set forth in this amendment effective less than 30 days after publication to allow the use of the proper assumptions to estimate the value of plan benefits for plans with valuation dates early in the second quarter of 2023.

PBGC has determined that this action is not a ''significant regulatory action'' under the criteria set forth in Executive Order 12866.

Because no general notice of proposed rulemaking is required for this amendment, the Regulatory Flexibility Act of 1980 does not apply. See 5 U.S.C. 601(2).

List of Subjects in 29 CFR Part 4044

Employee benefit plans, Pension insurance, Pensions.

In consideration of the foregoing, 29 CFR part 4044 is amended as follows:

PART 4044—ALLOCATION OF ASSETS IN SINGLE-EMPLOYER PLANS

■ 1. The authority citation for part 4044 continues to read as follows:

Authority: 29 U.S.C. 1301(a), 1302(b)(3), 1341, 1344, 1362.

■ 2. In appendix B to part 4044, an entry for ''April–June 2023'' is added at the end of the table to read as follows:

Appendix B to Part 4044—Interest Rates Used To Value Benefits

* * * * *

For valuation dates occurring in the month—	The values of i_t are:					
	i_t	for t =	i_t	for t =	i_t	for t =
* * *	*		*	*		*
April–June 2023	0.0538	1–20	0.0509	>20	N/A	N/A

Issued in Washington, DC.

Hilary Duke,

Assistant General Counsel for Regulatory Affairs, Pension Benefit Guaranty Corporation.

[FR Doc. 2023–05350 Filed 3–14–23; 8:45 am]

BILLING CODE 7709–02–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 9

RIN 2900–AQ53

Servicemembers' Group Life Insurance Traumatic Injury Protection Program

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This final rule adopts, with changes, a proposed rule amending the Department of Veterans Affairs (VA) Servicemembers' Group Life Insurance Traumatic Injury Protection (TSGLI) program regulations. This final rule allows nurse practitioners to sign a hospital or facility-approved pass for a member to leave a hospital or treating facility as part of the member's treatment plan. This final rule also responds to comments received during a reopened 60-day comment period on the response to a petition for rulemaking and withdraws a proposed revision to the TSGLI schedule of losses for traumatic injuries from burns.

DATES: This rule is effective April 14, 2023.

FOR FURTHER INFORMATION CONTACT: Paul Weaver, Department of Veterans Affairs Insurance Service (310/290B), 5000 Wissahickon Avenue, Philadelphia, PA 19144, (215) 842–2000, ext. 4263. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: On August 19, 2020, VA published a proposed rule in the **Federal Register**, 85 FR 50,973, to amend its regulations governing the TSGLI program, and addressed and denied a petition for rulemaking submitted to VA on March 16, 2015, requesting that VA amend the TSGLI regulations to cover traumatic injuries due to illness and disease caused by explosive ordnance. VA provided a 60-day comment period, which ended on October 19, 2020. We received comments from 10 individuals during this comment period. Overall, the comments supported our proposed rulemaking; however, several of the commenters made additional recommendations, which we address below.

On March 23, 2021, we published a supplemental notice of proposed rulemaking (SNPRM), 86 FR 15,448, that provided a new opportunity for the public to submit comments pertaining to our proposal to deny the petition for rulemaking requesting that VA amend the TSGLI regulations to cover traumatic injuries due to illness and disease caused by explosive ordnance. We received three comments during the SNPRM comment period and address these comments in this final rulemaking. In addition, we explain VA is withdrawing the proposed amendment to the TSGLI burn standard that was published in the **Federal Register** in August 2020.

1. Definition of Therapeutic Trip

We received one comment from the American Association of Nurse Practitioners, suggesting that VA amend the proposed definition of the term ''therapeutic trip'' in new 38 CFR 9.21(a)(11) to allow a nurse practitioner, as well as an attending physician, to sign a member's hospital or facility-approved pass to leave the hospital or facility as part of the member's treatment plan. The comment indicated that nurse practitioners have similar, full practice authority within VA medical facilities, and that these nurse practitioners will likely be the primary provider for members in settings such as hospitals and long-term care facilities. The comment also stated that the group believed that this change would serve to ensure that members are able to receive approved passes for therapeutic trips without unnecessary delay. We agree and, therefore, are revising the proposed

definition of the term therapeutic pass so that nurse practitioners will have authority to endorse a member's pass to leave a hospital or other facility as part of the member's treatment plan.

2. Eligibility Requirements Regarding Causation

One commenter stated that VA does not explain the standard we propose to determine whether an illness or disease caused a member's loss. They further stated the concept for using the standard is amorphous and highly subjective, and that medical opinions regarding the extent the illness or disease contributed to the member's loss could differ, making it very difficult to determine how much of a factor a pre-existing illness or disease could have been in contributing to the member's loss. TSGLI is modeled on commercial accidental death and dismemberment (AD&D) insurance coverage, and this coverage does not cover losses caused by illness or disease. 70 FR 75,940, 75,942 (Dec. 22, 2005). We explained in the TSGLI interim final rulemaking published in 2005 that 38 U.S.C. 1980A(e)(4) and (5) obligate VA ''to manage the TSGLI program 'on the basis of sound actuarial principles,' '' and that private AD&D coverage has proven to be actuarially sound over the long-term in the commercial insurance industry. *Id.* at 75,940. We also explained that limitations set forth in the TSGLI regulations follow insurance-industry standards and are based upon sound actuarial and financial principles that VA must utilize in administering TSGLI. *Id.* at 75,942. In addition, in our proposed rulemaking we stated that, in AD&D cases, courts have interpreted the phrase ''direct result of a traumatic injury and no other cause'' that 38 CFR 9.20(d)(2) uses, to mean that a loss is not covered if a preexisting condition or disease ''substantially contributed'' to the loss. 85 FR at 50,974. The proposed directive in 38 CFR 9.20(d)(2) that a scheduled loss would not result directly from a traumatic injury and no other cause if a preexisting disease, illness, or condition substantially contributed to the loss is based on the courts' interpretation. Because we are obligated to administer TSGLI on the basis of sound actuarial and financial principles that have been adopted by commercial insurers, and commercial AD&D insurers utilize the same ''substantially contributed'' standard to evaluate whether illness or disease caused the loss, we are not making any change to proposed 38 CFR 9.20(d).

3. TSGLI Payment Range

One commenter stated that the TSGLI payment schedule has not been addressed since 2005 and that the proposed rule should have adjusted the range of payment for TSGLI. When the TSGLI interim final rule was published in 2005, we explained that the TSGLI schedule follows the commercial AD&D model. We established the TSGLI payment range based on the AD&D policies that we reviewed. Since 2005, we have conducted a Year-One Review and a Year-Ten Review. *See* 73 FR 71,926 (Nov. 26, 2008); 85 FR at 50,973; *see also https://www.benefits.va.gov/INSURANCE/docs/TSGLI_YTR.pdf.* As a result of these reviews, we have published rulemakings that have amended certain sections of the TSGLI schedule to: (1) increase from one to two years the period of time for a loss from a traumatic injury to occur (72 FR 10,362, 10,363 (Mar. 8, 2007)); (2) provide TSGLI benefits for genitourinary losses (76 FR 75,458 (Dec. 2, 2011)); and (3) create a graduated, tiered standard for evaluating losses for reconstruction of limbs (85 FR at 50,981). Furthermore, after reviewing payment amounts during the Year-One and Year-Ten Reviews, we have found the current TSGLI benefit payouts to be larger than the payouts for many commercial AD&D policies. Further, Congress wanted VA to keep the TSGLI premium low to ease the financial stress for Servicemembers and their families and the current premium does not support additional payment amounts. *See* 151 Cong. Rec. S4095 (2005) (statement of Sen. Craig) (''To meet these needs, our amendment would create a traumatic insurance rider [that] would provide coverage for severely disabling conditions at a cost of approximately $1 a month . . . .''). Therefore, we will not make any change based on this comment.

4. TSGLI Appeals Process

One commenter stated that the proposed rule should have addressed the TSGLI appeals process because it was applied inconsistently for different members serving in various branches of the uniformed services. As part of the TSGLI Year-Ten Review, VA met with TSGLI adjudicators from the uniformed services and reviewed the TSGLI appeals process for each branch. Based on these meetings, VA developed the procedures that we proposed in revised 38 CFR 9.20(h). We explained with regard to the proposed amendments to paragraph (h) that the uniformed services and members must follow the established procedural process that each respective branch has developed for hearing TSGLI claims. 85 FR at 50,976. In addition, new 38 CFR 9.20(h)(4) states that a member is not precluded from pursuing legal remedies under 38 U.S.C. 1975 and 38 CFR 9.13 and can leave the TSGLI appeals process at any time and seek a different venue for their appeal. Because we have reviewed the TSGLI appeals process for the uniformed services and addressed it in the proposed rulemaking by making revisions to the process, we do not make any further changes based on this comment.

5. Two-Year Period To Suffer Loss From Traumatic Injury

Two commenters stated that the two-year eligibility period to suffer a loss from a traumatic injury should be expanded. The commenters indicated that certain losses, such as traumatic brain injury (TBI), often do not become disabling medical conditions until longer than two years following a traumatic injury. One of the commenters suggested increasing the two-year period for a member to suffer a loss from a traumatic injury to two years from the date of diagnosis of the traumatic injury or date surgery is performed, whichever is later. VA is obligated to administer TSGLI according to the sound actuarial and financial practices of commercial AD&D insurers. When TSGLI was created in 2005, a one-year loss period was established because the one-year period reflected the longest loss period for an individual insured under a policy of commercial AD&D. In 2007, we extended this one-year period to two years in response to concerns from the uniformed services that one year was not enough time for a member to decide whether to attempt to salvage a limb. This extension of an additional year to suffer a loss provides more extensive coverage than the coverage offered by most commercial AD&D insurers. Further extending the loss period risks undermining the actuarial soundness of TSGLI and would make it difficult for TSGLI adjudicators to determine if a nexus exists between a traumatic injury and a qualifying loss. Therefore, we do not make any change based on this comment.

6. Exposure to Burn Pits

One commenter stated that the proposed rule language should be more inclusive of toxic exposures that occur from military-specific events, such as burn pits. We define a qualifying traumatic event for purposes of TSGLI in 38 CFR 9.20(b) as an application of external force; application of violence or chemical, biological, or radiological

weapons; accidental ingestion of a contaminated substance; exposure to low temperatures, excessive heat, or non-penetrating blast waves; or an animal or insect bite or insect sting. We define traumatic injury in 38 CFR 9.20(c) to expressly exclude illnesses and diseases, unless the illness or disease was caused by a biological, chemical or radiological weapon, pyogenic infection, or accidental ingestion of a contaminated substance. For exposure to burn pit toxins to qualify as a traumatic event and for the resulting injury to qualify as a traumatic injury, the member would have to have been exposed to a burn pit that was burning nuclear, radiological, or chemical weapons. Exposure to nuclear, radiological, or chemical weapons causes an immediate harm to the member. As we explained in the TSGLI interim final rule in 2005, including immediate traumatic harm due to these unique hazards of military service is consistent with the purpose of TSGLI. 70 FR 75,940, 75,941 (Dec. 22, 2005). Exposure to burn pits where conventional weapons or materials were burned would not cause such immediate traumatic harm so as to fall within the purpose of TSGLI. Therefore, we do not make a change based on this comment.

7. Petition for VA To Engage in TSGLI Rulemaking

One comment was submitted by counsel representing a member who is appealing the uniformed services' denial of his TSGLI claim. In our proposed rulemaking we evaluated the commenter's petition for VA to engage in a TSGLI rulemaking that would add illness and disease to the TSGLI schedule if the illness or disease was caused by explosive ordnance. The commenter stated that VA did not explain why it did not grant the member's petition and why it adopted a two-year time period for a loss from a traumatic injury to occur. The comments also stated that losses from explosive ordnance such as stroke do occur within two years of members' exposure to explosive ordnance and VA's denial of the petition is arbitrary and capricious and violates the Administrative Procedure Act.

In the proposed rulemaking, we explained that we were proposing to deny the petition for rulemaking because covering losses from illness or disease resulting from explosive ordnance would be inconsistent with the plain language of the authorizing statute and the purpose of TSGLI to cover injuries occurring immediately after a traumatic event as losses due to illness or disease do not result from immediate traumatic harm unless the harm is caused by nuclear, biological, or chemical weapons. 85 FR at 50,983. We included immediate traumatic harm caused by nuclear, biological, and chemical weapons as exceptions to the TSGLI illness and disease exclusion because these weapons are unique to the hazards of military service. *Id.* As we further explained in the proposed rulemaking, the legislative history of the TSGLI authorizing statute shows that Congress intended to provide TSGLI compensation for injuries, rather than diseases, that occur immediately after a traumatic event and that require prompt medical treatment. *Id.* Thus, we proposed to deny the commenter's petition to provide TSGLI coverage for physical illness or disease caused by TBI because losses from illness or disease caused by TBI may not immediately manifest but may manifest many years after the member's TBI. *Id.* Further, although the commenter noted that one of the medical studies cited by VA in the proposed rule found an average time of 543 days between a TBI patient's use of health care services and the onset of stroke, we identified other scientific reports suggesting a longer latent period before clinical presentation of adverse health effects such as meningioma and an increase in risk of brain tumors. *Id.* Additionally, we cited to a report that showed a delayed onset of symptoms of Parkinson Disease following TBI. *Id.*

The commenter also stated that VA has not provided sufficient justification for adopting a two-year period for a loss to occur following a traumatic injury and that we have offered no actuarial or statistical data to support the denial of the petition for rulemaking. As stated previously, VA is obligated to manage TSGLI according to sound actuarial principles, and we have modeled TSGLI on commercial AD&D policies. The TSGLI two-year period to suffer a loss provides more extensive coverage than the coverage offered by most commercial AD&D insurers; further extending the loss period risks the financial health of TSGLI and would make it difficult for TSGLI adjudicators to determine if a nexus exists between a traumatic injury and a qualifying loss. Accordingly, we make no change based on this commenter's comments and deny the petition for rulemaking.

8. Comments Received During SNPRM Comment Period

We received three additional comments in response to our supplemental notice of proposed rulemaking providing a new opportunity for the public to submit comments pertaining to our proposal to deny the petition for rulemaking described in the previous section. One commenter indicated that the types of illnesses and diseases that result from exposure to low-level blasts often are not diagnosed until as long as a decade later and should be covered under TSGLI. VA considers low-level blasts a traumatic event and calculates the two-year period from the last documented blast. Any ''immediate'' losses, such as hospitalization or the inability to perform ADL from a TBI resulting from a low-level blast, are losses covered under TSGLI. Covering a disease or illness that occurs many years following a traumatic event would be contrary to Congressional intent that TSGLI provide benefits for losses from traumatic injuries that are suffered soon after a traumatic event. *See* 85 FR at 50,983. Therefore, we do not make a change based on this comment.

VA received one comment from counsel representing the member appealing the uniformed services' denial of his TSGLI claim and who submitted the petition for rulemaking stating that our proposal to deny the petition to add illness and disease to the TSGLI schedule if the illness and disease was caused by explosive ordnance was arbitrary and capricious. The comment submitted was similar to a comment submitted during the prior notice and comment period. As stated previously, VA does not make any changes based on this comment because covering losses from illness or disease resulting from explosive ordnance would be inconsistent with commercial AD&D coverage after which Congress modeled TSGLI and the purpose of TSGLI to cover injuries occurring immediately after a traumatic event.

We received another comment from a licensed physician and the author of a report to which we cited in our August 2020 **Federal Register** submission that proposed to deny the petitioner's request. The commenter stated that TBI from explosive ordnance follows a disease process and that losses from illness and disease caused by TBI that is caused by explosive ordnance should be covered under TSGLI. As we explained in the proposed rulemaking and in previous sections of this final rulemaking, the types of long-term illnesses and diseases associated with TBI do not cause the immediate type of harm against which TSGLI is designed to protect. Our research shows that, while several conditions, such as Alzheimer's Disease and dementia, have a positive association with TBI, these conditions do not immediately manifest,

and losses from these conditions usually do not occur until more than two years after TBI. Institute of Medicine of the National Academies, *Gulf War and Health—Vol. 9: Long-Term Effects of Blast Exposures* (2014), *available at https://doi.org/10.17226/18253.* We also identified a positive association between TBI and Parkinson's Disease, however the symptoms from Parkinson's Disease that would cause a member to suffer a loss do not appear within the two-year loss period, but usually appear as many as twenty years following a TBI. *Id.* Further, members who suffer immediate harm due to TBI caused by explosive ordnance and are hospitalized or suffer the loss of ADL are eligible for TSGLI payment if the loss occurs during the two-year period for TSGLI losses. Therefore, we do not make any changes based on this comment and deny the petition for rulemaking.

9. Withdrawal of Proposal To Amend TSGLI Burn Standard

In our August 2020 proposed rulemaking, we indicated that we would revise the TSGLI burn standard to create a graduated, tiered standard based upon the varying levels of rehabilitation associated with differing types of burns and the extent of burns on the body. 85 FR at 50,979–50,980. We received several comments during and after the comment period indicating that the proposed standard would not provide equity in payment based on the severity of the burn and the burn would be difficult to assess under the proposed standard because medical documentation of the precise location of burns is not always available. Therefore, we are withdrawing the proposed amendments to the TSGLI burn standard and restating current § 9.20(e)(6)(xvii) and (f)(8) in new § 9.21(c)(8).

For the reasons discussed above, VA is adopting the proposed rule as a final rule with the above-noted changes.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. The Office of Information and Regulatory Affairs has determined that this final rule is not a significant regulatory action under Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov.*

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (5 U.S.C. 601–612). This final rule will generally be small business neutral as it applies only to members who are covered under TSGLI, and TSGLI is managed, processed, and conducted within VA and through Prudential Insurance Company of America, which is not considered to be a small business entity. Therefore, under 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Paperwork Reduction Act

We note that in the proposed rule we did not identify any information collections. *See* 85 FR 50,983. However, we subsequently received guidance from the Office of Management and Budget (OMB) informing us that the TSGLI application and appeals forms covered in proposed § 9.20 constitute information collections and are subject to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521) requiring approval by OMB. Accordingly, we requested OMB approval for these forms, and OMB granted emergency clearance under 44 U.S.C. 3507(j) and assigned OMB control number 2900–0919. On December 29, 2022, we published a separate **Federal Register** notice outside of this rulemaking requesting public comment on the information collections. *See* 87 FR 80262. If, based on public comments, OMB determines to modify its emergency clearance for these forms, VA would revise § 9.20 accordingly.

Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not a major rule, as defined by 5 U.S.C. 804(2).

Assistance Listing

The Assistance Listing number and title for the program affected by this document is 64.103, Life Insurance for Veterans.

List of Subjects in 38 CFR Part 9

Life insurance, Military personnel, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on January 12, 2023, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Luvenia Potts,

Regulations Development Coordinator, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons stated in the preamble, VA is amending 38 CFR part 9 as set forth below:

PART 9—SERVICEMEMBERS' GROUP LIFE INSURANCE AND VETERANS' GROUP LIFE INSURANCE

■ 1. The authority citation for part 9 continues to read as follows:

Authority: 38 U.S.C. 501, 1965–1980A, unless otherwise noted.

■ 2. Amend § 9.20 by:
■ a. Revising paragraph (b)(1);
■ b. Redesignating paragraph (c)(3) as (c)(4) and adding a new paragraph (c)(3);
■ c. Revising paragraphs (d)(2) and (4), (e)(1), (e)(3)(i)(C) and (ii), and (e)(6);
■ c. Removing paragraph (f);
■ d. Redesignating paragraph (h) as paragraph (f) and revising newly redesignated paragraph (f);
■ e. Revising paragraph (g);
■ f. Redesignating paragraphs (i) through (k) as paragraphs (h) through (j) respectively and revising newly redesignated paragraphs (h) through (j).

The revisions read as follows:

§ 9.20 Traumatic injury protection.

* * * * *

(b) * * * (1) A traumatic event is damage to a living being occurring on or after October 7, 2001, caused by:

(i) Application of an external force;

(ii) Application of violence or chemical, biological, or radiological weapons;

(iii) Accidental ingestion of a contaminated substance;

(iv) Exposure to low environmental temperatures, excessive heat, or documented non-penetrating blast waves; or

(v) An insect bite or sting or animal bite.

* * * * *

(c) * * *

(3) The term traumatic injury includes anaphylactic shock directly caused by an insect bite or sting or animal bite.

* * * * *

(d) * * *

(2) You must suffer a scheduled loss that results directly from a traumatic injury and from no other cause.

(i) A scheduled loss does not result directly from a traumatic injury and from no other cause if a pre-existing illness, condition, or disease or a post-service injury substantially contributed to the loss.

(ii) A scheduled loss results directly from a traumatic injury and no other cause if the loss is caused by a medical or surgical procedure used to treat the traumatic injury.

* * * * *

(4) You must suffer a scheduled loss under § 9.21(c) within two years of the traumatic injury.

(i) If a loss with a required time period milestone begins but is not completed within two years of the traumatic injury, the loss would nonetheless qualify for TSGLI if the requisite time period of loss continues uninterrupted and concludes after the end of the two-year period.

(ii) If a required time period for a loss is satisfied before the end of the two-year period and a member suffers another period of loss after expiration of the two-year time limit, the member is not entitled to TSGLI for this time period of loss.

* * * * *

(e) * * * (1) The term ''scheduled loss'' means a condition listed in the schedule in § 9.21(c) if directly caused by a traumatic injury and from no other cause. A scheduled loss is payable at the amount specified in the schedule.

* * * * *

(3) * * *

(i) * * *

(C) Diagnostic procedures, preventive medical procedures such as inoculations, medical or surgical treatment for an illness or disease, or any complications arising from such procedures or treatment, unless the diagnostic procedure or medical or surgical treatment is necessary to treat a traumatic injury;

* * * * *

(ii) Sustained while a member was committing an act that clearly violated a penal law classifying such an act as a felony.

* * * * *

(6) Definitions. For purposes of this section and § 9.21—

(i) The term *biological weapon* means biological agents or microorganisms intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(ii) The term *chemical weapon* means chemical substances intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(iii) The term *contaminated substance* means food or water made unfit for consumption by humans because of the presence of chemicals, radioactive elements, bacteria, or organisms.

(iv) The term *external force* means a sudden or violent impact from a source outside of the body that causes an unexpected impact and is independent of routine body motions such as twisting, lifting, bending, pushing, or pulling.

(v) The term *ingestion* means to take into the gastrointestinal tract by means of the mouth.

(vi) The term *medical professional* means a licensed practitioner of the healing arts acting within the scope of his or her practice, including, *e.g.,* a licensed physician, optometrist, nurse practitioner, registered nurse, physician assistant, or audiologist.

(vii) The term *medically incapacitated* means an individual who has been determined by a medical professional to be physically or mentally impaired by physical disability, mental illness, mental deficiency, advanced age, chronic use of drugs or alcohol, or other causes that prevent sufficient understanding or capacity to manage his or her own affairs competently.

(viii) The term *pyogenic infection* means a pus-producing infection.

(ix) The term *radiological weapon* means radioactive materials or radiation-producing devices intended to kill, seriously injure, or incapacitate humans through their physiological effects.

(f) *How does a member make a claim for traumatic injury protection benefits?* (1)(i) A member who believes he or she qualifies for traumatic injury protection benefits must complete and sign Part A of the TSGLI Benefits Form and submit evidence substantiating the member's traumatic injury and resulting loss. A medical professional must complete and sign Part B of the Application for TSGLI Benefits Form.

(ii) If a medical professional certifies in Part B of the Application for TSGLI Benefits Form that a member is unable to sign Part A of the Form because the member is medically incapacitated, the Form must be signed by one of the following: The member's guardian; if none, the member's agent or attorney acting under a valid Power of Attorney; if none, the member's military trustee.

(iii) If a member suffered a scheduled loss as a direct result of the traumatic injury, survived seven full days from the date of the traumatic event, and then died before the maximum benefit for which the service member qualifies is paid, the beneficiary or beneficiaries of the member's Servicemembers' Group Life Insurance policy should complete an Application for TSGLI Benefits Form.

(2) If a member seeks traumatic injury protection benefits for a scheduled loss occurring after submission of a completed Application for TSGLI Benefits Form for a different scheduled loss, the member must submit a completed Application for TSGLI Benefits Form for the new scheduled loss and for each scheduled loss that occurs thereafter and for each increment of a scheduled loss that occurs thereafter. For example, if a member seeks traumatic injury protection benefits for a scheduled loss due to coma from traumatic injury and/or the inability to carry out activities of daily living due to traumatic brain injury (§ 9.21(c)(17)), or the inability to carry out activities of daily living due to loss directly resulting from a traumatic injury other than an injury to the brain (§ 9.21(c)(20)), a completed Application for TSGLI Benefits Form must be submitted for each increment of time for which TSGLI is payable. Also, for example, if a member suffers a scheduled loss due to a coma, a completed Application for TSGLI Benefits Form should be filed after the 15th consecutive day that the member is in the coma, for which $25,000 is payable. If the member remains in a coma for another 15 days, another completed Application for TSGLI Benefits Form should be submitted and another $25,000 will be paid.

(g) *How will the uniformed service decide a TSGLI claim?* (1) Each uniformed service will certify its own members for traumatic injury protection benefits based upon section 1032 of Public Law 109–13, section 501 of Public Law 109–233, and this section. The uniformed service will certify whether a member was insured under Servicemembers' Group Life Insurance at the time of the traumatic injury and whether the member sustained a

qualifying traumatic injury and qualifying loss.

(2) The uniformed service office may request additional evidence from the member if the record does not contain sufficient evidence to decide the member's claim.

(3) The uniformed service office shall consider all medical and lay evidence of record, including all evidence provided by the member, and determine its probative value. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of TSGLI benefits, the uniformed service shall give the benefit of the doubt to the member.

(4) Notice of a decision regarding a member's eligibility for traumatic injury protection benefits will include an explanation of the procedure for obtaining review of the decision, and all negative decisions shall include a statement of the basis for the decision and a summary of the evidence considered.

(h) *How does a member or beneficiary appeal an adverse eligibility determination?* (1) Each uniformed service has a three-tiered appeal process. The first tier of appeal is called a reconsideration, followed by a second-level appeal and then a third-level appeal. A member, beneficiary, or other person eligible to submit a claim under paragraph (f)(1)(ii) or (iii) may submit an appeal using the appeal process of the uniformed service that issued the original decision.

(i) *Reconsideration.* (A) Reconsideration of an eligibility determination, such as whether the loss occurred within 730 days of the traumatic injury, whether the member was insured under Servicemembers' Group Life Insurance when the traumatic injury was sustained, or whether the injury was self-inflicted or whether a loss of hearing was total and permanent, is initiated by filing, with the office of the uniformed service identified in the eligibility decision within one year of the date of a denial of eligibility, a written notice of appeal that identifies the issues for which reconsideration is sought.

(B) The uniformed service TSGLI office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and issue a decision on the claim.

(ii) *Second-level appeal.* (A) A second-level appeal of the reconsideration decision is initiated by filing, with the second-level appeal office of the uniformed service within one year of the date of the reconsideration decision, a written notice of appeal that identifies the issues being appealed.

(B) The uniformed service second-level appeal office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and issue a decision on the claim.

(iii) *Third-level appeal.* (A) A third-level review of the second-level uniformed service appeal office is initiated by filing, with the third-level appeal office of the uniformed service within one year of the date of the decision by the second-level appeal office of the uniformed service, a written notice of appeal that identifies the issues being appealed.

(B) The uniformed service third-level appeal office will review the claim, including evidence submitted with the notice of appeal by or on behalf of the member that was not previously part of the record before the uniformed service, and issue a decision on the claim.

(2) If a timely notice of appeal seeking reconsideration of the initial decision by the uniformed service or seeking review of the decision by the second-level uniformed service appeal office is not filed, the initial decision by the uniformed service or the decision by the second-level uniformed service appeal office, respectively, shall become final, and the claim will not thereafter be readjudicated or allowed except as provided in paragraph (h)(3).

(3) New and material evidence. (i) If a member, beneficiary, or other person eligible to submit a claim under paragraph (f)(1)(ii) or (iii) submits new and material evidence with respect to a claim that has been finally disallowed as provided in paragraph (h)(2), the uniformed service office will consider the evidence, determine its probative value, and readjudicate the claim. New and material evidence is evidence that was not previously part of the record before the uniformed service, is not cumulative or redundant of evidence of record at the time of the prior decision and is likely to have a substantial effect on the outcome.

(ii) A decision finding that new and material evidence was not submitted may be appealed in accordance with paragraph (h)(1).

(4) Nothing in this section precludes a member from pursuing legal remedies under 38 U.S.C. 1975 and 38 CFR 9.13. However, if a member files suit in U.S. district court after an adverse initial decision on a TSGLI claim by a uniformed service, the member may not file an appeal pursuant to paragraph (h)(1) if the lawsuit is pending before a U.S. district court, a U.S. court of appeals, or the U.S. Supreme Court or the time for appeal or filing a petition for a writ of certiorari has not expired. If a member files suit in U.S. district court after filing an appeal pursuant to paragraph (h)(1), the appeal will be stayed if the lawsuit is pending before a U.S. district court, a U.S. court of appeals, or the U.S. Supreme Court or the time for appeal or filing a petition for a writ of certiorari has not expired.

(i) *Who will be paid the traumatic injury protection benefit?* The injured member who suffered a scheduled loss will be paid the traumatic injury protection benefit in accordance with 38 U.S.C. 1980A except under the following circumstances:

(A) If a member has been determined by a medical professional, in Part B of the Application for TSGLI Benefits Form, to be medically incapacitated, the member's guardian or, or if there is no guardian, the member's agent or attorney acting under a valid Power of Attorney will be paid the benefit on behalf of the member.

(B) If no guardian, agent, or attorney is authorized to act as the member's legal representative, a military trustee who has been appointed under the authority of 37 U.S.C. 602 will be paid the benefit on behalf of the member. The military trustee will report the receipt of the traumatic injury benefit payment and any disbursements from that payment to the Department of Defense.

(C) If a member dies before payment is made, the beneficiary or beneficiaries who will be paid the benefit will be determined in accordance with 38 U.S.C. 1970(a).

(j) The Traumatic Servicemembers' Group Life Insurance program will be administered in accordance with this rule, except to the extent that any regulatory provision is inconsistent with subsequently enacted applicable law.

(Approved by the Office of Management and Budget under control number 2900–0919.)

§§ 9.21 and 9.22 [Redesignated]

■ 3. Redesignate §§ 9.21 and 9.22 as §§ 9.22 and 9.23.

■ 4. Add new § 9.21 to read as follows:

§ 9.21 Schedule of Losses.

(a) Definitions. For purposes of the Schedule of Losses in paragraph (c)—

(1) The term *accommodating equipment* means tools or supplies that enable a member to perform an activity of daily living without the assistance of another person, including, but not limited to, a wheelchair; walker or cane;

reminder applications; Velcro clothing or slip-on shoes; grabber or reach extender; raised toilet seat; wash basin; shower chair; or shower or tub modifications such as wheelchair access or no-step access, grab-bar or handle.

(2) The term *adaptive behavior* means compensating skills that allow a member to perform an activity of daily living without the assistance of another person.

(3) The term *amputation* means the severance or removal of a limb or genital organ or part of a limb or genital organ resulting from trauma or surgery. With regard to limbs, an amputation above a joint means a severance or removal that is closer to the body than the specified joint is.

(4) The term *assistance from another person* means that a member, even while using accommodating equipment or adaptive behavior, is nonetheless unable to perform an activity of daily living unless another person physically supports the member, is needed to be within arm's reach of the member to provide assistance because the member's ability fluctuates, or provides oral instructions to the member while the member attempts to perform the activity of daily living.

(5) The term *avulsion* means a forcible detachment or tearing of bone and/or tissue due to a penetrating or crush injury.

(6) The term *consecutive* means to follow in uninterrupted succession.

(7) The term *discontinuity defect* means the absence of bone and/or tissue from its normal bodily location, which interrupts the physical consistency of the face and impacts at least one of the following functions: mastication, swallowing, vision, speech, smell, or taste.

(8) The term *hospitalization* means admission to a ''hospital'' as defined in 42 U.S.C. 1395x(e) or ''skilled nursing facility'' as defined in 42 U.S.C. 1395i–3(a).

(9) The term *inability to carry out activities of daily living* means the inability to perform at least two of the six following functions without assistance from another person, even while using accommodating equipment or adaptive behavior, as documented by a medical professional.

(i) *Bathing* means washing, while in a bathtub or shower or using a sponge bath, at least three of the six following regions of the body in its entirety: Head and neck, back, front torso, pelvis (including the buttocks), arms, or legs.

(ii) *Continence* means complete control of bowel and bladder functions or management of a catheter or colostomy bag, if present.

(iii) *Dressing* means obtaining clothes and shoes from a closet or drawers and putting on the clothing and shoes, excluding tying shoelaces or use of belts, buttons, or zippers.

(iv) *Eating* means moving food from a plate to the mouth or receiving nutrition via a feeding tube or intravenously but does not mean preparing or cutting food or obtaining liquid nourishment through a straw or cup.

(v) *Toileting* means getting on and off the toilet; taking clothes off before toileting or putting clothes on after toileting; cleaning organs of excretion after toileting; or using a bedpan or urinal.

(vi) *Transferring* means moving in and out of a bed or chair.

(10) The term *permanent* means clinically stable and reasonably certain to continue throughout the lifetime of the member.

(11) The term *therapeutic trip* means an approved pass, by the member's attending physician or nurse practitioner, to leave a hospital as defined in 42 U.S.C. 1395x(e) or ''skilled nursing facility'' as defined in 42 U.S.C. 1395i–3(a), accompanied or unaccompanied by hospital or facility staff, as part of a member's treatment plan and with which the member is able to return without having to be readmitted to the hospital or facility.

(b)(1) For losses listed in paragraphs (c)(1) through (19) of this section—

(i) Except where noted otherwise, multiple losses resulting from a single traumatic event may be combined for purposes of a single payment.

(ii) The total payment amount may not exceed $100,000 for losses resulting from a single traumatic event.

(2) For losses listed in paragraphs (c)(20) and (21) of this section—

(i) Payments may not be made in addition to payments for losses under paragraphs (c)(1) through (19); instead, the higher amount will be paid.

(ii) The total payment amount may not exceed $100,000 for losses resulting from a single traumatic event.

(3) Required period of consecutive days of loss. For losses in paragraphs (c)(17) through (18) and (20) through (21)—

(i) A period of consecutive days of loss that is interrupted by a day or more during which the criteria for the scheduled loss are not satisfied will not be added together with a subsequent period of consecutive days of loss. The counting of consecutive days starts over at the end of any period in which the criteria for a loss are not satisfied.

(ii) A required period of consecutive days will be satisfied if a loss begins within two years of a traumatic injury and continues without interruption after the end of the two-year period. A subsequent period of consecutive days of a scheduled loss will be satisfied if it follows uninterrupted immediately after an initial period of consecutive days of loss that ended after expiration of the two-year period.

(c) *Schedule of Losses.* (1) *Total and permanent loss of sight* is:

(i) Visual acuity in the eye of 20/200 or less/worse with corrective lenses lasting at least 120 days;

(ii) Visual acuity in the eye of greater/better than 20/200 with corrective lenses and a visual field of 20 degrees of less lasting at least 120 days; or

(iii) Anatomical loss of the eye.

(iv) The amount payable for the loss of each eye is $50,000.

(2) *Total and permanent loss of hearing* is:

(i) Average hearing threshold sensitivity for air conduction of at least 80 decibels, based on hearing acuity measured at 500, 1,000, and 2,000 Hertz via pure tone audiometry by air conduction, without amplification device.

(ii) The amount payable for loss of one ear is $25,000. The amount payable for the loss of both ears is $100,000.

(3) *Total and permanent loss of speech* is:

(i) Organic loss of speech or the ability to express oneself, both by voice and whisper, through normal organs for speech, notwithstanding the use of an artificial appliance to simulate speech.

(ii) The amount payable for the loss of speech is $50,000.

(4) *Quadriplegia* is:

(i) Total and permanent loss of voluntary movement of all four limbs resulting from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for quadriplegia is $100,000.

(5) *Hemiplegia* is:

(i) Total and permanent loss of voluntary movement of the upper and lower limbs on one side of the body from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for hemiplegia is $100,000.

(6) *Paraplegia* is:

(i) Total and permanent loss of voluntary movement of both lower limbs resulting from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for paraplegia is $100,000.

(7) *Uniplegia* is:

(i) Total and permanent loss of voluntary movement of one limb resulting from damage to the spinal cord, associated nerves, or brain.

(ii) The amount payable for the loss of each limb is $50,000.

(iii) Payment for uniplegia of arm cannot be combined with loss 9 or 10 for the same arm. The higher payment for uniplegia or loss 14 will be made for the same arm. Payment for uniplegia of leg cannot be combined with loss 11 or 12 for the same leg. The higher payment for uniplegia or loss 13 will be made for the same leg. The higher payment for uniplegia or loss 15 will be made for the same leg.

(8) *Burns* is: (i) 2nd degree (partial thickness) or worse burns covering at least 20 percent of the body, including the face and head, or 20 percent of the face alone. Percentage of the body burned may be measured using the Rule of Nines or any means generally accepted within the medical profession.

(ii) The amount payable for burns is $100,000.

(9) *Amputation of a hand at or above the wrist:* (i) The amount payable for the loss of each hand is $50,000.

(ii) Payment for amputation of hand cannot be combined with payment for loss 7 or 10 for the same hand. The higher payment for amputation of hand or loss 14 will be made for the same hand.

(10) *Amputation at or above the metacarpophalangeal joint(s) of either the thumb or the other 4 fingers on 1 hand:* (i) The amount payable for the loss of each hand is $50,000.

(ii) Payment for amputation of 4 fingers on 1 hand or thumb alone cannot be combined with payment for loss 7 or 9 for the same hand. The higher payment for amputation of 4 fingers on 1 hand or thumb alone or loss 14 will be made for the same hand. Payment for loss of the thumb cannot be made in addition to payment for loss of the other 4 fingers for the same hand.

(11) *Amputation of a foot at or above the ankle:* (i) The amount payable for the loss of each foot is $50,000.

(ii) Payment for amputation of foot cannot be combined with loss 7 or 12 for the same foot. The higher payment for amputation of foot or Loss 13 will be made for the same foot. The higher payment for amputation of foot or Loss 15 will be made for the same foot.

(12) *Amputation at or above the metatarsophalangeal joints of all toes on 1 foot:* (i) The amount payable for the loss of each foot is $50,000.

(ii) Payment for amputation of all toes including the big toe on 1 foot cannot be combined with loss 7 or 11 for the same foot. The higher payment for amputation of all toes including the big toe on 1 foot or loss 13 will be made for the same foot. The higher payment for amputation of all toes including the big toe on 1 foot or loss 15 will be made for the same foot.

(13) *Amputation at or above the metatarsophalangeal joint(s) of either the big toe or the other 4 toes on 1 foot:* (i) The amount payable for the loss of each foot is $25,000.

(ii) The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 7 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 11 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 12 will be made for the same foot. The higher payment for amputation of big toe only, or other 4 toes on 1 foot, or loss 15 will be made for the same foot.

(14) *Limb reconstruction of arm (for each arm):* (i) A surgeon must certify that a member had surgery to treat at least one of the following injuries to a limb:

(A) Bony injury requiring bone grafting to re-establish stability and enable mobility of the limb;

(B) Soft tissue defect requiring grafting/flap reconstruction to reestablish stability;

(C) Vascular injury requiring vascular reconstruction to restore blood flow and support bone and soft tissue regeneration; or

(D) Nerve injury requiring nerve reconstruction to allow for motor and sensory restoration and muscle re-enervation.

(ii) The amount payable for losses involving 1 of the 4 listed surgeries is $25,000. The amount payable for losses involving 2 or more of the 4 listed surgeries is $50,000.

(iii) The higher payment for limb reconstruction of arm or loss 7 will be made for the same arm. The higher payment for limb reconstruction of arm or loss 9 will be made for the same arm. The higher payment for limb reconstruction of arm or loss 10 will be made for the same arm.

(15) *Limb reconstruction of leg (for each leg):* (i) A surgeon must certify that a member had at least one of the following injuries to a limb requiring the identified surgery for the same limb:

(A) Bony injury requiring bone grafting to re-establish stability and enable mobility of the limb;

(B) Soft tissue defect requiring grafting/flap reconstruction to reestablish stability;

(C) Vascular injury requiring vascular reconstruction to restore blood flow and support bone and soft tissue regeneration; or

(D) Nerve injury requiring nerve reconstruction to allow for motor and sensory restoration and muscle re-enervation.

(ii) The amount payable for losses involving 1 of the 4 listed surgeries is $25,000. The amount payable for losses involving 2 or more of the 4 listed surgeries is $50,000.

(iii) The higher payment for limb reconstruction of leg or loss 7 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 11 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 12 will be made for the same leg. The higher payment for limb reconstruction of leg or loss 13 will be made for the same leg.

(16) *Facial reconstruction:* (i) A surgeon must certify that a member had surgery to correct a traumatic avulsion of the face or jaw that caused a discontinuity defect to one or more of the following facial areas:

(A) Surgery to correct discontinuity loss involving bone loss of the upper or lower jaw—the amount payable for this loss is $75,000;

(B) Surgery to correct discontinuity loss involving cartilage or tissue loss of 50% or more of the cartilaginous nose—the amount payable for this loss is $50,000;

(C) Surgery to correct discontinuity loss involving tissue loss of 50% or more of the upper or lower lip—the amount payable for loss of one lip is $50,000, and the amount payable for loss of both lips is $75,000;

(D) Surgery to correct discontinuity loss involving bone loss of 30% or more of the periorbita—the amount payable for loss of each eye is $25,000;

(E) Surgery to correct discontinuity loss involving loss of bone or tissue of 50% or more of any of the following facial subunits: Forehead, temple, zygomatic, mandibular, infraorbital, or chin—the amount payable for each facial subunit is $25,000.

(ii) Losses due to facial reconstruction may be combined with each other, but the maximum benefit for facial reconstruction may not exceed $75,000.

(iii) Any injury or combination of losses under facial reconstruction may be combined with other losses in § 9.21(c)(1)–(19) and treated as one loss, provided that all losses are the result of a single traumatic event. However, the total payment amount may not exceed $100,000.

(iv) Bone grafts for teeth implants alone do not meet the loss standard for facial reconstruction from jaw surgery.

(17) *Coma (8 or less on Glasgow Coma Scale) AND/OR Traumatic Brain Injury resulting in inability to perform at least 2 activities of daily living (ADL):* (i) The amount payable at the 15th consecutive day of ADL loss is $25,000.

(ii) The amount payable at the 30th consecutive day of ADL loss is an additional $25,000.

(iii) The amount payable at the 60th consecutive day of ADL loss is an additional $25,000.

(iv) The amount payable at the 90th consecutive day of ADL loss is an additional $25,000.

(v) Duration of coma and inability to perform ADLs include date of onset of coma or inability to perform ADLs and the first date on which member is no longer in a coma or is able to perform ADLs.

(18) *Hospitalization due to traumatic brain injury:* (i) The amount payable at the 15th consecutive day of hospitalization is $25,000.

(ii) Payment for hospitalization may only replace the first ADL milestone in loss 17. Payment will be made for 15-day hospitalization, coma, or the first ADL milestone, whichever occurs earlier. Once payment has been made for the first payment milestone in loss 17 for coma or ADL, there are no additional payments for subsequent 15-day hospitalization due to the same traumatic injury. To receive an additional ADL payment amount under loss 17 after payment for hospitalization in the first payment milestone, the member must reach the next payment milestones of 30, 60, or 90 consecutive days.

(iii) Duration of hospitalization includes the dates on which member is transported from the injury site to a hospital as defined in 42 U.S.C. 1395x(e) or skilled nursing facility as defined in 42 U.S.C. 1395i–3(a), admitted to the hospital or facility, transferred between a hospital or facility, leaves the hospital or facility for a therapeutic trip, and discharged from the hospital or facility.

(iv) In cases where a member is hospitalized for 15 consecutive days for a diagnostic assessment for a mental illness and/or brain or neurologic disorder, and the assessment determines the member has a mental illness or brain or neurologic disorder, and not TBI, this loss is not payable because the loss was due to illness or disease and is excluded from payment. If a member is hospitalized for 15 consecutive days for a diagnostic assessment to determine whether the member has TBI and is diagnosed with TBI, TBI and PTSD, or PTSD and not TBI, the loss is payable for $25,000. If a member is hospitalized for 15 consecutive days for a diagnostic assessment to determine whether the member has PTSD and is diagnosed with TBI or TBI and PTSD, the loss is payable for $25,000.

(19) *Genitourinary losses:* (i) Amputation of the glans penis or any portion of the shaft of the penis above glans penis (*i.e.,* closer to the body) or damage to the glans penis or shaft of the penis that requires reconstructive surgery—the amount payable for this loss is $50,000.

(ii) Permanent damage to the glans penis or shaft of the penis that results in complete loss of the ability to perform sexual intercourse—the amount payable for this loss is $50,000.

(iii) Amputation of or damage to a testicle that requires testicular salvage, reconstructive surgery, or both—the amount payable for this loss is $25,000.

(iv) Amputation of or damage to both testicles that requires testicular salvage, reconstructive surgery, or both—the amount payable for this loss is $50,000.

(v) Permanent damage to both testicles requiring hormonal replacement therapy—the amount payable for this loss is $50,000.

(vi) Complete or partial amputation of the vulva, uterus, or vaginal canal or damage to the vulva, uterus, or vaginal canal that requires reconstructive surgery—the amount payable for this loss is $50,000.

(vii) Permanent damage to the vulva or vaginal canal that results in complete loss of the ability to perform sexual intercourse—the amount payable for this loss is $50,000.

(viii) Amputation of an ovary or damage to an ovary that requires ovarian salvage, reconstructive surgery, or both—the amount payable for this loss is $25,000.

(ix) Amputation of both ovaries or damage to both ovaries that requires ovarian salvage, reconstructive surgery, or both—the amount payable for this loss is $50,000.

(x) Permanent damage to both ovaries requiring hormonal replacement therapy—the amount payable for this loss is $50,000.

(xi) Permanent damage to the urethra, ureter(s), both kidneys, bladder, or urethral sphincter muscle(s) that requires urinary diversion and/or hemodialysis—the amount payable for this loss is $50,000.

(xii) Losses due to genitourinary injuries may be combined with each other, but the maximum benefit for genitourinary losses may not exceed $50,000.

(xiii) Any genitourinary loss may be combined with other injuries listed in § 9.21(b)(1)–(18) and treated as one loss, provided that at all losses are the result of a single traumatic event. However, the total payment may not exceed $100,000.

(20) *Traumatic injury, other than traumatic brain injury, resulting in inability to perform at least 2 activities of daily living (ADL):* (i) The amount payable at the 15th consecutive day of ADL loss is $25,000.

(ii) The amount payable at the 30th consecutive day of ADL loss is an additional $25,000.

(iii) The amount payable at the 60th consecutive day of ADL loss is an additional $25,000.

(iv) The amount payable at the 90th consecutive day of ADL loss is an additional $25,000.

(v) Duration of inability to perform ADL includes the date of the onset of inability to perform ADL and the first date on which member is able to perform ADL.

(21) *Hospitalization due to traumatic injury other than traumatic brain injury:* (i) The amount payable at 15th consecutive day of ADL loss is $25,000.

(ii) Payment for hospitalization may only replace the first ADL milestone in loss 20. Payment will be made for 15-day hospitalization or the first ADL milestone, whichever occurs earlier. Once payment has been made for the first payment milestone in loss 20, there are no additional payments for subsequent 15-day hospitalization due to the same traumatic injury. To receive an additional ADL payment amount under loss 20 after payment for hospitalization in the first payment milestone, the member must reach the next payment milestones of 60, 90, or 120 consecutive days.

(iii) Duration of hospitalization includes the dates on which member is transported from the injury site to a hospital as defined in 42 U.S.C. 1395x(e) or skilled nursing facility as defined in 42 U.S.C. 1395i–3(a), admitted to the hospital or facility, transferred between a hospital or facility, leaves the hospital or facility for a therapeutic trip, and discharged from the hospital or facility.

(Authority: 38 U.S.C. 501(a), 1980A)

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 174

[EPA–HQ–OPP–2020–0237; 10775–01–OCSPP]

Modified Potato Acetolactate Synthase (StmALS) in Potato; Exemption From the Requirement of a Tolerance

AGENCY: Environmental Protection Agency (EPA).