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Medical

Book I

Title 38, Parts 17, 46, 47, 51–53,
58–64, 70, 71, and 200

Supplement No. 106

Covering period of *Federal Register* issues
through May 1, 2017

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GENERAL INSTRUCTIONS

Custom Federal Regulations Service™

Supplemental Materials for *Book I*

Code of Federal Regulations

Title 38, Parts 17, 46, 47, 51–53, 58–64, 70, 71, and 200

Medical

Supplement No. 106

5 May 2017

Covering the period of Federal Register issues
through May 1, 2017

When **Book I** was originally prepared, it was current through final regulations published in the *Federal Register* of 15 January 2000. These supplemental materials are designed to keep your regulations up to date. You should file the attached pages immediately, and record the fact that you did so on the *Supplement Filing Record* which is at page I-8 of Book I, *Medical*.

**To ensure accuracy and timeliness of your materials,
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1. Always file your supplemental materials immediately upon receipt.
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3. After filing, enter the relevant information on the Supplement Filing Record sheet (page I-8)—the date filed, name/initials of filer, and date through which the *Federal Register* is covered.
4. If as a result of a failure to file, or an undelivered supplement, you have more than one supplement to file at a time, be certain to file them in chronological order, lower number first.
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FILING INSTRUCTIONS

**Book I, Supplement No. 106
May 5, 2017**

<i>Remove these <u>old pages</u></i>	<i>Add these <u>new pages</u></i>	<i>Section(s) <u>Affected</u></i>
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**Do not file this supplement until you confirm that
all prior supplements have been filed**

17.INDEX-1 to 17.INDEX-2	17.INDEX-1 to 17.INDEX-2	Part 17 Index
17.169-3 to 17.169-4	17.169-3 to 17.169-4	§17.169

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HIGHLIGHTS

Book I, Supplement No. 106 May 5, 2017

Supplement Highlights references: Where substantive changes are made in the text of regulations, the paragraphs of *Highlights* sections are cited at the end of the relevant section of text. Thus, if you are reading §17.100, you will see a note at the end of that section which reads: “Supplement *Highlights* references—37(1).” This means that paragraph 1 of the *Highlights* section in Supplement No. 37 contains information about the changes made in §17.100. By keeping and filing the *Highlights* sections, you will have a reference source explaining all substantive changes in the text of the regulations.

Supplement frequency: Beginning 1 January 2000, supplements for this Book I will be issued *every month* during which a final rule addition or modification is made to the parts of Title 38 covered by this book. Supplements will be numbered consecutively as issued.

Modifications in this supplement include the following:

1. On 4 April 2017, the VA published a final rule effective that same day, to reflect the codification of the authority for the VA Dental Insurance Program (VADIP). Changes:
 - In Part 17 Index, revised the authority citations,
 - In §17.169, removed the sectional authority citation.

❏

Part 17 — Medical

Authority: Authority: 38 U.S.C. 501, and as noted in specific sections.

Section 17.169 also issued under 38 U.S.C. 1712C.

Sections 17.640 and 17.647 also issued under Pub. L. 114-2, sec. 4.

Sections 17.641 through 17.646 also issued under 38 U.S.C. 501(a) and Pub. L. 114-2, sec. 4.

Section 17.415 is also issued under 38 U.S.C. 7301, 7304, 7402 and 7403.

Ed. Note: Nomenclature changes to Part 17 appear at 61 FR 7216, Feb. 27, 1996

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- (C) Other drugs and/or medications.
- (D) Treatment of postsurgical complications.
- (E) Crowns.
- (F) Bridges.
- (G) Dentures.

(3) *Selection of participating insurer.* VA will use the Federal competitive contracting process to select a participating insurer, and the insurer will be responsible for the administration of VADIP.

(d) *Enrollment.*

(1) VA, in connection with the participating insurer, will market VADIP through existing VA communication channels to notify all eligible persons of their right to voluntarily enroll in VADIP. The participating insurer will prescribe all further enrollment procedures, and VA will be responsible for confirming that a person is eligible under paragraph (b) of this section.

(2) The initial period of enrollment will be for a period of 12 calendar months, followed by month-to-month enrollment, subject to paragraph (e)(5) of this section, as long as the insured remains eligible for coverage under paragraph (b) of this section and chooses to continue enrollment, so long as VA continues to authorize VADIP.

(3) The participating insurer will agree to continue to provide coverage to an insured who ceases to be eligible under paragraphs (b)(1) through (2) of this section for at least 30 calendar days after eligibility ceased. The insured must pay any premiums due during this 30-day period. This 30-day coverage does not apply to an insured who is disenrolled under paragraph (e) of this section.

(e) *Disenrollment.*

(1) Insureds may be involuntarily disenrolled at any time for failure to make premium payments.

(2) Insureds must be permitted to voluntarily disenroll, and will not be required to continue to pay any copayments or premiums, under any of the following circumstances:

(i) For any reason, during the first 30 days that the beneficiary is covered by the plan, if no claims for dental services or benefits were filed by the insured.

(ii) If the insured relocates to an area outside the jurisdiction of the plan that prevents the use of the benefits under the plan.

(iii) If the insured is prevented by serious medical condition from being able to obtain benefits under the plan.

(iv) If the insured would suffer severe financial hardship by continuing in VADIP.

(v) For any reason during the month-to-month coverage period, after the initial 12-month enrollment period.

(3) All insured requests for voluntary disenrollment must be submitted to the insurer for determination of whether the insured qualifies for disenrollment under the criteria in paragraphs (e)(2)(i) through (v) of this section. Requests for disenrollment due to a serious medical condition or financial hardship must include submission of written documentation that verifies the existence of a serious medical condition or financial hardship. The written documentation submitted to the insurer must show that circumstances leading to a serious medical condition or financial hardship originated after the effective date coverage began, and will prevent the insured from maintaining the insurance benefits.

(4) If the participating insurer denies a request for voluntary disenrollment because the insured does not meet any criterion under paragraphs (e)(2)(i) through (v) of this section, the participating insurer must issue a written decision and notify the insured of the basis for the denial and how to appeal. The participating insurer will establish the form of such appeals whether orally, in writing, or both. The decision and notification of appellate rights must be issued to the insured no later than 30 days after the request for voluntary disenrollment is received by the participating insurer. The appeal will be decided and that decision issued in writing to the insured no later than 30 days after the appeal is received by the participating insurer. An insurer's decision of an appeal is final.

(5) Month-to-month enrollment, as described in paragraph (d)(2) of this section, may be subject to conditions in insurance contracts, whereby upon voluntarily disenrolling, an enrollee may be prevented from re-enrolling for a certain period of time as specified in the insurance contract.

(f) Other appeals procedures. Participating insurers will establish and be responsible for determination and appeal procedures for all issues other than voluntary disenrollment.

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900-0789.)

[78 FR 32130; May 29, 2013; as amended at 82 FR 16288, Apr. 4, 2017]

Supplement *Highlights* references: 77(3), 106(1).