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the tenant specifying the grounds for the action. The property owner may waive the written notice requirement for termination in dangerous or egregious situations involving the tenant.

(c) All transitional or permanent housing for homeless individuals or families or low-income families must be safe and sanitary. The housing must meet all applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located.

(d) For sales or rentals of residential housing units constructed or rehabilitated using YouthBuild funds, YouthBuild grantees must ensure that owners of the property record a restrictive covenant at the time that an occupancy permit is issued against such property which includes the use restrictions set forth in paragraphs (a), (b), and (c) of this section and incorporates the following definitions at § 672.110: Homeless Individual; Low- Income Housing; and Transitional Housing. The term of the restrictive covenant must be at least 10 years from the time of the issuance of the occupancy permit, unless a time period of more than 10 years has been established by the grantee. Any additional stipulations imposed by a grantee or property owner should be clearly stated in the covenant.

(e) Any conveyance document prepared in the 10-year period of the restrictive covenant must inform the buyer of the property that all residential housing units constructed or rehabilitated using YouthBuild funds are subject to the restrictions set forth in paragraphs (a), (b), (c), and (d) of this section.

PARTS 673–699 [RESERVED]

CHAPTER VI—OFFICE OF WORKERS' COMPENSATION PROGRAMS, DEPARTMENT OF LABOR

SUBCHAPTER A—LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT AND RELATED STATUTES

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SUBCHAPTER A—LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT AND RELATED STATUTES

PART 700 [RESERVED]

PART 701—GENERAL; ADMINISTERING AGENCY; DEFINITIONS AND USE OF TERMS

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701.503 Did the American Recovery and Reinvestment Act of 2009 amend the recreational vessel exclusion?
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701.505 May an employer stop paying benefits awarded before February 17, 2009 if the employee would now fall within the exclusion?

AUTHORITY: 5 U.S.C. 301, 8171 *et seq.;* 33 U.S.C. 939; 36 D.C. Code 501 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1333; Reorganization Plan No. 6 of 1950, 15 FR 3174, 3 CFR, 1949–1953 Comp., p. 1004, 64 Stat. 1263; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 38 FR 26860, Sept. 26, 1973, unless otherwise noted.

RULES IN THIS SUBCHAPTER

§ 701.101 Scope of this subchapter and subchapter B.

(a) This subchapter contains the regulations governing the administration of the Longshore and Harbor Workers' Compensation Act, as amended (LHWCA), 33 U.S.C. 901 *et seq.*, except activities, pursuant to 33 U.S.C. 941, assigned to the Assistant Secretary of Labor for Occupational Safety and Health. It also contains the regulations governing the administration of the direct extensions of the LHWCA: the Defense Base Act (DBA), 42 U.S.C. 1651 *et seq.;* the Outer Continental Shelf Lands Act (OCSLA), 43 U.S.C. 1331; and the Nonappropriated Fund Instrumentalities Act (NFIA), 5 U.S.C. 8171 *et seq.*

(b) The regulations in this subchapter also apply to claims filed under the District of Columbia Workmen's Compensation Act (DCCA), 36 D.C. Code 501 *et seq.* That law applies to all claims for injuries or deaths based on employment events that occurred prior to July 26, 1982, the effective date of the District of Columbia Workers' Compensation Act, as amended (D.C. Code 32–1501 *et seq.*).

(c) The regulations governing the administration of the Black Lung Benefits Program are in subchapter B of this chapter.

[70 FR 43232, July 26, 2005]

§ 701.102 Organization of this subchapter.

Part 701 provides a general description of the regulations in this subchapter; sets forth information regarding the persons and agencies within the Department of Labor authorized by the Secretary of Labor to administer the Longshore and Harbor Workers' Compensation Act, its extensions and the regulations in this subchapter; and defines and clarifies use of specific terms in the several parts of this subchapter. Part 702 of this subchapter contains the general administrative regulations governing claims filed under the LHWCA. Part 703 of this subchapter

contains the regulations governing insurance carrier authorizations, insurance carrier security deposits, self-insurer authorizations, and certificates of compliance with the insurance regulations, as required by sections 32 and 37 of the LHWCA (33 U.S.C. 932, 937). Because the extensions of the LHWCA (*see* § 701.101) incorporate by reference nearly all the provisions of the LHWCA, the regulations in parts 701, 702 and 703 also apply to the administration of the extensions (DBA, DCCA, OCSLA, and NFIA), unless otherwise noted. Part 704 of this subchapter contains the exceptions to the general applicability of parts 702 and 703 for the DBA, the DCCA, the OCSLA, and the NFIA.

[70 FR 43232, July 26, 2005]

OFFICE OF WORKERS' COMPENSATION PROGRAMS

§ 701.201 Office of Workers' Compensation Programs.

The Office of Workers' Compensation Programs is responsible for administering the LHWCA and its extensions.

[75 FR 63380, Oct. 15, 2010]

§§ 701.202–701.203 [Reserved]

DEFINITIONS AND USE OF TERMS

§ 701.301 What do certain terms in this subchapter mean?

(a) As used in this subchapter, except where the context clearly indicates otherwise:

(1) *Act* or *LHWCA* means the Longshore and Harbor Workers' Compensation Act, as amended (33 U.S.C. 901 *et seq.*), and includes the provisions of any statutory extension of such Act (*see* § 701.101(a) and (b)) pursuant to which compensation on account of an injury is sought.

(2) *Secretary* means the Secretary of Labor, United States Department of Labor, or his authorized representative.

(3)–(4) [Reserved]

(5) *Office of Workers' Compensation Programs* or *OWCP* or *the Office* means the Office of Workers' Compensation Programs, referred to in § 701.201. The term *Office of Workmen's Compensation Programs* shall have the same meaning as *Office of Workers' Compensation Programs* (*see* 20 CFR 1.6(b)).

(6) *Director* means the Director of OWCP, or his or her authorized representative.

(7) *District Director* means a person appointed as provided in sections 39 and 40 of the LHWCA or his or her designee, authorized to perform functions with respect to the processing and determination of claims for compensation under the LHWCA and its extensions as provided therein and under this subchapter. The term District Director is substituted for the term *Deputy Commissioner* used in the statute. This substitution is for administrative purposes only and in no way affects the power or authority of the position as established in the statute.

(8) *Administrative Law Judge* means a person appointed as provided in 5 U.S.C. 3105 and subpart B of 5 CFR part 930, who is qualified to preside at hearings under 5 U.S.C. 557 and is empowered by the Secretary to conduct formal hearings whenever necessary in respect of any claim for compensation arising under the LHWCA and its extensions.

(9) *Chief Administrative Law Judge* means the Chief Judge of the Office of Administrative Law Judges, United States Department of Labor, whose office is at the location set forth in 29 CFR 18.3(a).

(10) *Board or Benefits Review Board* means the Benefits Review Board established by section 21 of the LHWCA (33 U.S.C. 921) as amended and constituted and functioning pursuant to the provisions of chapter VII of this title and Secretary of Labor's Order No. 38–72 (38 FR 90), whose office is at the location set forth in 20 CFR 802.204.

(11) *Department* means the United States Department of Labor.

(12) *Employer* includes any employer who may be obligated as an employer under the provisions of the LHWCA as amended or any of its extensions to pay and secure compensation as provided therein.

(13) *Carrier* means an insurance carrier or self-insurer meeting the requirements of section 32 of the LHWCA as amended and of this subchapter with respect to authorization to provide insurance fulfilling the obligation of an

employer to secure the payment of compensation due his employees under the LHWCA as amended or a statutory extension thereof.

(14) The terms *wages*, *national average weekly wage*, *injury*, *disability*, *death*, and *compensation* shall have the meanings set forth in section 2 of the LHWCA.

(15) *Claimant* includes any person claiming compensation or benefits under the provisions of the LHWCA as amended or a statutory extension thereof on account of the injury or death of an employee.

(b) The definitions contained in paragraph (a) of this section shall not be considered to derogate from any definitions or delimitations of terms in the LHWCA as amended or any of its statutory extensions in any case where such statutory definitions or delimitations would be applicable.

(c) As used in this subchapter, the singular includes plural and the masculine includes the feminine.

[38 FR 26860, Sept. 26, 1973, as amended at 42 FR 3848, Jan. 21, 1977; 50 FR 391, Jan. 3, 1985; 51 FR 4281, Feb. 3, 1986; 55 FR 28606, July 12, 1990; 70 FR 43233, July 26, 2005; 76 FR 82127, Dec. 30, 2011; 77 FR 37286, June 21, 2012]

§ 701.302 Who is an employee?

(a) *Employee* means any person engaged in maritime employment, including:

(1) Any longshore worker or other person engaged in longshoring operations;

(2) Any harbor worker, including a ship repairer, shipbuilder and shipbreaker; and

(3) Any other individual to whom an injury may be the basis for a compensation claim under the LHWCA as amended, or any of its extensions;

(b) The term does not include:

(1) A master or member of a crew of any vessel; or

(2) Any person engaged by a master to load or unload or repair any small vessel under eighteen tons net.

(c) Nor does this term include the following individuals (whether or not the injury occurs over the navigable waters of the United States) where it is first determined that they are covered by a state workers' compensation act:

(1) Individuals employed exclusively to perform office clerical, secretarial, security, or data processing work (but not longshore cargo checkers and cargo clerks);

(2) Individuals employed by a club (meaning a social or fraternal organization whether profit or nonprofit), camp, recreational operation (meaning any recreational activity, including but not limited to scuba diving, commercial rafting, canoeing or boating activities operated for pleasure of owners, members of a club or organization, or renting, leasing or chartering equipment to another for the latter's pleasure), restaurant, museum or retail outlet;

(3) Individuals employed by a marina, provided they are not engaged in its construction, replacement or expansion, except for routine maintenance such as cleaning, painting, trash removal, housekeeping and small repairs;

(4) Employees of suppliers, vendors and transporters temporarily doing business on the premises of a covered employer, provided they are not performing work normally performed by employees of the covered employer;

(5) Aquaculture workers, meaning those employed by commercial enterprises involved in the controlled cultivation and harvest of aquatic plants and animals, including the cleaning, processing or canning of fish and fish products, the cultivation and harvesting of shellfish, and the controlled growing and harvesting of other aquatic species; or

(6) Individuals employed to build any recreational vessel under sixty-five feet in length, or individuals employed to repair any recreational vessel, or to dismantle any part of a recreational vessel in connection with the repair of such vessel. For purposes of this paragraph, the special rules set forth at §§ 701.501 through 701.505 apply.

[76 FR 82127, Dec. 30, 2011]

COVERAGE UNDER STATE COMPENSATION PROGRAMS

§ 701.401 Coverage under state compensation programs.

(a) Exclusions from the definition of ''employee'' under § 701.301(a)(12), and the employees of small vessel facilities

otherwise covered which are exempted from coverage under § 702.171, are dependent upon coverage under a state workers' compensation program. For these purposes, a worker or dependent must first claim compensation under the appropriate state program and receive a final decision on the merits of the claim, denying coverage, before any claim may be filed under this Act.

(b) The intent of the Act is that state law will apply to those categories of employees if it otherwise would. Accordingly, not withstanding any contrary state law, claims by any of the categories of workers excluded under § 701.301 or 702.171 must be made to and processed by the state and a merit decision denying coverage on jurisdictional grounds must be made before coverage or benefits under the Act may be sought.

(c) The time for filing notice and claim under the Act (see subpart B of part 702) does not begin to run for purposes of claims by those workers or dependents described in § 701.301(a)(12) and § 702.171, until a final adverse decision denying coverage under a state compensation act is received.

[50 FR 392, Jan. 3, 1985]

SPECIAL RULES FOR THE RECREATIONAL VESSEL EXCLUSION FROM THE DEFINITION OF ''EMPLOYEE''

§ 701.501 What is a recreational vessel?

(a) *Recreational vessel* means a vessel—

(1) Being manufactured or operated primarily for pleasure; or

(2) Leased, rented, or chartered to another for the latter's pleasure.

(b) In applying the definition in paragraph (a) of this section, the following rules apply:

(1) A vessel being *manufactured* or *built*, or being repaired under warranty by its manufacturer or builder, is a *recreational vessel* if the vessel appears intended, based on its design and construction, to be for ultimate recreational uses. The manufacturer or builder bears the burden of establishing that a vessel is recreational under this standard.

(2) A vessel being *repaired, dismantled for repair*, or *dismantled at the end of its life* is not a *recreational vessel* if the vessel had been operating, around the time of its repair or dismantling, in one or more of the following categories on more than an infrequent basis—

(A) ''Passenger vessel'' as defined by 46 U.S.C. 2101(22);

(B) ''Small passenger vessel'' as defined by 46 U.S.C. 2101(35);

(C) ''Uninspected passenger vessel'' as defined by 46 U.S.C. 2101(42);

(D) Vessel routinely engaged in ''commercial service'' as defined by 46 U.S.C. 2101(5); or

(E) Vessel that routinely carries ''passengers for hire'' as defined by 46 U.S.C. 2101(21a).

(3) Notwithstanding paragraph (b)(2) of this section, a vessel will be deemed recreational if it is a *public vessel, i.e.*, a vessel owned or bareboat-chartered and operated by the United States, or by a State or political subdivision thereof, at the time of repair, dismantling for repair, or dismantling, provided that such vessel shares elements of design and construction with traditional recreational vessels and is not normally engaged in a military, commercial or traditionally commercial undertaking.

(c) All subsequent amendments to the statutes referenced in paragraph (b)(2) of this section and the regulations implementing those provisions in Title 46 of the Code of Federal Regulations will apply when determining whether a vessel is recreational.

[76 FR 82128, Dec. 30, 2011]

§ 701.502 What types of work may exclude a recreational-vessel worker from the definition of "employee"?

(a) An individual who works on recreational vessels may be excluded from the definition of ''employee'' when:

(1) The individual's date of injury is before February 17, 2009, the injury is covered under a State workers' compensation law, and the individual is employed to:

(i) Build any recreational vessel under sixty-five feet in length; or

(ii) Repair any recreational vessel under sixty-five feet in length; or

(iii) Dismantle any recreational vessel under sixty-five feet in length.

(2) The individual's date of injury is on or after February 17, 2009, the injury

is covered under a State workers' compensation law, and the individual is employed to:

(i) Build any recreational vessel under sixty-five feet in length; or

(ii) Repair any recreational vessel; or

(iii) Dismantle any recreational vessel to repair it.

(b) In applying paragraph (a) of this section, the following principles apply:

(1) ''Length'' means a straight line measurement of the overall length from the foremost part of the vessel to the aftmost part of the vessel, measured parallel to the center line. The measurement must be from end to end over the deck, excluding sheer. Bow sprits, bumpkins, rudders, outboard motor brackets, handles, and other similar fittings, attachments, and extensions are not included in the measurement.

(2) ''Repair'' means any repair of a vessel including installations, painting and maintenance work. Repair does not include alterations or conversions that render the vessel a non-recreational vessel under § 701.501. For example, a worker who installs equipment on a private yacht to convert it to a passenger-carrying whale-watching vessel is not employed to ''repair'' a recreational vessel. Repair also does not include alterations or conversions that render a non-recreational vessel recreational under § 701.501.

(3) ''Dismantle'' means dismantling any part of a vessel to complete a repair but does not include dismantling any part of a vessel to complete alterations or conversions that render the vessel a non-recreational vessel under § 701.501, or render the vessel recreational under § 701.501, or, if the date of injury is on or after February 17, 2009, to scrap or dispose of the vessel at the end of the vessel's life.

[76 FR 82128, Dec. 30, 2011]

§ 701.503 Did the American Recovery and Reinvestment Act of 2009 amend the recreational vessel exclusion?

Yes. The amended exclusion was effective February 17, 2009, the effective date of the American Recovery and Reinvestment Act of 2009.

[76 FR 82128, Dec. 30, 2011]

§ 701.504 When does the recreational vessel exclusion in the American Recovery and Reinvestment Act of 2009 apply?

(a) *Date of injury*. Whether the amended version applies depends on the date of the injury for which compensation is claimed. The following rules apply to determining the date of injury:

(1) *Traumatic injury*. If the individual claims compensation for a traumatic injury, the date of injury is the date the employee suffered harm. For example, if the individual injures an arm or leg in the course of his or her employment, the date of injury is the date on which the individual was hurt.

(2) *Occupational disease or infection*. Occupational illnesses and infections generally involve delayed onset of symptoms following exposure to a harmful workplace substance or condition. If the individual claims compensation for an occupational illness or infection, the date of injury is the date the individual was exposed to the substance or condition.

(3) *Hearing loss*. If the individual claims compensation for hearing loss, the date of injury is the date the individual was exposed to harmful workplace noise or other stimulus that is capable of causing hearing loss.

(4) *Death-benefit claims*. If the individual claims compensation for an employee's death, the date of injury is the date of the workplace event or incident that caused, hastened, or contributed to the death.

(5) *Cumulative trauma*. If the individual claims compensation for cumulative trauma, in which multiple traumas contribute to an overall medical condition, such as a neck condition resulting from repetitive motion, the date of injury is any date on which a workplace trauma worsened the individual's condition. A workplace event will not be deemed a contributing trauma if a corresponding worsening of the condition is due solely to its natural progression, rather than the workplace event.

(b) If the date of injury is before February 17, 2009, the individual's entitlement is governed by section 2(3)(F) as it existed prior to the 2009 amendment.

(c) If the date of injury is on or after February 17, 2009, the individual's entitlement is governed by the 2009 amendment to section 2(3)(F).

[76 FR 82128, Dec. 30, 2011]

§ 701.505 May an employer stop paying benefits awarded before February 17, 2009 if the employee would now fall within the exclusion?

No. If an individual was awarded compensation for an injury occurring before February 17, 2009, the employer must still pay all benefits awarded, including disability compensation and medical benefits, even if the employee would be excluded from coverage under the amended exclusion.

[76 FR 82129, Dec. 30, 2011]

PART 702—ADMINISTRATION AND PROCEDURE

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AUTHORITY: 5 U.S.C. 301, 8171 *et seq.;* 33 U.S.C. 939; 36 D.C. Code 501 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1333; Reorganization Plan No. 6 of 1950, 15 FR 3174, 3 CFR 1949–1953, Comp., p. 1004, 64 Stat. 1263; Secretary's Order 10–2009, 74 FR 58834.

AUTHORITY: 5 U.S.C. 301, and 8171 *et seq.;* 33 U.S.C. 901 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1333; Reorganization Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 38 FR 26861, Sept. 26, 1973, unless otherwise noted.

Subpart A—General Provisions

ADMINISTRATION

§ 702.101 Exchange of documents and information.

(a) Except as otherwise required by the regulations in this subchapter, all documents and information sent to OWCP under this subchapter must be submitted—

(1) In hard copy by postal mail, commercial delivery service (such as Federal Express or United Parcel Service), or hand delivery;

(2) Electronically through an OWCP-authorized system; or

(3) As otherwise allowed by OWCP.

(b) Except as otherwise required by the regulations in this subchapter, all documents and information sent under

this subchapter by OWCP to parties and their representatives or from any party or representative to another party or representative must be sent—

(1) In hard copy by postal mail, commercial delivery service (such as Federal Express or United Parcel Service), or hand delivery;

(2) Electronically by a reliable electronic method if the receiving party or representative agrees in writing to receive documents and information by that method; or

(3) Electronically through an OWCP-authorized system that provides service of documents on the parties and their representatives.

(c) Reliable electronic methods for delivering documents include, but are not limited to, email, facsimile and web portal.

(d) Any party or representative may revoke his or her agreement to receive documents and information electronically by giving written notice to OWCP, the party, or the representative with whom he or she had agreed to receive documents and information electronically, as appropriate.

(e) The provisions in paragraphs (a) through (d) of this section apply when parties are directed by the regulations in this subchapter to: Advise; apply; approve; authorize; demand; file; forward; furnish; give; give notice; inform; issue; make; notice, notify; provide; publish; receive; recommend; refer; release; report; request; respond; return; send; serve; service; submit; or transmit.

(f) Any reference in this subchapter to an application, copy, filing, form, letter, written notice, or written request includes both hard-copy and electronic documents.

(g) Any requirement in this subchapter that a document or information be submitted in writing, or that it be signed, executed, or certified does not preclude its submission or exchange electronically.

(h) Any reference in this subchapter to transmitting information to an entity's address may include that entity's electronic address or electronic portal.

(i) Any requirement in this subchapter that a document or information—

(1) Be sent to a specific district director means that the document or information should be sent to the physical or electronic address provided by OWCP for that district director; and

(2) Be filed by a district director in his or her office means that the document or information may be filed in a physical or electronic location specified by OWCP for that district director.

[80 FR 12928, Mar. 12, 2015]

§ 702.102 Establishment and modification of compensation districts, establishment of suboffices and jurisdictional areas.

(a) The Director has, pursuant to section 39(b) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 939(b), established compensation districts as required for improved administration or as otherwise determined by the Director (see 51 FR 4282, Feb. 3, 1986). The boundaries of the compensation districts may be modified at any time, and the Director will notify all interested parties directly of the modifications.

(b) As administrative exigencies from time to time may require, the Director may, by administrative order, establish special areas outside the continental United States, Alaska, and Hawaii, or change or modify any areas so established, notwithstanding their inclusion within an established compensation district. Such areas will be designated ''jurisdictional areas.'' The Director will also designate which of his district directors will be in charge thereof.

(c) To further aid in the efficient administration of the OWCP, the Director may from time to time establish suboffices within compensation districts or jurisdictional areas, and will designate a person to be in charge thereof.

[80 FR 12928, Mar. 12, 2015]

§ 702.103 Effect of establishment of suboffices and jurisdictional areas.

Whenever the Director establishes a suboffice or jurisdictional area, those reports, records, or other documents with respect to processing of claims that are required to be filed with the district director of the compensation district in which the injury or death occurred, may instead be required to be

filed with the suboffice, or office established for the jurisdictional area.

[80 FR 12928, Mar. 12, 2015

§ 702.104 Transfer of individual case file.

(a) At any time after a claim is filed, the district director having jurisdiction thereof may, with the prior or subsequent approval of the Director, transfer such case to the district director in another compensation district for the purpose of making an investigation, ordering medical examinations, or taking such other action as may be necessary or appropriate to further develop the claim. If, after filing a claim, the claimant moves to another compensation district, the district director may, upon request by the claimant or the employer and with the approval of the Director, transfer the case to such other compensation district.

(b) The district director making the transfer may by letter or memorandum to the district director to whom the case is transferred give advice, comments, suggestions, or directions if appropriate to the particular case. All interested parties will be advised of the transfer.

[42 FR 45301, Sept. 9, 1977, as amended at 80 FR 12928, Mar. 12, 2015]

§ 702.105 Use of the title District Director in place of Deputy Commissioner.

Wherever the statute refers to Deputy Commissioner, these regulations have substituted the term District Director. The substitution is purely an administrative one, and in no way effects the authority of or the powers granted and responsibilities imposed by the statute on that position.

[55 FR 28606, July 12, 1990]

RECORDS

§ 702.111 Employer's records.

Every employer shall maintain adequate records of injury sustained by employees while in his employ, and which shall also contain information of disease, other impairments or disabilities, or death relating to said injury. Such records shall be available for inspection by the OWCP or by any State authority. Records required by this section shall be retained by the employer for three years following the date of injury; this applies to records for lost-time and no-lost-time injuries.

(Approved by the Office of Management and Budget under control number 1215–0160)

(Pub. L. No. 96–511, 94 Stat. 2812 (44 U.S.C. 3501 *et seq.*))

[38 FR 26861, Sept. 26, 1973, as amended at 47 FR 145, Jan. 5, 1982; 50 FR 393, Jan. 3, 1985]

§ 702.112 Records of the OWCP.

All reports, records, or other documents filed with the OWCP with respect to claims are the records of the OWCP. The Director shall be the official custodian of those records maintained by the OWCP at its national office, and the district director shall be the official custodian of those records maintained at the headquarters office in each compensation district.

§ 702.113 Inspection of records of the OWCP.

Any party in interest may be permitted to examine the record of the case in which he is interested. The official custodian of the record sought to be inspected shall permit or deny inspection in accordance with the Department of Labor's regulations pertaining thereto (see 29 CFR part 70). The original record in any such case shall not be removed from the office of the custodian for such inspection. The custodian may, in his discretion, deny inspection of any record or part thereof which is of a character specified in 5 U.S.C. 552(b) if in his opinion such inspection may result in damage, harm, or harassment to the beneficiary or to any other person. For special provisions concerning release of information regarding injured employees undergoing vocational rehabilitation, see § 702.508.

§ 702.114 Copying of records of OWCP.

Any party in interest may request copies of records he has been permitted to inspect. Such requests shall be addressed to the official custodian of the records sought to be copied. The official custodian shall provide the requested copies under the terms and conditions specified in the Department

of Labor's regulations relating thereto (see 29 CFR part 70).

FORMS

§ 702.121 Forms.

The Director may from time to time prescribe, and require the use of, forms for the reporting of any information required to be reported by the regulations in this subchapter, or by the Act or any of its extensions.

REPRESENTATION

§ 702.131 Representation of parties in interest.

(a) Claimants, employers and insurance carriers may be represented in any proceeding under the Act by an attorney or other person previously authorized in writing by such claimant, employer or carrier to so act.

(b) The Secretary shall annually publish a list of individuals who are disqualified from representing claimants under the Act. Individuals on this list are not authorized to represent claimants under the Act subject to the provision of section 31(b)(2)(C) of the Act, 33 U.S.C. 931(b)(2)(C), and they shall not have their representation fee approved as provided in section 28(e), 33 U.S.C. 928(e).

(c) Individuals shall be included on the list mentioned in (b) if the Secretary determines, after proceedings under §§ 702.432(b) through 702.434, that such individual:

(1) Has been convicted (without regard to pending appeal) of any crime in connection with the representation of a claimant under this Act or any workers' compensation statute;

(2) Has engaged in fraud in connection with the presentation of a claim under this or any workers' compensation statute, including, but not limited to, knowingly making false representations, concealing or attempting to conceal material facts with respect to a claim, or soliciting or otherwise procuring false testimony;

(3) Has been prohibited from representing claimants before any other workers' compensation agency for reasons of professional misconduct which are similar in nature to those which would be grounds for disqualification under this section; or

(4) Has accepted fees for representing claimants under the Act which were not approved, or which were in excess of the amount approved pursuant to section 28 of the Act, 33 U.S.C. 928.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 394, Jan. 3, 1985]

§ 702.132 Fees for services.

(a) Any person seeking a fee for services performed on behalf of a claimant with respect to claims filed under the Act shall make application therefor to the district director, administrative law judge, Board, or court, as the case may be, before whom the services were performed (See 33 U.S.C. 928(c)). The application shall be filed and serviced upon the other parties within the time limits specified by such district director, administrative law judge, Board, or court. The application shall be supported by a complete statement of the extent and character of the necessary work done, described with particularity as to the professional status (e.g., attorney, paralegal, law clerk, or other person assisting an attorney) of each person performing such work, the normal billing rate for each such person, and the hours devoted by each such person to each category of work. Any fee approved shall be reasonably commensurate with the necessary work done and shall take into account the quality of the representation, the complexity of the legal issues involved, and the amount of benefits awarded, and when the fee is to be assessed against the claimant, shall also take into account the financial circumstances of the claimant. No contract pertaining to the amount of a fee shall be recognized.

(b) No fee shall be approved for a representative whose name appears on the Secretary's list of disqualified representatives under § 702.131(b).

(c) Where fees are included in a settlement agreement submitted under § 702.241, *et seq.* approval of that agreement shall be deemed approval of attorney fees for purposes of this subsection for work performed before the Administrative Law Judge or district director approving the settlement.

[50 FR 394, Jan. 3, 1985]

§ 702.133 Unapproved fees; solicitation of claimants; penalties.

Under the provisions of section 28(e) of the Act, 33 U.S.C. 928(e), any person who receives any fees, other consideration, or any gratuity on account of services rendered as a representative of a claimant, unless such consideration or gratuity is approved under § 702.132, or who makes it a business to solicit employment for an attorney, or for himself in respect of any claim under the Act, shall upon conviction thereof, for each offense be punished by a fine of not more than $1,000 or by imprisonment for not more than 1 year, or by both fine and imprisonment.

§ 702.134 Payment of claimant's attorney's fees in disputed claims.

(a) If the employer or carrier declines to pay any compensation on or before the 30th day after receiving written notice from the district director of a claim for compensation having been filed, on the ground that there is no liability for compensation within the provisions of this Act, and the person seeking benefits shall thereafter have utilized the services of an attorney at law in the successful prosecution of his claim, there shall be awarded, in addition to the award of compensation, in a compensation order, a reasonable attorney's fee against the employer or carrier in an amount approved by the person, administrative body or court before whom the service was performed, which shall be paid directly by the employer or carrier to the attorney for the claimant in a lump sum after the compensation order becomes final (Act, section 28(a)).

(b) If the employer or carrier pays or tenders payment of compensation without an award pursuant to § 702.231 and section 14 (a) and (b) of this Act, and thereafter a controversy develops over the amount of additional compensation, if any, to which the employee may be entitled, the district director, administrative law judge, or Board shall set the matter for an informal conference and following such conference the district director, administrative law judge, or Board shall recommend in writing a disposition of the controversy. If the employer or carrier refuses to accept such written recommendation, within 14 days after its receipt by them, they shall pay or tender to the employee in writing the additional compensation, if any, to which they believe the employee is entitled. If the employee refuses to accept such payment or tender of compensation, and thereafter utilizes the services of an attorney at law, and if the compensation thereafter awarded is greater than the amount paid or tendered by the employer or carrier, a reasonable attorney's fee based solely upon the difference between the amount awarded and the amount tendered or paid shall be awarded in addition to the amount of compensation. The foregoing sentence shall not apply if the controversy relates to degree or length of disability, and if the employer or carrier offers to submit the case for evaluation by physicians employed or selected by the district director, as authorized by section 7(e) of the Act and § 702.408, and offers to tender an amount of compensation based upon the degree or length of disability found by the independent medical report at such time as an evaluation of disability can be made. If the claimant is successful in review proceedings before the Board or court in any such case an award may be made in favor of the claimant and against the employer or carrier for a reasonable attorney's fee for claimant's counsel in accord with the above provisions. In all other cases any claim for legal services shall not be assessed against the employer or carrier (see Act, section 28(b)).

§ 702.135 Payment of claimant's witness fees and mileage in disputed claims.

In cases where an attorney's fee is awarded against an employer or carrier there may be further assessed against such employer or carrier as costs, fees and mileage for necessary witnesses attending the hearing at the instance of claimant. Both the necessity for the witness and the reasonableness of the fees of expert witnesses must be approved by the hearing officer, the Board, or the court, as the case may be. The amounts awarded against an employer or carrier as attorney's fees, costs, fees and mileage for witnesses

shall not in any respect affect or diminish the compensation payable under this Act (see Act, section 28 (d)).

INFORMATION AND ASSISTANCE FOR CLAIMANTS

§ 702.136 Requests for information and assistance.

(a) *General assistance.* The Director shall, upon request, provide persons covered by the Act with information and assistance relating to the Act's coverage and compensation and the procedures for obtaining such compensation including assistance in processing a claim.

(b) *Legal assistance to claimants.* The Secretary may, upon request, provide a claimant with legal assistance in processing a claim under the Act. Such assistance may be made available to a claimant in the discretion of the Solicitor of Labor or his designee at any time prior to or during which the claim is being processed and shall be furnished without charge to the claimant. Legal representation of the claimant in adjudicatory proceedings may be furnished in cases in which the Secretary's interest in the case is not adverse to that of the claimant.

(c) *Other assistance.* The district directors and their staff, as designees of the Director, shall promptly and fully comply with the request of a claimant receiving compensation for information about, and assistance in obtaining, medical, manpower, and vocational rehabilitation services (see also subparts D and E of this part).

COMMUTATION OF PAYMENTS AND SPECIAL FUND

§ 702.142 Commutation of payments; aliens not residents or about to become nonresidents.

(a) Pursuant to section 9(g) of the Act, 33 U.S.C. 909(g), compensation paid to aliens not residents, or about to become nonresidents, of the United States or Canada shall be in the same amount as provided for residents except that dependents in any foreign country shall be limited to surviving spouse and child or children, or if there be no surviving spouse or child or children, to surviving father or mother whom the employee has supported, either wholly or in part, for the period of 1 year prior to the date of injury, and except that the Director, OWCP, may, at his option, or upon the application of the insurance carrier he shall, commute all future installments of compensation to be paid to such aliens by paying or causing to be paid to them one-half of the commuted amount of such future installments of compensation as determined by the Director.

(b) Applications for commutation under this section shall be made in writing to the district director having jurisdiction, and forwarded by the district director to the Director, for final action.

(c) Applications for commutations shall be made effective, if approved by the Director, on the date received by the district director, or on a later date if shown to be appropriate on the application.

(d) Commutations shall not be made with respect to a person journeying abroad for a visit who has previously declared an intention to return and has stated a time for returning, nor shall any commutation be made except upon the basis of a compensation order fixing the right of the beneficiary to compensation.

[50 FR 394, Jan. 3, 1985]

§ 702.143 Establishment of special fund.

Congress, by section 44 of the Act, 33 U.S.C. 944, established in the U.S. Treasury a special fund, to be administered by the Secretary. The Treasurer of the United States is the custodian of such fund, and all monies and securities in such fund shall be held in trust by the Treasurer and shall not be money or property of the United States. The Treasurer shall make disbursements from such funds only upon the order of the Director, OWCP, as delegatee of the Secretary. The Act requires that the Treasurer give bond, in an amount to be fixed and with securities to be approved by the Secretary of the Treasury and the Comptroller General of the United States, conditioned upon the faithful performance of his duty as custodian of such fund.

§ 702.144 Purpose of the special fund.

This special fund was established to give effect to a congressional policy determination that, under certain circumstances, the employer of a particular employee should not be required to bear the entire burden of paying for the compensation benefits due that employee under the Act. Instead, a substantial portion of such burden should be borne by the industry generally. Section 702.145 describes this special circumstance under which the particular employer is relieved of some of his burden. Section 702.146 describes the manner and circumstances of the input into the fund.

§ 702.145 Use of the special fund.

(a) *Under section 10 of the Act.* This section provides for initial and subsequent annual adjustments in compensation and continuing payments to beneficiaries in cases of permanent total disability or death which commenced or occurred prior to enactment of the 1972 Amendments to this Act (Pub. L. 92–576, approved Oct. 27, 1972). At the discretion of the Director, such payments may be paid directly by him to eligible beneficiaries as the obligation accrues, one-half from the special fund and one-half from appropriations, or he may require insurance carriers or self-insured employers already making payments to such beneficiaries to pay such additional compensation as the amended Act requires. In the latter case such carriers and self-insurers shall be reimbursed by the Director for such additional amounts paid, in the proportion of one-half the amount from the special fund and one-half the amount from appropriations. To obtain reimbursement, the carriers and self-insurers shall submit claims for payments made by them during previous periods at intervals of not less than 6 months. A form has been prescribed for such purpose and shall be used. No administrative claims service expense incurred by the carrier or self-insurer shall be included in the claim and no such expense shall be allowed. The amounts reimbursed to such carrier or self-insurer shall be limited to amounts actually due and previously paid to beneficiaries.

(b) Under section 8(f) of the Act (Second Injuries). In any case in which an employee having an existing permanent partial disability suffers injury, the employer shall provide compensation for such disability as is found to be attributable to that injury based upon the average weekly wages of the employee at the time of injury. If, following an injury falling within the provisions of section 8(c)(1)–(20), the employee with the pre-existing permanent partial disability becomes permanently and totally disabled after the second injury, but such total disability is found not to be due solely to his second injury, the employer (or carrier) shall be liable for compensation as provided by the provisions of section 8(c)(1)–(20) of the Act, 33 U.S.C. 908(c)(1)–(20) or for 104 weeks, whichever is greater. However, if the injury is a loss of hearing covered by section 8(c)(13), 33 U.S.C. 908(c)(13), the liability shall be the lesser of these periods. In all other cases of a second injury causing permanent total disability (or death), wherein it is found that such disability (or death) is not due solely to the second injury, and wherein the employee had a pre-existing permanent partial disability, the employer (or carrier) shall first pay compensation under section 8(b) or (e) of the Act, 33 U.S.C. 908(b) or (e), if any is payable thereunder, and shall then pay 104 weeks compensation for such total disability or death, and none otherwise. If the second injury results in permanent partial disability, and if such disability is compensable under section 8(c)(1)–(20) of the Act, 33 U.S.C. 908(c)(1)–(20), but the disability so compensable did not result solely from such second injury, and the disability so compensable is materially and substantially greater than that which would have resulted from the second injury alone, then the employer (or carrier) shall only be liable for the amount of compensation provided for in section 8(c)(1)–(20) that is attributable to such second injury, or for 104 weeks, whichever is greater. However, if the injury is a loss of hearing covered by section 8(c)(13), 33 U.S.C. 908(c)(13), the liability shall be the lesser of these periods. In all other cases wherein the employee is permanently

and partially disabled following a second injury, and wherein such disability is not attributable solely to that second injury, and wherein such disability is materially and substantially greater than that which would have resulted from the second injury alone, and wherein such disability following the second injury is not compensable under section 8(c)(1)–(20) of the Act, then the employer (or carrier) shall be liable for such compensation as may be appropriate under section 8(b) or (e) of the Act, 33 U.S.C. 908(b) or (e), if any, to be followed by a payment of compensation for 104 weeks, and none other. The term ''compensation'' herein means money benefits only, and does not include medical benefits. The procedure for determining the extent of the employer's (or carrier's) liability under this paragraph shall be as provided for in the adjudication of claims in subpart C of this part 702. Thereafter, upon cessation of payments which the employer is required to make under this paragraph, if any additional compensation is payable in the case, the district director shall forward such case to the Director for consideration of an award to the person or persons entitled thereto out of the special fund. Any such award from the special fund shall be by order of the Director or Acting Director.

(c) *Under sections 8(g) and 39(c)(2) of the Act.* These sections, 33 U.S.C. 908(g) and 939(c)(2), respectively, provide for vocational rehabilitation of disabled employees, and authorize, under appropriate circumstances, a maintenance allowance for the employee (not to exceed $25 a week) in additional to other compensation benefits otherwise payable for his injury-related disability. Awards under these sections are made from the special fund upon order of the Director or his designee. The district directors may be required to make investigations with respect to any case and forward to the Director their recommendations as to the propriety and need for such maintenance.

(d) *Under section 39(c)(2) of the Act.* In addition to the maintenance allowance for the employee discussed in paragraph (c) of this section, the Director is further authorized to use the fund in such amounts as may be necessary to procure the vocational training services.

(e) *Under section 7(e) of the Act.* This provision, 33 U.S.C. 907(e), authorizes payment by the Director from the special fund for special medical examinations, *i.e.*, those obtained from impartial specialists to resolve disputes, when such special examinations are deemed necessary under that statutory provision. The Director has the discretionary power, however, to charge the cost of such examination to the insurance carrier or self-insured employer.

(f) *Under section 18(b) of the Act.* This section, 33 U.S.C. 918(b), provides a source for payment of compensation benefits in cases where the employer is insolvent, or other circumstances preclude the payment of benefits due in any case. In such situations, the district director shall forward the case to the Director for consideration of an award from the special fund, together with evidence with respect to the employer's insolvency or other reasons for nonpayment of benefits due. Benefits, as herein used, means medical care or supplies within the meaning of section 7 of the Act, 33 U.S.C. 907, and subpart D of this part 702, as well as monetary benefits. Upon receipt of the case, the Director shall promptly determine whether an award from the special fund is appropriate and advisable in the case, having due regard for all other current commitments from the special fund. If such an award is made, the employer shall be liable for the repayment into the fund of the amounts paid therefrom, as provided in 33 U.S.C. 918(b).

(The information collection requirements contained in paragraph (a) were approved by the Office of Management and Budget under control number 1215–0065. The information collection requirements contained in paragraph (b) were approved by the Office of Management and Budget under control number 1215–0073)

(Pub. L. No. 96–511)

[38 FR 26861, Sept. 26, 1973, as amended at 49 FR 18294, Apr. 30, 1984; 51 FR 4282, Feb. 3, 1986]

§ 702.146 Source of the special fund.

(a) All amounts collected as fines and penalties under the several provisions

of the Act shall be paid into the special fund (33 U.S.C. 44(c)(3)).

(b) Whenever an employee dies under circumstances creating a liability on an employer to pay death benefits to the employee's beneficiaries, and whenever there are no such beneficiaries entitled to such payments, the employer shall pay $5,000 into the special fund (Act, section 44(c)(1)). In such cases, the compensation order entered in the case shall specifically find that there is such liability and that there are no beneficiaries entitled to death benefits, and shall order payment by the employer into the fund. Compensation orders shall be made and filed in accordance with the regulations in subpart C of this part 702, except that for this purpose the district director settling the case under § 702.315 shall formalize the memorandum of conference in a compensation order, and shall file such order as provided for in § 702.349.

(c) The Director annually shall assess an amount against insurance carriers and self-insured employers authorized under the Act and part 703 of this subchapter to replenish the fund. That total amount to be charged all carriers and self-insurers to be assessed shall be based upon an estimate of the probable expenses of the fund during the calendar year. The assessment against each carrier and self-insurer shall be based upon (1) the ratio of the amount each paid during the prior calendar year for compensation in relation to the amount all such carriers of self-insurers paid during that period for compensation, and (2) the ratio of the amount of payments made by the special fund for all cases being paid under section 8(f) of the Act, 33 U.S.C. 908(f), during the preceding calendar year which are attributable to the carrier or self-insurer in relation to the total of such payments during such year attributable to all carriers and self-insurers. The resulting sum of the percentages from paragraphs (c) (1) and (2) of this section will be divided by two, and the resulting percentage multiplied by the probable expenses of the fund. The Director may, in his or her discretion, condition continuance or renewal of authorization under part 703 upon prompt payment of the assessment. However, no action suspending or revoking such authorization shall be taken without affording such carrier or self-insurer a hearing before the Director or his/her designee.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 395, Jan. 3, 1985; 51 FR 4282, Feb. 3, 1986]

§ 702.147 Enforcement of special fund provisions.

(a) As provided in section 44(d)(1) of the Act, 33 U.S.C. 944(d)(1), for the purpose of making rules, regulations, and determinations under the special fund provisions in section 44 and for providing enforcement thereof, the Director may investigate and gather appropriate data from each carrier and self-insured employer, and may enter and inspect such places and records (and make such transcriptions of records), question such employees, and investigate such facts, conditions, practices, or other matters as he may deem necessary or appropriate. The Director may require the employer to have audits performed of claims activity relating to this Act. The Director may also require detailed reports of payments made under the Act, and of estimated future liabilities under the Act, from any or all carriers of self-insurers. The Director may require that such reports be certified and verified in whatever manner is considered appropriate.

(b) Pursuant to section 44(d)(3) of the Act, 33 U.S.C. 944(d)(3), for the purpose of any hearing or investigation related to determinations or the enforcement of the provisions of section 44 with respect to the special fund, the provisions of 15 U.S.C. 49 and 50 as amended (the Federal Trade Commission Act provisions relating to attendance of witnesses and the production of books, papers, and documents) are made applicable to the jurisdiction, powers, and duties of the Director, OWCP, as the Secretary's delegatee.

(c) Civil penalties and unpaid assessments shall be collected by civil suits brought by and in the name of the Secretary.

(Approved by the Office of Management and Budget under control number 1215–0160)

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 395, Jan. 3, 1985]

§ 702.148 Insurance carriers' and self-insured employers' responsibilities.

(a) Each carrier and self-insured employer shall make, keep, and preserve such records, and make such reports and provide such additional information as the Director prescribes or orders, which he considers necessary or appropriate to effectively carry out his responsibilities.

(b) Consistent with their greater direct liability stemming from the amended assessment formula, employers and insurance carriers are given the authority to monitor their claims in the special fund as outlined in paragraph (c) of this section. For purposes of monitoring these claims, employers and insurance carriers remain parties in interest to the claim and are allowed access to all records relating to the claim. Similarly, employers and insurance carriers can initiate proceeding to modify an award of compensation after the special fund has assumed the liability to pay benefits. It is intended that employers and insurance carriers have neither a greater nor a lesser responsibility in this new role that they not have with regard to cases that remain their sole liability. (See § 702.373(d).)

(c) An employer or insurance carrier may conduct any reasonable investigation regarding cases placed into the special fund by the employer or insurance carrier. Such investigation may include, but shall not be limited to, a semi-annual request for earnings information pursuant to section 8(j) of the Act, 33 U.S.C. 908(j) (See § 702.285) periodic medical examinations, vocational rehabilitation evaluations, and requests for any additional information needed to effectively monitor such a case.

(Approved by the Office of Management and Budget under control number 1215–0118)

(Pub. L. No. 96–511, 94 Stat. 2812 (44 U.S.C. 3501 *et seq.*))

[38 FR 26861, Sept. 26, 1973, as amended at 47 FR 145, Jan. 5, 1982; 50 FR 395, Jan. 3, 1985]

LIENS ON COMPENSATION

§ 702.161 Liens against assets of insurance carriers and employers.

Where payments have been made from the special fund pursuant to section 18(b) of the Act, 33 U.S.C. 918(b) and § 704.145(f) the Secretary of Labor shall, for the benefit of the fund, be subrogated to all the rights of the person receiving such payments. The Secretary may institute proceedings under either section 18 or 21(d) of the Act, 33 U.S.C. 918 or 921(d), or both, to recover the amount expended by the fund or so much as in the judgement of the Secretary is possible, or the Secretary may settle or compromise any such claim.

[50 FR 395, Jan. 3, 1985]

§ 702.162 Liens on compensation authorized under special circumstances.

(a) Pursuant to section 17 of the Act, 33 U.S.C. 917, when a trust fund which complies with section 302(c) of the Labor-Management Relations Act of 1947, 29 U.S.C. 186(c) [LMRA], established pursuant to a collective bargaining agreement in effect between an employer and an employee entitled to compensation under this Act, has paid disability benefits to an employee which the employee is legally obligated to repay by reason of his entitlement to compensation under this Act, a lien shall be authorized on such compensation in favor of the trust fund for the amount of such payments.

(b)(1) An application for such a lien shall be filed on behalf of the trust fund with the district director for the compensation district where the claim for compensation has been filed, 20 CFR 702.101. Such application shall include a certified statement by an authorized official of the trust fund that:

(i) The trust fund is entitled to a lien in its favor by reason of its payment of disability payments to a claimant-employee (including his name therein);

(ii) The trust fund was created pursuant to a collective bargaining agreement covering the claimant-employee;

(iii) The trust fund complies with section 302(c) of the Labor-Management Relations Act of 1947, 29 U.S.C. 186(c);

(iv) The trust agreement contains a subrogation provision entitling the fund to reimbursement for disability benefits paid to the claimant-employee who is entitled to compensation under the Longshoremen's Act;

(2) The statement shall also state the amount paid to the named claimant-employee and whether such disability benefit payments are continuing to be paid.

(3) If the claimant has signed a statement acknowledging receipt of disability benefits from the trust fund and/or a statement recognizing the trust fund's entitlement to a lien against compensation payments which may be received under the Longshoremen's and Harbor Worker's Compensation Act as a result of his present claim and for which the fund is providing disability payments, such statement(s) shall also be included with or attached to the application.

(c) Upon receipt of this application, the district director shall, within a reasonable time, notify the claimant, the employer and/or its compensation insurance carrier that the request for a lien has been filed and each shall be provided with a copy of the application. If the claimant disputes the right of the trust fund to the lien or the amount stated, if any, he shall, within 30 days after receipt of the application or such other longer period as the district director may set, notify the district director and he shall be given an opportunity to challenge the right of the trust fund to, or the amount of, the asserted lien; notice to either the employer or its compensation insurance carrier shall constitute notice to both of them.

(d) If the claim for compensation benefits is resolved without a formal hearing and if there is no dispute over the amount of the lien or the right of the trust fund to the lien, the district director may order and impose the lien and he shall notify all parties of the amount of the lien and manner in which it is to be paid.

(e) If the claimant's claim for compensation cannot be resolved informally, the district director shall transfer the case to the Office of the Chief Administrative Law Judge for a formal hearing, pursuant to section 19(d) of the Act, 33 U.S.C. 919(d), and 20 CFR 702.317. The district director shall also submit therewith the application for the lien and all documents relating thereto.

(f) If the administrative law judge issues a compensation order in favor of the claimant, such order shall establish a lien in favor of the trust fund if it is determined that the trust fund has satisfied all of the requirements of the Act and regulations.

(g) If the claim for compensation is not in dispute, but there is a dispute as to the right of the trust fund to a lien, or the amount of the lien, the district director shall transfer the matter together with all documents relating thereto to the Office of the Chief Administrative Law Judge for a formal hearing pursuant to section 19(d) of the Act, 33 U.S.C. 919(d), and 20 CFR 702.317.

(h) In the event that either the district director or the administrative law judge is not satisfied that the trust fund qualifies for a lien under section 17, the district director or administrative law judge may require further evidence including but not limited to the production of the collective bargaining agreement, trust agreement or portions thereof.

(i) Before any such lien is approved, if the trust fund has provided continued disability payments after the application for a lien has been filed, the trust fund shall submit a further certified statement showing the total amount paid to the claimant as disability payments. The claimant shall likewise be given an opportunity to contest the amount alleged in this subsequent statement.

(j) In approving a lien on compensation, the district director or administrative law judge shall not order an initial payment to the trust fund in excess of the amount of the past due compensation. The remaining amount to which the trust fund is entitled shall thereafter be deducted from the affected employee's subsequent compensation payments and paid to the trust fund, but any such payment to the trust fund shall not exceed 10 percent of the claimant-employee's biweekly compensation payments.

(Approved by the Office of Management and Budget under control number 1215–0160)

[42 FR 45301, Sept. 9, 1977, as amended at 50 FR 395, Jan. 3, 1985; 51 FR 4282, Feb. 3, 1986]

CERTIFICATION OF EXEMPTION

§ 702.171 Certification of exemption, general.

An employer may apply to the Director or his/her designee to certify a particular facility as one engaged in the building, repairing or dismantling of exclusively small vessels, as defined. Once certified, injuries sustained at that facility would not be covered under the Act except for injuries which occur over the navigable waters of the United States including any adjoining pier, wharf, dock, facility over land for launching vessels or for hauling, lifting or drydocking vessels. A facility otherwise covered under the Act remains covered until certification of exemption is issued; a certification will be granted only upon submission of a complete application (described in § 702.174), and only for as long as a facility meets the requirements detailed in section 3(d) of the Act, 33 U.S.C. 903(d). This exemption from coverage is not intended to be used by employers whose facilities from time to time may temporarily meet the criteria for qualification but only for facilities which work on exclusively small vessels, as defined.

[50 FR 396, Jan. 3, 1985]

§ 702.172 Certification; definitions.

For purposes of §§ 702.171 through 702.175 dealing with certification of small vessel facilities, the following definitions are applicable.

(a)(1) ''Small vessel'' means only those vessels described in section 3(d)(3) of the Act, 33 U.S.C. 903(d)(3), that is:

(i) A commercial barge which is under 900 lightship displacement tons (long); or

(ii) A commercial tugboat, towboat, crewboat, supply boat, fishing vessel or other work vessel which is under 1,600 tons gross.

(2) For these purposes: (i) One gross ton equals 100 cubic feet, as measured by the current formula contained in the Act of May 6, 1894 as amended through 1974 (46 U.S.C. 77); (ii) one long ton equals 2,240 lbs; and (iii) ''Commercial'' as it applies to ''vessel'' means any vessel engaged in commerce but does not include military vessels or Coast Guard vessels.

(b) ''Federal Maritime Subsidy'' means the construction differential subsidy (CDS) or operating differential subsidy under the Merchant Marine Act of 1936 (46 U.S.C. 1101 *et seq.*).

(c) *facility* means an operation of an employer at a particular contiguous geographic location.

[51 FR 4283, Feb. 3, 1986]

§ 702.173 Exemptions; requirements, limitations.

(a) Injuries at a facility otherwise covered by the Act are exempted only upon certification that the facility is: (1) Engaged in the building, repairing or dismantling of exclusively small commercial vessels; and (2) does not receive a Federal maritime subsidy.

(b) The exemption does not apply to: (1) Injuries at any facility which occur over the navigable waters of the United States or upon any adjoining pier, wharf, dock, facility over land for launching vessels or for hauling, lifting or drydocking vessels; or (2) where the employee at such facility is not subject to a State workers' compensation law.

[50 FR 396, Jan. 3, 1985]

§ 702.174 Exemptions; necessary information.

(a) *Application.* Before any facility is exempt from coverage under the Act, the facility must apply for and receive a certificate of exemption from the Director or his/her designee. The application must be made by the owner of the facility; where the owner is a partnership it must be made by a partner and where a corporation by an officer of the corporation or the manager in charge of the facility for which an exemption is sought. The information submitted must include the following:

(1) Name, location, physical description and a site plan or aerial photograph of the facility for which an exemption is sought.

(2) Description of the nature of the business.

(3) An affidavit (signed by a partner if the facility is owned by a partnership or an officer if owned by a corporation) vertifying and/or acknowledging that:

(i) the facility is, as of the date of the application, engaged in the business of building, repairing or dismantling exclusively small commercial vessels and that it does not then nor foreseeably will it engage in the building, repairing or dismantling of other than small vessels.

(ii) The facility does not receive any Federal maritime subsidy.

(iii) The signator has the duty to immediately inform the district director of any change in these or other conditions likely to result in a termination of an exemption.

(iv) the employer has secured appropriate compensation liability under a State workers' compensation law.

(v) Any false, relevant statements relating to the application or the failure to notify the district director of any changes in circumstances likely to result in termination of the exemption will be grounds for revocation of the exemption certificate and will subject the employer to all provisions of the Act, including all duties, responsibilities and penalties, retroactive to the date of application or date of change in circumstances, as appropriate.

(b) *Action by the Director*. The Director or his/her designee must review the application within thirty (30) days of its receipt.

(1) Where the application is complete and shows that all requirements under § 702.173 are met, the Director must promptly notify the employer that certification has been approved and will be effective on the date specified. The employer is required to post notice of the exemption at a conspicuous location.

(2) Where the application is incomplete or does not substantiate that all requirements of section 3(d) of the Act, 33 U.S.C. 903(d), have been met, or evidence shows the facility is not eligible for exemption, the Director must promptly notify the employer by issuing a letter which details the reasons for the deficiency or the rejection. The employer/applicant may reapply for certification, correcting deficiencies and/or responding to the reasons for the Director's denial. The Director or his/her designee must issue a new decision within a reasonable time of reapplication following denial. Such action will be the final administrative review and is not appealable to the Administrative Law Judge or the Benefits Review Board.

(c) The Director or another designated individual at any time has the right to enter on and inspect any facility seeking exemption for purposes of verifying information provided on the application form.

(d) *Action by the employer*. Immediately upon receipt of the certificate of exemption from coverage under the Act the employer must post:

(1) A general notice in a conspicuous place that the Act does not cover injuries sustained at the facility in question, the basis of the exemption, the effective date of the exemption and grounds for termination of the exemption.

(2) A notice, where applicable, at the entrances to all areas to which the exemption does not apply.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 396, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986; 80 FR 12928, Mar. 12, 2015]

§ 702.175 Effect of work on excluded vessels; reinstatement of certification.

(a) When a vessel other than a small commercial vessel, as defined in § 702.172, enters a facility which has been certified as exempt from coverage, the exemption shall automatically terminate as of the date such a vessel enters the facility. The exemption shall also terminate on the date a contract for a Federal maritime subsidy is entered into, and, in the situation where the facility undertakes to build a vessel other than a small vessel, when the construction first takes on the characteristics of a vessel, *i.e.*, when the keel is laid. All duties, obligations and requirements imposed by the Act, including the duty to secure compensation liability as required by sections 4 and 32 of the Act, 33 U.S.C. 904 and 932, and to keep records and forward reports, are effective immediately. The employer shall notify the Director or his/her designee immediately where this occurs.

(b) Where an exemption certification is terminated because of circumstances described in (a), the employer may

apply for reinstatement of the exemption once the event resulting in termination of the exemption ends. The reapplication shall consist of a reaffirmation of the nature of the business, an explanation of the circumstances leading to the termination of exemption, and an affidavit by the appropriate person affirming that the circumstances prompting the termination no longer exists nor will they reoccur in the forseeable future and that the facility is engaged in building, repairing or dismantling exclusively small vessels. The Director or the Director's designee shall respond to the complete reapplication within ten working days of receipt.

[50 FR 397, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986]

Subpart B—Claims Procedures

EMPLOYER'S REPORTS

§ 702.201 Reports from employers of employee's injury or death.

(a) Within 10 days from the date of an employee's injury or death, or 10 days from the date an employer has knowledge of an employee's injury or death, including any disease or death proximately caused by the employment, the employer shall furnish a report thereof to the district director for the compensation district in which the injury or death occurred, and shall thereafter furnish such additional or supplemental reports as the district director may request.

(b) No report shall be filed unless the injury causes the employee to lose one or more shifts from work. However, the employer shall keep a record containing the information specified in § 702.202. Compliance with the current OSHA injury record keeping requirements at 29 CFR part 1904 will satisfy the record keeping requirements of this section for no lost time injuries.

(Approved by the Office of Management and Budget under control number 1215–0160)

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 397, Jan. 3, 1985; 51 FR 4283, Feb. 3, 1986]

§ 702.202 Employer's report; form and contents.

The employer's report of an employee's injury or death shall be in writing and on a form prescribed by the Director for this purpose, and shall contain:

(a) The name, address and business of the employer;

(b) The name, address, occupation and Social Security Number (SSN) of the employee;

(c) The cause, nature, and other relevant circumstances of the injury or death;

(d) The year, month, day, and hour when, and the particular locality where, the injury or death occurred;

(e) Such other information as the Director may require.

(Approved by the Office of Management and Budget under control numbers 1215–0031 and 1215–0063)

[58 FR 68032, Dec. 23, 1993]

§ 702.203 Employer's report; how given.

(a) The employer must file its report of injury with the district director.

(b) If the employer sends its report of injury by U.S. postal mail or commercial delivery service, the report will be considered filed on the date that the employer mails the document or gives it to the commercial delivery service. If the employer sends its report of injury by a permissible electronic method, the report will be considered filed on the date that the employer completes all steps necessary for the transmission.

[80 FR 12929, Mar. 12, 2015]

§ 702.204 Employer's report; penalty for failure to furnish and or falsifying.

Any employer, insurance carrier, or self-insured employer who knowingly and willfully fails or refuses to send any report required by § 702.201, or who knowingly or willfully makes a false statement or misrepresentation in any report, shall be subject to a civil penalty not to exceed $10,000.00 for each such failure, refusal, false statement, or misrepresentation. *Provided, however,* that for any violations occurring on or after November 17, 1997 the maximum civil penalty may not exceed

$11,000.00. The district director has the authority and responsibility for assessing a civil penalty under this section.

[62 FR 53956, Oct. 17, 1997]

§ 702.205 Employer's report; effect of failure to report upon time limitations.

Where the employer, or agent in charge of the business, or carrier has been given notice or has knowledge of an employee's injury or death, and fails, neglects, or refuses to file a report thereof as required by § 702.201, the time limitations provisions with respect to the filing of claims for compensation for disability or death (33 U.S.C. 913(a), and see § 702.221) shall not begin to run until such report shall have been furnished as required herein.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 397, Jan. 3, 1985]

NOTICE

§ 702.211 Notice of employee's injury or death; designation of responsible official.

(a) In order to claim compensation under the Act, an employee or claimant must first give notice of the fact of an injury or death to the employer and also may give notice to the district director for the compensation district in which the injury or death occurred. Notice to the employer must be given to that individual whom the employer has designated to receive such notices. If no individual has been so designated notice may be given to: (1) The first line supervisor (including foreman, hatchboss or timekeeper), local plant manager or personnel office official; (2) to any partner if the employer is a partnership; or (3) if the employer is a corporation, to any authorized agent, to an officer or to the person in charge of the business at the place where the injury occurred. In the case of a retired employee, the employee/claimant may submit the notice to any of the above persons, whether or not the employer has designated an official to receive such notice.

(b) In order to facilitate the filing of notices, each employer shall designate at least one individual responsible for receiving notices of injury or death; this requirement applies to all employers. The designation shall be by position and the employer shall provide the name and/or position, exact location and telephone number of the individual to all employees by the appropriate method described below.

(1) *Type of individual.* Designees must be a first line supervisor (including a foreman, hatchboss or timekeeper), local plant manager, personnel office official, company nurse or other individual traditionally entrusted with this duty, who is located full-time on the premises of the covered facility. The employer must designate at least one individual at each place of employment or one individual for each work crew where there is no fixed place of employment (in that case, the designation should always be the same position for all work crews).

(2) *How designated.* The name and/or title, the location and telephone number of the individual who is selected by the employer to receive all notices shall be given to the district director for the compensation district in which the facility is located; posting on the worksite in a conspicuous place shall fulfill this requirement. A redesignation shall be effected by a change in posting.

(3) *Publication.* Every employer shall post the name and/or position, the exact location and telephone number of the designated official. The posting shall be part of the general posting requirement, done on a form prescribed by the Director, and placed in a conspicuous location. Posting must be done at each worksite.

(4) *Effect of failure to designate.* Where an employer fails to properly designate and to properly publish the name and/or position of the individual authorized to receive notices of injury or death, such failure shall constitute satisfactory reasons for excusing the employee/claimant's failure to give notice as authorized by section 12(d)(3)(ii) of the Act, 33 U.S.C. 912(d)(3)(ii).

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 397, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986]

§ 702.212 Notice; when given; when given for certain occupational diseases.

(a) For other than occupational diseases described in (b), the employee must give notice within thirty (30) days of the date of the injury or death. For this purpose the date of injury or death is:

(1) The day on which a traumatic injury occurs;

(2) The date on which the employee or claimant is or by the exercise of reasonable diligence or by reason of medical advice, should have been aware of a relationship between the injury or death and the employment; or

(3) In the case of claims for loss of hearing, the date the employee receives an audiogram, with the accompanying report which indicates the employee has suffered a loss of hearing that is related to his or her employment. (See § 702.441).

(b) In the case of an occupational disease which does not immediately result in disability or death, notice must be given within one year after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice, should have been aware, of the relationship between the employment, the disease and the death or disability. For purposes of these occupational diseases, therefore, the notice period does not begin to run until the employee is disabled, or in the case of a retired employee, until a permanent impairment exists.

(c) For purposes of workers whose coverage under this Act is dependent on denial of coverage under a State compensation program, as described in § 701.401, the time limitations set forth above do not begin to run until a final decision denying State coverage is issued under the State compensation act.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 397, Jan. 3, 1985, as amended at 51 FR 4283, Feb. 3, 1986]

§ 702.213 Notice; by whom given.

Notice shall be given by the injured employee or someone on his behalf, or in the case of death, by the deceased employee's beneficiary or someone on his behalf.

[38 FR 26861, Sept. 26, 1973. Redesignated at 50 FR 397, Jan. 3, 1985]

§ 702.214 Notice; form and content.

Notice shall be in writing on a form prescribed by the Director for this purpose; such form shall be made available to the employee or beneficiary by the employer. The notice shall be signed by the person authorized to give notice, and shall contain the name, address and Social Security Number (SSN) of the employee and, in death cases, also the SSN of the person seeking survivor benefits, and a statement of the time, place, nature and cause of the injury or death.

[58 FR 68032, Dec. 23, 1993]

§ 702.215 Notice; how given.

Notice must be effected by delivering it to the individual designated to receive such notices at the physical or electronic address designated by the employer. Notice may be given to the district director by submitting a copy of the form supplied by OWCP to the district director, or orally in person or by telephone.

[80 FR 12929, Mar. 12, 2015]

§ 702.216 Effect of failure to give notice.

Failure to give timely notice to the employer's designated official shall not bar any claim for compensation if: (a) The employer, carrier, or designated official had actual knowledge of the injury or death; or (b) the district director or ALJ determines the employer or carrier has not been prejudiced: or (c) the district director excuses failure to file notice. For purposes of this subsection, actual knowledge shall be deemed to exist if the employee's immediate supervisor was aware of the injury and/or in the case of a hearing loss, where the employer has furnished to the employee an audiogram and report which indicates a loss of hearing. Failure to give notice shall be excused by the district director if: a) Notice,

while not given to the designated official, was given to an official of the employer or carrier, and no prejudice resulted; or b) for some other satisfactory reason, notice could not be given. Failure to properly designate and post the individual so designated shall be considered a satisfactory reason. In any event, such defense to a claim must be raised by the employer/carrier at the first hearing on the claim.

[51 FR 4283, Feb. 3, 1986]

§ 702.217 Penalty for false statement, misrepresentation.

(a) Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

(b) Any person including, but not limited to, an employer, its duly authorized agent or an employee of an insurance carrier, who knowingly and willingly makes a false statement or representation for the purpose of reducing, denying or terminating benefits to an injured employee, or his dependents pursuant to section 9, 33 U.S.C. 909, if the injury results in death, shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or both.

[50 FR 398, Jan. 3, 1985]

CLAIMS

§ 702.221 Claims for compensation; time limitations.

(a) Claims for compensation for disability or death shall be in writing and filed with the district director for the compensation district in which the injury or death occurred. The Social Security Number (SSN) of the injured employee and, in cases of death, the SSN of the person seeking survivor benefits shall also be set forth on each claim. Claims may be filed anytime after the seventh day of disability or anytime following the death of the employee. Except as provided below, the right to compensation is barred unless a claim is filed within one year of the injury or death, or (where payment is made without an award) within one year of the date on which the last compensation payment was made.

(b) In the case of a hearing loss claim, the time for filing a claim does not begin to run until the employee receives an audiogram with the accompanying report which indicates the employee has sustained a hearing loss that is related to his or her employment. (See § 702.441).

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 398, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986; 58 FR 68032, Dec. 23, 1993]

§ 702.222 Claims; exceptions to time limitations.

(a) Where a person entitled to compensation under the Act is mentally incompetent or a minor, the time limitation provision of § 702.221 shall not apply to a mentally incompetent person so long as such person has no guardian or other authorized representative, but § 702.221 shall be applicable from the date of appointment of such guardian or other representative. In the case of minor who has no guardian before he or she becomes of age, time begins to run from the date he or she becomes of age.

(b) Where a person brings a suit at law or in admiralty to recover damages in respect of an injury or death, or files a claim under a State workers' compensation act because such person is excluded from this Act's coverage by reason of section 2(3) or 3(d) of the Act (33 U.S.C. 902(3) or 903(d)), and recovery is denied because the person was an employee and defendant was an employer within the meaning of the Act, and such employer had secured compensation to such employee under the Act, the time limitation in § 702.221 shall not begin to run until the date of termination of such suit or proceeding.

(c) Notwithstanding the provisions in paragraph (a) of this section, where the claim is one based on disability or death due to an occupational disease which does not immediately result in death or disability, it must be filed within two years after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice, should have been

aware of the relationship between the employment, the disease and the death or disability, or within one year of the date of last payment of compensation, whichever is later. For purposes of occupational disease, therefore, the time limitation for filing a claim does not begin to run until the employee is disabled, or in the case of a retired employee, where a permanent impairment exists.

(d) The time limitations set forth above do not apply to claims filed under section 49 of the Act, 33 U.S.C. 949.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 398, Jan. 3, 1985]

§ 702.223 Claims; time limitations; time to object.

Notwithstanding the requirements of § 702.221, failure to file a claim within the period prescribed in such section shall not be a bar to such right unless objection to such failure is made at the first hearing of such claim in which all parties in interest are given reasonable notice and opportunity to be heard.

[38 FR 26861, Sept. 26, 1973. Redesignated and amended at 50 FR 397, Jan. 3, 1985]

§ 702.224 Claims; notification of employer of filing by employee.

Within 10 days after the filing of a claim for compensation for injury or death under the Act, the district director must give written notice thereof to the employer or carrier.

[80 FR 12929, Mar. 12, 2015]

§ 702.225 Withdrawal of a claim.

(a) *Before adjudication of claim.* A claimant (or an individual who is authorized to execute a claim on his behalf) may withdraw his previously filed claim: *Provided*, That:

(1) He files with the district director with whom the claim was filed a written request stating the reasons for withdrawal;

(2) The claimant is alive at the time his request for withdrawal is filed;

(3) The district director approves the request for withdrawal as being for a proper purpose and in the claimant's best interest; and

(4) The request for withdrawal is filed, on or before the date the OWCP makes a determination on the claim.

(b) *After adjudication of claim.* A claim for benefits may be withdrawn by a written request filed after the date the OWCP makes a determination on the claim: *Provided*, That:

(1) The conditions enumerated in paragraphs (a) (1) through (3) of this section are met; and

(2) There is repayment of the amount of benefits previously paid because of the claim that is being withdrawn or it can be established to the satisfaction of the Office that repayment of any such amount is assured.

(c) *Effect of withdrawal of claim.* Where a request for withdrawal of a claim is filed and such request for withdrawal is approved, such withdrawal shall be without prejudice to the filing of another claim, subject to the time limitation provisions of section 13 of the Act and of the regulations in this part.

[38 FR 26861, Sept. 26, 1973. Redesignated at 50 FR 397, Jan. 3, 1985]

NONCONTROVERTED CLAIMS

§ 702.231 Noncontroverted claims; payment of compensation without an award.

Unless the employer controverts its liability to pay compensation under this Act, the employer or insurance carrier shall pay periodically, promptly and directly to the person entitled thereto benefits prescribed by the Act. For this purpose, where the employer furnishes to an employee a copy of an audiogram with a report thereon, which indicates the employee has sustained a hearing loss causally related to factors of that employment, the employer or insurance carrier shall pay appropriate compensation or at that time controvert the liability to pay compensation under this Act.

[50 FR 399, Jan. 3, 1985]

§ 702.232 Payments without an award; when; how paid.

The first installment of compensation shall become due by the fourteenth (14th) day after the employer has been notified, through the designated official or by any other means

described in § 702.211 *et seq.*, or has actual knowledge of the injury or death. All compensation due on that fourteenth (14th) day shall be paid then and appropriate compensation due thereafter must be paid in semi-monthly installments, unless the district director determines otherwise.

[50 FR 399, Jan. 3, 1985]

§ 702.233 Penalty for failure to pay without an award.

If any installment of compensation payable without an award is not paid within 14 days after it becomes due, there shall be added to such unpaid installment an amount equal to 10 per centum thereof which shall be paid at the same time as, but in addition to, such installment unless the employer files notice of controversion in accordance with § 702.261, or unless such nonpayment is excused by the district director after a showing by the employer that owing to conditions over which he had no control such installment could not be paid within the period prescribed for the payment.

§ 702.234 Report by employer of commencement and suspension of payments.

Immediately upon making the first payment of compensation, and upon the suspension of payments once begun, the employer must notify the district director who is administering the claim of the commencement or suspension of payments, as the case may be.

[80 FR 12929, Mar. 12, 2015]

§ 702.235 Report by employer of final payment of compensation.

(a) Within 16 days after the final payment of compensation has been made, the employer, the insurance carrier, or where the employer is self-insured, the employer shall notify the district director on a form prescribed by the Secretary, stating that such final payment has been made, the total amount of compensation paid, the name and address of the person(s) to whom payments were made, the date of the injury or death and the name of the injured or deceased employee, and the inclusive dates during which compensation was paid.

(b) A ''final payment of compensation'' for the purpose of applying the penalty provision of § 702.236 shall be deemed any one of the following:

(1) The last payment of compensation made in accordance with a compensation order awarding disability or death benefits, issued by either a district director or an administrative law judge;

(2) The payment of an agreed settlement approved under section 8(i) (A) or (B), of the Act, 33 U.S.C. 908(i);

(3) The last payment made pursuant to an agreement reached by the parties through informal proceedings;

(4) Any other payment of compensation which anticipates no further payments under the Act.

(Approved by the Office of Management and Budget under control number 1215–0024)

(Pub. L. No. 96–511)

[42 FR 45302, Sept. 9, 1977, as amended at 49 FR 18294, Apr. 30, 1984; 50 FR 399, Jan. 3, 1985]

§ 702.236 Penalty for failure to report termination of payments.

Any employer failing to notify the district director that the final payment of compensation has been made as required by § 702.235 shall be assessed a civil penalty in the amount of $100.00. *Provided, however*, that for any violation occurring on or after November 17, 1997 the civil penalty will be $110.00. The district director has the authority and responsibility for assessing a civil penalty under this section.

[62 FR 53956, Oct. 17, 1997]

AGREED SETTLEMENTS

§ 702.241 Definitions and supplementary information.

(a) As used hereinafter, the term *adjudicator* shall mean district director or administrative law judge (ALJ).

(b) If a settlement application is submitted to an adjudicator and the case is pending at the Office of Administrative Law Judges, the Benefits Review Board, or any Federal circuit court of appeals, the parties may request that the case be remanded to the adjudicator for consideration of the application. The thirty day period as described in paragraph (f) of this section begins

when the remanded case is received by the adjudicator.

(c) If a settlement application is first submitted to an ALJ, the thirty day period mentioned in paragraph (f) of this section does not begin until five days before the date the formal hearing is set. This rule does not preclude the parties from submitting the application at any other time such as (1) after the case is referred for hearing, (2) at the hearing, or (3) after the hearing but before the ALJ issues a decision and order. Where a case is pending before the ALJ but not set for a hearing, the parties may request the case be remanded to the district director for consideration of the settlement.

(d) A settlement agreement between parties represented by counsel, which is deemed approved when not disapproved within thirty days, as described in paragraph (f) of this section, shall be considered to have been filed in the office of the district director on the thirtieth day for purposes of sections 14 and 21 of the Act, 33 U.S.C. 914 and 921.

(e) A fee for representation which is included in an agreement that is approved in the manner described in paragraph (d) of this section, shall also be considered approved within the meaning of section 28(e) of the Act, 33 U.S.C. 928(e).

(f) The thirty day period for consideration of a settlement agreement shall be calculated from the day after receipt unless the parties are advised otherwise by the adjudicator. (See § 702.243(b)). If the last day of this period is a holiday or occurs during a weekend, the next business day shall be considered the thirtieth day.

(g) An agreement among the parties to settle a claim is limited to the rights of the parties and to claims then in existence; settlement of disability compensation or medical benefits shall not be a settlement of survivor benefits nor shall the settlement affect, in any way, the right of survivors to file a claim for survivor's benefits.

(h) For purposes of this section and § 702.243 the term *counsel* means any attorney admitted to the bar of any State, territory or the District of Columbia.

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986]

§ 702.242 Information necessary for a complete settlement application.

(a) The settlement application shall be a self-sufficient document which can be evaluated without further reference to the administrative file. The application shall be in the form of a stipulation signed by all parties and shall contain a brief summary of the facts of the case to include: a description of the incident, a description of the nature of the injury to include the degree of impairment and/or disability, a description of the medical care rendered to date of settlement, and a summary of compensation paid and the compensation rate or, where benefits have not been paid, the claimant's average weekly wage.

(b) The settlement application shall contain the following:

(1) A full description of the terms of the settlement which clearly indicates, where appropriate, the amounts to be paid for compensation, medical benefits, survivor benefits and representative's fees which shall be itemized as required by § 702.132.

(2) The reason for the settlement, and the issues which are in dispute, if any.

(3) The claimant's date of birth and, in death claims, the names and birth dates of all dependents.

(4) Information on whether or not the claimant is working or is capable of working. This should include, but not be limited to, a description of the claimant's educational background and work history, as well as other factors which could impact, either favorably or unfavorably, on future employability.

(5) A current medical report which fully describes any injury related impairment as well as any unrelated conditions. This report shall indicate whether maximum medical improvement has been reached and whether further disability or medical treatment is anticipated. If the claimant has already reached maximum medical improvement, a medical report prepared at the time the employee's condition stabilized will satisfy the requirement for a current medical report. A medical

report need not be submitted with agreements to settle survivor benefits unless the circumstances warrant it.

(6) A statement explaining how the settlement amount is considered adequate.

(7) If the settlement application covers medical benefits an itemization of the amount paid for medical expenses by year for the three years prior to the date of the application. An estimate of the claimant's need for future medical treatment as well as an estimate of the cost of such medical treatment shall also be submitted which indicates the inflation factor and/or the discount rate used, if any. The adjudicator may waive these requirements for good cause.

(8) Information on any collateral source available for the payment of medical expenses.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986]

§ 702.243 Settlement application; how submitted, how approved, how disapproved, criteria.

(a) When the parties to a claim for compensation, including survivor benefits and medical benefits, agree to a settlement they must submit a complete application to the adjudicator. The application must contain all the information outlined in § 702.242 and must be sent by certified mail with return receipt requested, commercial delivery service with tracking capability that provides reliable proof of delivery to the adjudicator, or electronically through an OWCP-authorized system. Failure to submit a complete application will toll the thirty day period mentioned in section 8(i) of the Act, 33 U.S.C. 908(i), until a complete application is received.

(b) The adjudicator must consider the settlement application within thirty days and either approve or disapprove the application. The liability of an employer/insurance carrier is not discharged until the settlement is specifically approved by a compensation order issued by the adjudicator. However, if the parties are represented by counsel, the settlement will be deemed approved unless specifically disapproved within thirty days after receipt of a complete application. This thirty day period does not begin until all the information described in § 702.242 has been submitted. The adjudicator will examine the settlement application within thirty days and must immediately serve on all parties notice of any deficiency. This notice must also indicate that the thirty day period will not commence until the deficiency is corrected.

(c) If the adjudicator disapproves a settlement application, the adjudicator must serve on all parties a written statement or order containing the reasons for disapproval. This statement must be served within thirty days of receipt of a complete application (as described in § 702.242) if the parties are represented by counsel. If the disapproval was made by a district director, any party to the settlement may request a hearing before an ALJ as provided in sections 8 and 19 of the Act, 33 U.S.C. 908 and 919, or an amended application may be submitted to the district director. If, following the hearing, the ALJ disapproves the settlement, the parties may: (1) Submit a new application, (2) file an appeal with the Benefits Review Board as provided in section 21 of the Act, 33 U.S.C. 921, or (3) proceed with a hearing on the merits of the claim. If the application is initially disapproved by an ALJ, the parties may (1) submit a new application or (2) proceed with a hearing on the merits of the claim.

(d) The parties may submit a settlement application solely for compensation, or solely for medical benefits or for compensation and medical benefits combined.

(e) If either portion of a combined compensation and medical benefits settlement application is disapproved the entire application is disapproved unless the parties indicate on the face of the application that they agree to settle either portion independently.

(f) When presented with a settlement, the adjudicator must review the application and determine whether, considering all of the circumstances, including, where appropriate, the probability of success if the case were formally litigated, the amount is adequate. The criteria for determining the adequacy

of the settlement application will include, but not be limited to:

(1) The claimant's age, education and work history;

(2) The degree of the claimant's disability or impairment;

(3) The availability of the type of work the claimant can do;

(4) The cost and necessity of future medical treatment (where the settlement includes medical benefits).

(g) In cases being paid pursuant to a final compensation order, where no substantive issues are in dispute, a settlement amount which does not equal the present value of future compensation payments commuted, computed at the discount rate specified below, must be considered inadequate unless the parties to the settlement show that the amount is adequate. The probability of the death of the beneficiary before the expiration of the period during which he or she is entitled to compensation will be determined according to the most current United States Life Table, as developed by the United States Department of Health and Human Services, which will be updated from time to time. The discount rate will be equal to the coupon issue yield equivalent (as determined by the Secretary of the Treasury) of the average accepted auction price for the last auction of 52 weeks U.S. Treasury Bills settled immediately prior to the date of the submission of the settlement application.

[50 FR 399, Jan. 3, 1985, as amended at 51 FR 4284, Feb. 3, 1986; 60 FR 51348, Oct. 2, 1995; 80 FR 12929, Mar. 12, 2015]

CONTROVERTED CLAIMS

§ 702.251 Employer's controversion of the right to compensation.

Where the employer controverts the right to compensation after notice or knowledge of the injury or death, or after receipt of a written claim, he must give notice thereof, stating the reasons for controverting the right to compensation, using the form prescribed by the Director. Such notice, or answer to the claim, must be filed with the district director within 14 days from the date the employer receives notice or has knowledge of the injury or death. A copy of the notice must also be given to the claimant.

[80 FR 12929, Mar. 12, 2015]

§ 702.252 Action by district director upon receipt of notice of controversion.

Upon receiving the employer's notice of controversion, the district director shall forthwith commence proceedings for the adjudication of the claim in accordance with the procedures set forth in subpart C of this part.

CONTESTED CLAIMS

§ 702.261 Claimant's contest of actions taken by employer or carrier with respect to the claim.

Where the claimant contests an action by the employer or carrier reducing, suspending, or terminating benefits, including medical care, he should immediately notify the office of the district director who is administering the claim and set forth the facts pertinent to his complaint.

[80 FR 12929, Mar. 12, 2015]

§ 702.262 Action by district director upon receipt of notice of contest.

Upon receipt of the claimant's notice of contest, the district director shall forthwith commence proceedings for adjudication of the claim in accordance with the procedures set forth in subpart C of this part.

DISCRIMINATION

§ 702.271 Discrimination; against employees who bring proceedings, prohibition and penalty.

(a)(1) No employer or its duly authorized agent may discharge or in any manner discriminate against an employee as to his/her employment because that employee: (i) Has claimed or attempted to claim compensation under this Act; or (ii) has testified or is about to testify in a proceeding under this Act. To discharge or refuse to employ a person who has been adjudicated to have filed a fraudulent claim for compensation or otherwise made a false statement or misrepresentation under section 31(a)(1) of the Act, 33 U.S.C. 931(a)(1), is not a violation of this section.

(2) Any employer who violates this section shall be liable to a penalty of not less that $1,000.00 or more than $5,000.00 to be paid (by the employer alone, and not by a carrier) to the district director for deposit in the special fund described in section 44 of the Act, 33 U.S.C. 944; and shall restore the employee to his or her employment along with all wages lost due to the discrimination unless the employee has ceased to be qualified to perform the duties of employment. *Provided however*, that for any violation occurring on or after November 17, 1997 the employer shall be liable to a penalty of not less than $1,100.00 or more than $5,500.00.

(b) When a district director receives a complaint from an employee alleging discrimination as defined under section 49, he or she shall notify the employer, and within five working days, initiate specific inquiry to determine all the facts and circumstances pertaining thereto. This may be accomplished by interviewing the employee, employer representatives and other parties who may have information about the matter. Interviews may be conducted by written correspondence, telephone or personal interview.

(c) If circumstances warrant, the district director may also conduct an informal conference on the issue as described in §§ 702.312 through 702.314.

(d) Any employee discriminated against is entitled to be restored to his employment and to be compensated by the employer for any loss of wages arising out of such discrimination provided that the employee is qualified to perform the duties of the employment. If it is determined that the employee has been discriminated against, the district director shall also determine whether the employee is qualified to perform the duties of the employment. The district director may use medical evidence submitted by the parties or he may arrange to have the employee examined by a physician selected by the district director. The cost of the medical examination arranged for by the district director may be charged to the special fund established by section 44, 33 U.S.C. 944.

[42 FR 45302, Sept. 9, 1977, as amended at 50 FR 400, Jan. 3, 1985; 62 FR 53956, Oct. 17, 1997]

§ 702.272 Informal recommendation by district director.

(a) If the district director determines that the employee has been discharged or suffered discrimination and is able to resume his or her duties, the district director will recommend that the employer reinstate the employee and/or make such restitution as is indicated by the circumstances of the case, including compensation for any wage loss suffered as the result of the discharge or discrimination. The district director may also assess the employer an appropriate penalty, as determined under authority vested in the district director by the Act. If the district director determines that no violation occurred he must notify the parties of his findings and the reasons for recommending that the complaint be denied. If the employer and employee accept the district director's recommendation, within 10 days it will be incorporated in an order, to be filed and served in accordance with § 702.349.

(b) If the parties do not agree to the recommendation, the district director must, within 10 days after receipt of the rejection, prepare a memorandum summarizing the disagreement, send a copy to all interested parties, and within 14 days thereafter, refer the case to the Office of the Chief Administrative Law Judge for hearing pursuant to § 702.317.

[42 FR 45302, Sept. 9, 1977, as amended at 80 FR 12929, Mar. 12, 2015]

§ 702.273 Adjudication by Office of the Chief Administrative Law Judge.

The Office of Administrative Law Judges is responsible for final determinations of all disputed issues connected with the discrimination complaint, including the amount of penalty to be assessed, and shall proceed with a formal hearing as described in §§ 702.331 to 702.394.

[42 FR 45302, Sept. 9, 1977]

§ 702.274 Employer's refusal to pay penalty.

In the event the employer refuses to pay the penalty assessed, the district

director shall refer the complete administrative file to the Associate Director, Division of Longshore and Harbor Workers' Compensation, for subsequent transmittal to the Associate Solicitor for Employee Benefits, with the request that appropriate legal action be taken to recover the penalty.

[42 FR 45302, Sept. 9, 1977]

THIRD PARTY

§ 702.281 Third party action.

(a) Every person claiming benefits under this Act (or the representative) must promptly notify the employer and the district director when:

(1) A claim is made that someone other than the employer or person or persons in its employ, is liable in damages to the claimant because of the injury or death and identify such party by name and address.

(2) Legal action is instituted by the claimant or the representative against some person or party other than the employer or a person or persons in his employ, on the ground that such other person is liable in damages to the claimant on account of the compensable injury and/or death; specify the amount of damages claimed and identify the person or party by name and address.

(3) Any settlement, compromise or any adjudication of such claim has been effected and report the terms, conditions and amounts of such resolution of claim.

(b) Where the claim or legal action instituted against a third party results in a settlement agreement which is for an amount less than the compensation to which a person would be entitled under this Act, the person (or the person's representative) must obtain the prior, written approval of the settlement from the employer and the employer's carrier before the settlement is executed. Failure to do so relieves the employer and/or carrier of liability for compensation described in section 33(f) of Act, 33 U.S.C. 933(f) and for medical benefits otherwise due under section 7 of the Act, 33 U.S.C. 907, regardless of whether the employer or carrier has made payments of acknowledged entitlement to benefits under the Act. The approval must be on a form provided by OWCP and must be filed, within thirty days after the settlement is entered into, with the district director who is administering the claim.

[42 FR 45303, Sept. 9, 1977, as amended at 50 FR 400, Jan. 3, 1985; 51 FR 4284, Feb. 3, 1986; 80 FR 12930, Mar. 12, 2015]

REPORT OF EARNINGS

§ 702.285 Report of earnings.

(a) An employer, carrier or the Director (for those cases being paid from the Special Fund) may require an employee to whom it is paying compensation to submit a report on earnings from employment or self-employment. This report may not be required any more frequently than semi-annually. The report shall be made on a form prescribed by the Director and shall include all earnings from employment and self-employment and the periods for which the earnings apply. The employee must return the complete report on earnings even where he or she has no earnings to report.

(b) For these purposes the term ''earnings'' is defined as all monies received from any employment and includes but is not limited to wages, salaries, tips, sales commissions, fees for services provided, piecework and all revenue received from self-employment even if the business or enterprise operated at a loss of if the profits were reinvested.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 400, Jan. 3, 1985]

§ 702.286 Report of earnings; forfeiture of compensation.

(a) Any employee who fails to submit the report on earnings from employment or self-employment under § 702.285 or, who knowingly and willingly omits or understates any part of such earnings, shall upon a determination by the district director forfeit all right to compensation with respect to any period during which the employee was required to file such a report. The employee must return the completed report on earnings (even where he or she reports no earnings) within thirty (30) days of the date of receipt; this period may be extended for good cause, by the

district director, in determining whether a violation of this requirement has occurred.

(b) Any employer or carrier who believes that a violation of paragraph (a) of this section has occurred may file a charge with the district director. The allegation shall be accompanied by evidence which includes a copy of the report, with proof of service requesting the information from the employee and clearly stating the dates for which the employee was required to report income. Where the employer/carrier is alleging an omission or understatement of earnings, it shall, in addition, present evidence of earnings by the employee during that period, including copies of checks, affidavits from employers who paid the employee earnings, receipts of income from self-employment or any other evidence showing earnings not reported or underreported for the period in question. Where the district director finds the evidence sufficient to support the charge he or she shall convene an informal conference as described in subpart C and shall issue a compensation order affiming or denying the charge and setting forth the amount of compensation for the specified period. If there is a conflict over any issue relating to this matter any party may request a formal hearing before an Administrative Law Judge as described in subpart C.

(c) Compensation forfeited under paragraph (b) of this section, if already paid, shall be recovered by a deduction from the compensation payable to the employee if any, on such schedule as determined by the district director. The district director's discretion in such cases extends only to rescheduling repayment by crediting future compensation and not to whether and in what amounts compensation is forfeited. For this purpose, the district director shall consider the employee's essential expenses for living, income from whatever source, and assets, including cash, savings and checking accounts, stocks, bonds, and other securities.

[50 FR 400, Jan. 3, 1985]

Subpart C—Adjudication Procedures

GENERAL

§ 702.301 Scope of this subpart.

The regulations in this subpart govern the adjudication of claims in which the employer has filed a notice of controversion under § 702.251, or the employee has filed notice of contest under § 702.261. In the vast majority of cases, the problem giving rise to the controversy results from misunderstandings, clerical or mechanical errors, or mistakes of fact or law. Such problems seldom require resolution through formal hearings, with the attendant production of expert witnesses. Accordingly, by § 702.311 *et seq.*, the district directors are empowered to amicably and promptly resolve such problems by informal procedures. Where there is a genuine dispute of fact or law which cannot be so disposed of informally, resort must be had to the formal hearing procedures as set forth beginning at § 702.331. Supplementary compensation orders, modifications, and interlocutory matters are governed by regulations beginning with § 702.371. Thereafter, appeals from compensation orders are discussed beginning with § 702.391 (the regulations of the Benefits Review Board are set forth in full in part 802 of this title).

ACTION BY DISTRICT DIRECTORS

§ 702.311 Handling of claims matters by district directors; informal conferences.

The district director is empowered to resolve disputes with respect to claims in a manner designed to protect the rights of the parties and also to resolve such disputes at the earliest practicable date. This will generally be accomplished by informal discussions by telephone or by conferences at the district director's office. Some cases will be handled by written correspondence. The regulations governing informal conferences at the district director's office with all parties present are set forth below. When handling claims by telephone, or at the office with only one of the parties, the district director and his staff shall make certain that a

full written record be made of the matters discussed and that such record be placed in the administrative file. When claims are handled by correspondence, copies of all communications shall constitute the administrative file.

§ 702.312 Informal conferences; called by and held before whom.

Informal conferences shall be called by the district director or his designee assigned or reassigned the case and held before that same person, unless such person is absent or unavailable. When so assigned, the designee shall perform the duties set forth below assigned to the district director, except that a compenstion order following an agreement shall be issued only by a person so designated by the Director to perform such duty.

[42 FR 45303, Sept. 9, 1977]

§ 702.313 Informal conferences; how called; when called.

Informal conferences may be called upon not less than 10 days' notice to the parties, unless the parties agree to meet at an earlier date. The notice may be given by telephone, but shall be confirmed by use of a written notice on a form prescribed by the Director. The notice shall indicate the date, time and place of the conference, and shall also specify the matters to be discussed. For good cause shown conferences may be rescheduled. A copy of such notice shall be placed in the administrative file.

§ 702.314 Informal conferences; how conducted; where held.

(a) No stenographic report shall be taken at informal conferences and no witnesses shall be called. The district director shall guide the discussion toward the achievement of the purpose of such conference, recommending courses of action where there are disputed issues, and giving the parties the benefit of his experience and specialized knowledge in the field of workmen's compensation.

(b) Conferences generally shall be held at the district director's office. However, such conferences may be held at any place which, in the opinion of the district director, will be of greater convenience to the parties or to their representatives.

§ 702.315 Conclusion of conference; agreement on all matters with respect to the claim.

(a) Following an informal conference at which agreement is reached on all issues, the district director must (within 10 days after conclusion of the conference), embody the agreement in a memorandum or within 30 days issue a formal compensation order, to be filed and served in accordance with § 702.349. If either party requests that a formal compensation order be issued, the district director must, within 30 days of such request, prepare, file, and serve such order in accordance with § 702.349. Where the problem was of such nature that it was resolved by telephone discussion or by exchange of written correspondence, the district director must prepare a memorandum or order setting forth the terms agreed upon and notify the parties either by telephone or in writing, as appropriate. In either instance, when the employer or carrier has agreed to pay, reinstate or increase monetary compensation benefits, or to restore or appropriately change medical care benefits, such action must be commenced immediately upon becoming aware of the agreement, and without awaiting receipt of the memorandum or the formal compensation order.

(b) Where there are several conferences or discussions, the provisions of paragraph (a) of this section do not apply until the last conference. The district director must, however, prepare and place in his administrative file a short, succinct memorandum of each preceding conference or discussion.

[80 FR 12930, Mar. 12, 2015]

§ 702.316 Conclusion of conference; no agreement on all matters with respect to the claim.

When it becomes apparent during the course of the informal conference that agreement on all issues cannot be reached, the district director shall bring the conference to a close, shall evaluate all evidence available to him or her, and after such evaluation shall prepare a memorandum of conference

setting forth all outstanding issues, such facts or allegations as appear material and his or her recommendations and rationale for resolution of such issues. Copies of this memorandum shall then be sent to each of the parties or their representatives, who shall then have 14 days within which to signify in writing to the district director whether they agree or disagree with his or her recommendations. If they agree, the district director shall proceed as in § 702.315(a). If they disagree (Caution: See § 702.134), then the district director may schedule such further conference or conferences as, in his or her opinion, may bring about agreement; if he or she is satisfied that any further conference would be unproductive, or if any party has requested a hearing, the district director shall prepare the case for transfer to the Office of the Chief Administrative Law Judge (See § 702.317, §§ 702.331–702.351).

[42 FR 42551, Aug. 23, 1977, as amended at 60 FR 51348, Oct. 2, 1995]

§ 702.317 Preparation and transfer of the case for hearing.

A case is prepared for transfer in the following manner:

(a) The district director will furnish each of the parties or their representatives with a copy of a prehearing statement form.

(b) Each party must, within 21 days after receipt of such form, complete it and return it to the district director and serve copies on all other parties. Extensions of time for good cause may be granted by the district director.

(c) Upon receipt of the completed forms, the district director, after checking them for completeness and after any further conferences that, in his or her opinion, are warranted, will transmit them to the Office of the Chief Administrative Law Judge by letter of transmittal together with all available evidence which the parties intend to submit at the hearings (exclusive of X-rays, slides and other materials not suitable for transmission which may be offered into evidence at the time of the hearing); the materials transmitted must not include any recommendations expressed or memoranda prepared by the district director pursuant to § 702.316.

(d) If the completed pre-hearing statement forms raise new or additional issues not previously considered by the district director or indicate that material evidence will be submitted that could reasonably have been made available to the district director before he or she prepared the last memorandum of conference, the district director will transfer the case to the Office of the Chief Administrative Law Judge only after having considered such issues or evaluated such evidence or both and having issued an additional memorandum of conference in conformance with § 702.316.

(e) If a party fails to complete or return his or her pre-hearing statement form within the time allowed, the district director may, at his or her discretion, transmit the case without that party's form. However, such transmittal must include a statement from the district director setting forth the circumstances causing the failure to include the form, and such party's failure to submit a pre-hearing statement form may, subject to rebuttal at the formal hearing, be considered by the administrative law judge, to the extent intransigence is relevant, in subsequent rulings on motions which may be made in the course of the formal hearing.

[80 FR 12930, Mar. 12, 2015]

§ 702.318 The record; what constitutes; nontransferability of the administrative file.

For the purpose of any further proceedings under the Act, the formal record of proceedings shall consist of the hearing record made before the administrative law judge (see § 702.344). When transferring the case for hearing pursuant to § 702.317, the district director shall not transfer the administrative file under any circumstances.

§ 702.319 Obtaining documents from the administrative file for reintroduction at formal hearings.

Whenever any party considers any document in the administrative file essential to any further proceedings under the Act, it is the responsibility of such party to obtain such document

from the district director and reintroduce it for the record before the administrative law judge. The type of document that may be obtained will be limited to documents previously submitted to the district director, including documents or forms with respect to notices, claims, controversions, contests, progress reports, medical services or supplies, etc. The work products of the district director or his staff will not be subject to retrieval. The procedure for obtaining documents will be for the requesting party to inform the district director in writing of the documents he wishes to obtain, specifying them with particularity. Upon receipt, the district director must promptly forward a copy of the requested materials to the requesting party. A copy of the letter of request and a statement of whether it has been satisfied must be kept in the case file.

[80 FR 12930, Mar. 12, 2015]

SPECIAL FUND

§ 702.321 Procedures for determining applicability of section 8(f) of the Act.

(a) *Application: filing, service, contents.* (1) An employer or insurance carrier which seeks to invoke the provisions of section 8(f) of the Act must request limitation of its liability and file a fully documented application with the district director. A fully documented application must contain a specific description of the pre-existing condition relied upon as constituting an existing permanent partial disability and the reasons for believing that the claimant's permanent disability after the injury would be less were it not for the pre-existing permanent partial disability or that the death would not have ensued but for that disability. These reasons must be supported by medical evidence as specified in this paragraph. The application must also contain the basis for the assertion that the pre-existing condition relied upon was manifest in the employer and documentary medical evidence relied upon in support of the request for section 8(f) relief. This medical evidence must include, but not be limited to, a current medical report establishing the extent of all impairments and the date of maximum medical improvement. If the claimant has already reached maximum medical improvement, a report prepared at that time will satisfy the requirement for a current medical report. If the current disability is total, the medical report must explain why the disability is not due solely to the second injury. If the current disability is partial, the medical report must explain why the disability is not due solely to the second injury and why the resulting disability is materially and substantially greater than that which would have resulted from the subsequent injury alone. If the injury is loss of hearing, the pre-existing hearing loss must be documented by an audiogram which complies with the requirements of § 702.441. If the claim is for survivor's benefits, the medical report must establish that the death was not due solely to the second injury. Any other evidence considered necessary for consideration of the request for section 8(f) relief must be submitted when requested by the district director or Director.

(2) If claim is being paid by the special fund and the claimant dies, an employer need not reapply for section 8(f) relief. However, survivor benefits will not be paid until it has been established that the death was due to the accepted injury and the eligible survivors have been identified. The district director will issue a compensation order after a claim has been filed and entitlement of the survivors has been verified. Since the employer remains a party in interest to the claim, a compensation order will not be issued without the agreement of the employer.

(b) *Application: Time for filing.* (1) A request for section 8(f) relief should be made as soon as the permanency of the claimant's condition becomes known or is an issue in dispute. This could be when benefits are first paid for permanent disability, or at an informal conference held to discuss the permanency of the claimant's condition. Where the claim is for death benefits, the request should be made as soon as possible after the date of death. Along with the request for section 8(f) relief, the applicant must also submit all the supporting documentation required by this section, described in paragraph (a) of

this section. Where possible, this documentation should accompany the request, but may be submitted separately, in which case the district director must, at the time of the request, fix a date for submission of the fully documented application. The date must be fixed as follows:

(i) Where notice is given to all parties that permanency will be an issue at an informal conference, the fully documented application must be submitted at or before the conference. For these purposes, notice means when the issue of permanency is noted on the form LS–141, Notice of Informal Conference. All parties are required to list issues reasonably anticipated to be discussed at the conference when the initial request for a conference is made and to notify all parties of additional issues which arise during the period before the conference is actually held.

(ii) Where the issue of permanency is first raised at the informal conference and could not have reasonably been anticipated by the parties prior to the conference, the district director must adjourn the conference and establish the date by which the fully documented application must be submitted and so notify the employer/carrier. The date will be set by the district director after reviewing the circumstances of the case.

(2) At the request of the employer or insurance carrier, and for good cause, the district director, at his/her discretion, may grant an extension of the date for submission of the fully documented application. In fixing the date for submission of the application under circumstances other than described above or in considering any request for an extension of the date for submitting the application, the district director must consider all the circumstances of the case, including but not limited to: Whether the claimant is being paid compensation and the hardship to the claimant of delaying referral of the case to the Office of Administrative Law Judges (OALJ); the complexity of the issues and the availability of medical and other evidence to the employer; the length of time the employer was or should have been aware that permanency is an issue; and, the reasons listed in support of the request. If the employer/carrier requested a specific date, the reasons for selection of that date will also be considered. Neither the date selected for submission of the fully documented application nor any extension therefrom can go beyond the date the case is referred to the OALJ for formal hearing.

(3) Where the claimant's condition has not reached maximum medical improvement and no claim for permanency is raised by the date the case is referred to the OALJ, an application need not be submitted to the district director to preserve the employer's right to later seek relief under section 8(f) of the Act. In all other cases, failure to submit a fully documented application by the date established by the district director will be an absolute defense to the liability of the special fund. This defense is an affirmative defense which must be raised and pleaded by the Director. The absolute defense will not be raised where permanency was not an issue before the district director. In all other cases, where permanency has been raised, the failure of an employer to submit a timely and fully documented application for section 8(f) relief will not prevent the district director, at his/her discretion, from considering the claim for compensation and transmitting the case for formal hearing. The failure of an employer to present a timely and fully documented application for section 8(f) relief may be excused only where the employer could not have reasonably anticipated the liability of the special fund prior to the consideration of the claim by the district director. Relief under section 8(f) is not available to an employer who fails to comply with section 32(a) of the Act, 33 U.S.C. 932(a).

(c) *Application: Approval, disapproval.* If all the evidence required by paragraph (a) of this section was submitted with the application for section 8(f) relief and the facts warrant relief under this section, the district director must award such relief after concurrence by the Associate Director, DLHWC, or his or her designee. If the district director or the Associate Director or his or her designee finds that the facts do not warrant relief under section 8(f) the district director must advise the employer of the grounds for the denial.

The application for section 8(f) relief may then be considered by an administrative law judge. When a case is transmitted to the Office of Administrative Law Judges the district director must also attach a copy of the application for section 8(f) relief submitted by the employer, and notwithstanding § 702.317(c), the district director's denial of the application.

(Approved by the Office of Management and Budget under control number 1215–0160)

[51 FR 4285, Feb. 3, 1986, as amended at 80 FR 12930, Mar. 12, 2015]

FORMAL HEARINGS

§ 702.331 Formal hearings; procedure initiating.

Formal hearings are initiated by transmitting to the Office of the Chief Administrative Law Judge the prehearing statement forms, the available evidence which the parties intend to submit at the formal hearing, and the letter of transmittal from the district director as provided in § 702.316 and § 702.317.

[42 FR 42552, Aug. 23, 1977]

§ 702.332 Formal hearings; how conducted.

Formal hearings shall be conducted by the administrative law judge assigned the case by the Office of the Chief Administrative Law Judge in accordance with the provisions of the Administrative Procedure Act, 5 U.S.C. 554 *et seq*. All hearings shall be transcribed.

§ 702.333 Formal hearings; parties.

(a) The necessary parties for a formal hearing are the claimant and the employer or insurance carrier, and the administrative law judge assigned the case.

(b) The Solicitor of Labor or his designee may appear and participate in any formal hearing held pursuant to these regulations on behalf of the Director as an interested party.

§ 702.334 Formal hearings; representatives of parties.

The claimant and the employer or carrier may be represented by persons of their choice.

§ 702.335 Formal hearings; notice.

On a form prescribed for this purpose, the Office of the Chief Administrative Law Judge shall notify the parties (See § 702.333) of the place and time of the formal hearing not less than 30 days in advance thereof.

[42 FR 42552, Aug. 23, 1977]

§ 702.336 Formal hearings; new issues.

(a) If, during the course of the formal hearing, the evidence presented warrants consideration of an issue or issues not previously considered, the hearing may be expanded to include the new issue. If in the opinion of the administrative law judge the new issue requires additional time for preparation, the parties shall be given a reasonable time within which to prepare for it. If the new issue arises from evidence that has not been considered by the district director, and such evidence is likely to resolve the case without the need for a formal hearing, the administrative law judge may remand the case to the district director for his or her evaluation and recommendation pursuant to, § 702.316.

(b) At any time prior to the filing of the compensation order in the case, the administrative law judge may in his discretion, upon the application of a party or upon his own motion, give notice that he will consider any new issue. The parties shall be given not less than 10 days' notice of the hearing on such new issue. The parties may stipulate that the issue may be heard at an earlier time and shall proceed to a hearing on the new issue in the same manner as on an issue initially considered.

[38 FR 26861, Sept. 26, 1973, as amended at 42 FR 42552, Aug. 23, 1977]

§ 702.337 Formal hearings; change of time or place for hearings; postponements.

(a) Except for good cause shown, hearings shall be held at convenient locations not more than 75 miles from the claimant's residence.

(b) Once a formal hearing has been scheduled, continuances shall not be granted except in cases of extreme hardship or where attendance of a party or his or her representative is

mandated at a previously scheduled judicial proceeding. Unless the ground for the request arises thereafter, requests for continuances must be received by the Chief Administrative Law Judge at least 10 days before the scheduled hearing date, must be served upon the other parties and must specify the extreme hardship or previously scheduled judicial proceeding claimed.

(c) The Chief Administrative Law Judge or the administrative law judge assigned to the case may change the time and place of the hearing, or temporarily adjourn a hearing, on his own motion or for good cause shown by a party. The parties shall be given not less than 10 days' notice of the new time and place of the hearing, unless they agree to such change without notice.

[42 FR 42552, Aug. 23, 1977]

§ 702.338 Formal hearings; general procedures.

All hearings shall be attended by the parties or their representatives and such other persons as the administrative law judge deems necessary and proper. The administrative law judge shall inquire fully into the matters at issue and shall receive in evidence the testimony of witnesses and any documents which are relevant and material to such matters. If the administrative law judge believes that there is relevant and material evidence available which has not been presented at the hearing, he may adjourn the hearing or, at any time, prior to the filing of the compensation order, reopen the hearing for the receipt of such evidence. The order in which evidence and allegations shall be presented and the procedures at the hearings generally, except as these regulations otherwise expressly provide, shall be in the discretion of the administrative law judge and of such nature as to afford the parties a reasonable opportunity for a fair hearing.

§ 702.339 Formal hearings; evidence.

In making an investigation or inquiry or conducting a hearing, the administrative law judge shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by 5 U.S.C. 554 and these regulations; but may make such investigation or inquiry or conduct such hearing in such a manner as to best ascertain the rights of the parties.

§ 702.340 Formal hearings; witnesses.

(a) Witnesses at the hearing shall testify under oath or affirmation. The administrative law judge may examine the witnesses and shall allow the parties or their representatives to do so.

(b) No person shall be required to attend as a witness in any proceeding before an administrative law judge at a place more than 100 miles from his place of residence, unless his lawful mileage and fees for one day's attendance shall be paid or tendered to him in advance of the hearing date.

§ 702.341 Formal hearings; depositions; interrogatories.

The testimony of any witness, including any party represented by counsel, may be taken by deposition or interrogatory according to the Federal Rules of Civil Procedure as supplemented by local rules of practice for the Federal district court for the judicial district in which the case is pending. However, such depositions or interrogatories must be completed within reasonable times to be fixed by the Chief Administrative Law Judge or the administrative law judge assigned to the case.

[42 FR 42552, Aug. 23, 1977]

§ 702.342 Formal hearings; witness fees.

Witnesses summoned in a formal hearing before an administrative law judge or whose depositions are taken shall receive the same fees and mileage as witnesses in courts of the United States (33 U.S.C. 925).

§ 702.343 Formal hearings; oral argument and written allegations.

Any party upon request shall be allowed a reasonable time for presentation of oral argument and shall be permitted to file a pre-hearing brief or other written statement of fact or law. A copy of any such pre-hearing brief or other written statement shall be filed with the Chief Administrative Law Judge or the administrative law judge

assigned to the case before or during the proceeding at which evidence is submitted to the administrative law judge and shall be served upon each other party. Post-hearing briefs will not be permitted except at the request of the administrative law judge or upon averment on the record of a party that the case presents a specific novel or difficult legal or factual issue (or issues) that cannot be adequately addressed in oral summation. When permitted, any such brief shall be limited to the issue or issues specified by the administrative law judge or by the party in his or her averment and shall be due from any party desiring to address such issue or issues within 15 days of the conclusion of the proceeding at which evidence is submitted to the administrative law judge. Enlargement of the time for filing such briefs shall be granted only if the administrative law judge is persuaded that the brief will be helpful to him or her and that the enlargement granted will not delay decision of the case.

[42 FR 42552, Aug. 23, 1977]

§ 702.344 Formal hearings; record of hearing.

All formal hearings shall be open to the public and shall be stenographically reported. All evidence upon which the administrative law judge relies for his final decision shall be contained in the transcript of testimony either directly or by appropriate reference. All medical reports, exhibits, and any other pertinent document or record, in whole or in material part, shall be incorporated into the record either by reference or as an appendix.

§ 702.345 Formal hearings; consolidated issues; consolidated cases.

(a) When one or more additional issues are raised by the administrative law judge pursuant to § 702.336, such issues may, in the discretion of the administrative law judge, be consolidated for hearing and decision with other issues pending before him.

(b) When two or more cases are transferred for formal hearings and have common questions of law or which arose out of a common accident, the Chief Administrative Law Judge may consolidate such cases for hearing.

§ 702.346 Formal hearings; waiver of right to appear.

If all parties waive their right to appear before the administrative law judge or to present evidence or argument personally or by representative, it shall not be necessary for the administrative law judge to give notice of and conduct an oral hearing. A waiver of the right to appear and present evidence and allegations as to facts and law shall be made in writing and filed with the Chief Administrative Law Judge or the administrative law judge. Where such a waiver has been filed by all parties, and they do not appear before the administrative law judge personally or by representative, the administrative law judge shall make a record of the relevant written evidence submitted by the parties, together with any pleadings they may submit with respect to the issues in the case. Such documents shall be considered as all of the evidence in the case and the decision shall be based on them.

§ 702.347 Formal hearings; termination.

(a) Formal hearings are normally terminated upon the conclusion of the proceeding at which evidence is submitted to the administrative law judge.

(b) In exceptional cases the Chief Administrative Law Judge or the administrative law judge assigned to the case may, in his or her discretion, extend the time for official termination of the hearing.

[42 FR 42552, Aug. 23, 1977]

§ 702.348 Formal hearings; preparation of final decision and order; content.

Within 20 days after the official termination of the hearing as defined by § 702.347, the administrative law judge shall have prepared a final decision and order, in the form of a compensation order, with respect to the claim, making an award to the claimant or rejecting the claim. The compensation order shall contain appropriate findings of facts and conclusions of law with respect thereto, and shall be concluded with one or more paragraphs containing the order of the administrative law judge, his signature, and the date of issuance.

§ 702.349 Formal hearings; filing and mailing of compensation orders; waiver of service; disposition of transcripts.

(a) An administrative law judge must, within 20 days after the official termination of the hearing, deliver by mail, or otherwise, to the district director that administered the claim, the transcript of the hearing, other documents or pleadings filed with him with respect to the claim, and his signed compensation order. Upon receipt thereof, the district director, being the official custodian of all records with respect to claims he administers, must formally date and file the transcript, pleadings, and compensation order in his office. Such filing must be accomplished by the close of business on the next succeeding working day, and the district director must, on the same day as the filing was accomplished, serve a copy of the compensation order on the parties and on the representatives of the parties, if any. Service on the parties and their representatives must be made by certified mail unless a party has previously waived service by this method under paragraph (b) of this section.

(b) All parties and their representatives are entitled to be served with compensation orders via registered or certified mail. Parties and their representatives may waive this right and elect to be served with compensation orders electronically by filing the appropriate waiver form with the district director responsible for administering the claim. To waive service by registered or certified mail, employers, insurance carriers, and their representatives must file form LS–801 (Waiver of Service by Registered or Certified Mail for Employers and/or Insurance Carriers), and claimants and their representatives must file form LS–802 (Waiver of Service by Registered or Certified Mail for Claimants and/or Authorized Representatives). A signature on a waiver form represents a knowing and voluntary waiver of that party's or representative's right to receive compensation orders via registered or certified mail.

(1) Waiving parties and representatives must provide a valid electronic address on the waiver form.

(2) Parties and representatives must submit a separate waiver form for each case in which they intend to waive the right to certified or registered mail service.

(3) A representative may not sign a waiver form on a party's behalf.

(4) All compensation orders issued in a claim after receipt of the waiver form will be sent to the electronic address provided on the waiver form. Any changes to the address must be made by submitting another waiver form. Individuals may revoke their service waiver at any time by submitting a new waiver form that specifies that the service waiver is being revoked.

(5) If it appears that service in the manner selected by the individual has not been effective, the district director will serve the individual by certified mail.

[80 FR 12931, Mar. 12, 2015]

§ 702.350 Finality of compensation orders.

Compensation orders shall become effective when filed in the office of the district director, and unless proceedings for suspension or setting aside of such orders are instituted within 30 days of such filing, shall become final at the expiration of the 30th day after such filing, as provided in section 21 of the Act 33 U.S.C. 921. If any compensation payable under the terms of such order is not paid within 10 days after it becomes due, section 14(f) of the Act requires that there be added to such unpaid compensation an amount equal to 20 percent thereof which shall be paid at the same time as, but in addition to, such compensation unless review of the compensation order is had as provided in such section 21 and an order staying payment has been issued by the Benefits Review Board or the reviewing court.

§ 702.351 Withdrawal of controversion of issues set for formal hearing; effect.

Whenever a party withdraws his controversion of the issues set for a formal hearing, the administrative law judge shall halt the proceedings upon receipt from said party of a signed statement to that effect and forthwith notify the district director who shall

then proceed to dispose of the case as provided for in § 702.315.

INTERLOCUTORY MATTERS, SUPPLEMENTARY ORDERS, AND MODIFICATIONS

§ 702.371 Interlocutory matters.

Compensation orders shall not be made or filed with respect to interlocutory matters of a procedural nature arising during the pendency of a compensation case.

§ 702.372 Supplementary compensation orders.

(a) In any case in which the employer or insurance carrier is in default in the payment of compensation due under any award of compensation, for a period of 30 days after the compensation is due and payable, the person to whom such compensation is payable may, within 1 year after such default, apply in writing to the district director for a supplementary compensation order declaring the amount of the default. Upon receipt of such application, the district director will institute proceedings with respect to such application as if such application were an original claim for compensation, and the matter will be disposed of as provided for in § 702.315, or if agreement on the issue is not reached, then as in §§ 702.316 through 702.319.

(b) If, after disposition of the application as provided for in paragraph (a) of this section, a supplementary compensation order is entered declaring the amount of the default, which amount may be the whole of the award notwithstanding that only one or more installments is in default, a copy of such supplementary order must be filed and served in accordance with § 702.349. Thereafter, the applicant may obtain and file with the clerk of the Federal district court for the judicial district where the injury occurred or the district in which the employer has his principal place of business or maintains an office, a certified copy of said order and may seek enforcement thereof as provided for by section 18 of the Act, 33 U.S.C. 918.

[80 FR 12932, Mar. 12, 2015]

§ 702.373 Modification of awards.

(a) Upon his/her own initiative, or upon application of any party in interest (including an employer or carrier which has been granted relief under section 8(f) of the Act, 33 U.S.C. 908(f)), the district director may review any compensation case (including a case under which payments are made pursuant to section 44(i) of the Act, 33 U.S.C. 944(i)) in accordance with the procedure in subpart C of this part, and after such review of the case under § 702.315, or review at formal hearings under the regulations governing formal hearings in subpart C of this part, file a new compensation order terminating, continuing, reinstating, increasing or decreasing such compensation, or awarding compensation. Such new order shall not affect any compensation previously paid, except that an award increasing the compensation rate may be made retroactive from the date of injury, and if any part of the compensation due or to become due is unpaid, an award decreasing the compensation rate may be made effective from the date of the injury, and any payment made prior thereto in excess of such decreased rate shall be deducted from any unpaid compensation, in such manner and by such method as may be determined by the district director or the administrative law judge. Settlements cannot be modified.

(b) Review of a compensation case under this section may be made at any time prior to 1 year after the date of the last payment of compensation, whether or not a compensation order has been issued, or at any time prior to 1 year after the rejection of a claim.

(c) Review of a compensation case may be had only for the reason that there is a change in conditions or that there was a mistake in the determination of facts.

(d) If the investigation, described in § 702.148(c), discloses a change in conditions and the employer or insurance carrier intends to pursue modification of the award of compensation the district director and claimant shall be notified through an informal conference. At the conclusion of the informal conference the district director shall issue a recommendation either for or against

the modification. This recommendation shall also be sent to the Associate Director, Division of Longshoremen's and Harbor Workers' Compensation (DLHWC) for a determination on whether or not to participate in the modification proceeding on behalf of the special fund. Lack of concurrence of the Associate Director, DLHWC or lack of participation by a representative of the special fund shall not be a bar to the modification proceeding.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 401, Jan. 3, 1985]

APPEALS

§ 702.391 Appeals; where.

Appeals may be taken to the Benefits Review Board, U.S. Department of Labor, Washington, D.C. 20210, by filing a notice of appeals with the office of the district director for the compensation district in which the decision or order appealed from was filed and by submitting to the Board a petition for review of such decision or order, in accordance with the provisions of part 802 of this title 20.

§ 702.392 Appeals; what may be appealed.

An appeal raising a substantial question of law or fact may be taken from a decision with respect to a claim under the Act. Such appeals may be taken from compensation orders when they have been filed as provided for in § 702.349.

§ 702.393 Appeals; time limitations.

The notice of appeal (see § 702.391) shall be filed with the district director within 30 days of the filing of the decision or order complained of, as defined and described in §§ 802.205 and 802.206 of this title. A petition for review of the decision or order is required to be filed within 30 days after receipt of the Board's acknowledgment of the notice of appeal, as provided in § 802.210 of this title.

§ 702.394 Appeals; procedure.

The procedure for appeals to the Benefits Review Board shall be as provided by the Board in its Rules of Practice and Procedure, set forth in part 802 of this title.

Subpart D—Medical Care and Supervision

§ 702.401 Medical care defined.

(a) Medical care shall include medical, surgical, and other attendance or treatment, nursing and hospital services, laboratory, X-ray and other technical services, medicines, crutches, or other apparatus and prosthetic devices, and any other medical service or supply, including the reasonable and necessary cost of travel incident thereto, which is recognized as appropriate by the medical profession for the care and treatment of the injury or disease.

(b) An employee may rely on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a recognized church or religious denomination, by an accredited practitioner of such recognized church or religious denomination, and nursing services rendered in accordance with such tenets and practice without loss or diminution of compensation or benefits under the Act. For purposes of this section, a recognized church or religious denomination shall be any religious organization: (1) That is recognized by the Social Security Administration for purposes of reimbursements for treatment under Medicare and Medicaid or (2) that is recognized by the Internal Revenue Service for purposes of tax exempt status.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.402 Employer's duty to furnish; duration.

It is the duty of the employer to furnish appropriate medical care (as defined in § 702.401(a)) for the employee's injury, and for such period as the nature of the injury or the process of recovery may require.

[50 FR 402, Jan. 3, 1985]

§ 702.403 Employee's right to choose physician; limitations.

The employee shall have the right to choose his/her attending physician from among those authorized by the Director, OWCP, to furnish such care and treatment, except those physicians included on the Secretary's list of

debarred physicians. In determining the choice of a physician, consideration must be given to availability, the employee's condition and the method and means of transportation. Generally 25 miles from the place of injury, or the employee's home is a reasonable distance to travel, but other pertinent factors must also be taken into consideration.

[50 FR 402, Jan. 3, 1985]

§ 702.404 Physician defined.

The term *physician* includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. The term includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation shown by X-ray or clinical findings. Physicians defined in this part may interpret their own X-rays. All physicians in these categories are authorized by the Director to render medical care under the Act. Naturopaths, faith healers, and other practitioners of the healing arts which are not listed herein are not included within the term ''physician'' as used in this part.

[42 FR 45303, Sept. 9, 1977]

§ 702.405 Selection of physician; emergencies.

Whenever the nature of the injury is such that immediate medical care is required and the injured employee is unable to select a physician, the employer shall select a physician. Thereafter the employee may change physicians when he is able to make a selection. Such changes shall be made upon obtaining written authorization from the employer or, if consent is withheld, from the district director. The Director will direct reimbursement of medical claims for services rendered by physicians or health care providers who are on the list of those excluded from providing care under the Act, if such services were rendered in an emergency. (See §§ 702.417 and 702.435(b)).

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.406 Change of physicians; nonemergencies.

(a) Whenever the employee has made his initial, free choice of an attending physician, he may not thereafter change physicians without the prior written consent of the employer (or carrier) or the district director. Such consent shall be given in cases where an employee's initial choice was not of a specialist whose services are necessary for, and appropriate to, the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.

(b) The district director for the appropriate compensation district may order a change of physicians or hospitals when such a change is found to be necessary or desirable or where the fees charged exceed those prevailing within the community for the same or similar services or exceed the provider's customary charges.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.407 Supervision of medical care.

The Director, OWCP, through the district directors and their designees, shall actively supervise the medical care of an injured employee covered by the Act. Such supervision shall include:

(a) The requirement that periodic reports on the medical care being rendered be filed in the office of the district director, the frequency thereof being determined by order of the district director or sound judgment of the attending physician as the nature of the injury may dictate;

(b) The determination of the necessity, character and sufficiency of any medical care furnished or to be furnished the employee, including whether the charges made by any medical care provider exceed those permitted under the Act;

(c) The determination of whether a change of physicians, hospitals or other persons or locales providing treatment should be made or is necessary;

(d) The further evaluation of medical questions arising in any case under the

Act, with respect to the nature and extent of the covered injury, and the medical care required therefor.

[38 FR 26861, Sept. 26, 1973, as amended at 50 FR 402, Jan. 3, 1985]

§ 702.408 Evaluation of medical questions; impartial specialists.

In any case in which medical questions arise with respect to the appropriate diagnosis, extent, effect of, appropriate treatment, and the duration of any such care or treatment, for an injury covered by the Act, the Director, OWCP, through the district directors having jurisdiction, shall have the power to evaluate such questions by appointing one or more especially qualified physicians to examine the employee, or in the case of death to make such inquiry as may be appropriate to the facts and circumstances of the case. The physician or physicians, including appropriate consultants, should report their findings with respect to the questions raised as expeditiously as possible. Upon receipt of such report, action appropriate therewith shall be taken.

§ 702.409 Evaluation of medical questions; results disputed.

Any party who is dissatisfied with such report may request a review or reexamination of the employee by one or more different physicians employed by or selected by the Director, and such review or reexamination shall be granted unless it is found that it is clearly unwarranted. Such review shall be completed within 2 weeks from the date ordered unless it is impossible to complete the review and render a report thereon within such time period. Upon receipt of the report of this additional review and reexamination, such action as may be appropriate shall forthwith be taken.

§ 702.410 Duties of employees with respect to special examinations.

(a) For any special examination required of an employee by §§ 702.408 and 702.409, the employee shall submit to such examination at such place as is designated in the order to report, but the place so selected shall be reasonably convenient for the employee.

(b) Where an employee fails to submit to an examination required by §§ 702.408 and 702.409, the district director or administrative law judge may order that no compensation otherwise payable shall be paid for any period during which the employee refuses to submit to such examination unless circumstances justified the refusal.

(c) Where an employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the district director or administrative law judge may by order suspend the payment of further compensation during such time as the refusal continues. Except that refusal to submit to medical treatment because of adherence to the tenets of a recognized church or religious denomination as described in § 702.401(b) shall not cause the suspension of compensation.

[42 FR 45303, Sept. 9, 1977, as amended at 50 FR 402, Jan. 3, 1985; 51 FR 4286, Feb. 3, 1986]

§ 702.411 Special examinations; nature of impartiality of specialists.

(a) The special examinations required by § 702.408 shall be accomplished in a manner designed to preclude prejudgment by the impartial examiner. No physician previously connected with the case shall be present, nor may any other physician selected by the employer, carrier, or employee be present. The impartial examiner may be made aware, by any party or by the OWCP, of the opinions, reports, or conclusions of any prior examining physician with respect to the nature and extent of the impairment, its cause, or its effect upon the wage-earning capacity of the injured employee, if the district director determines that, for good cause, such opinions, reports, or conclusions shall be made available. Upon request, any party shall be given a copy of all materials made available to the impartial examiner.

(b) The impartiality of the specialists shall not be considered to have been compromised if the district director deems it advisable to, and does, apprise the specialist by memorandum of those undisputed facts pertaining to the nature of the employee's employment, of the nature of the injury, of the post-injury employment activity, if any, and

of any other facts which are not disputed and are deemed pertinent to the type of injury and/or the type of examination being conducted.

(c) No physician selected to perform impartial examinations shall be, or shall have been for a period of 2 years prior to the examination, an employee of an insurance carrier or self-insured employer, or who has accepted or participated in any fee from an insurance carrier or self-insured employer, unless the parties in interest agree thereto.

[38 FR 26861, Sept. 26, 1973, as amended at 42 FR 45303, Sept. 9, 1977]

§ 702.412 Special examinations; costs chargeable to employer or carrier.

(a) The Director or his designee ordering the special examination shall have the power, in the exercise of his discretion, to charge the cost of the examination or review to the employer, to the insurance carrier, or to the special fund established by section 44 of the Act, 33 U.S.C. 944.

(b) The Director or his designee may also order the employer or the insurance carrier to provide the employee with the services of an attendant, where the district director considers such services necessary, because the employee is totally blind, has lost the use of both hands, or both feet or is paralyzed and unable to walk, or because of other disability making the employee so helpless as to require constant attendance in the discretion of the district director. Fees payable for such services shall be in accord with the provisions of § 702.413.

[42 FR 45303, Sept. 9, 1977]

§ 702.413 Fees for medical services; prevailing community charges.

All fees charged by medical care providers for persons covered by this Act shall be limited to such charges for the same or similar care (including supplies) as prevails in the community in which the medical care provider is located and shall not exceed the customary charges of the medical care provider for the same or similar services. Where a dispute arises concerning the amount of a medical bill, the Director shall determine the prevailing community rate using the OWCP Medical Fee Schedule (as described in 20 CFR 10.805 *through 10.810*) to the extent appropriate, and where not appropriate, may use other state or federal fee schedules. The opinion of the Director that a charge by a medical care provider disputed under the provisions of section 702.414 exceeds the charge which prevails in the community in which said medical care provider is located shall constitute sufficient evidence to warrant further proceedings pursuant to section 702.414 and to permit the Director to direct the claimant to select another medical provider for care to the claimant.

[60 FR 51348, Oct. 2, 1995, as amended at 77 FR 37286, June 21, 2012]

§ 702.414 Fees for medical services; unresolved disputes on prevailing charges.

(a) The Director may, upon written complaint of an interested party, or upon the Director's own initiative, investigate any medical care provider or any fee for medical treatment, services, or supplies that appears to exceed prevailing community charges for similar treatment, services or supplies or the provider's customary charges. The OWCP medical fee schedule (see section 702.413) shall be used by the Director, where appropriate, to determine the prevailing community charges for a medical procedure by a physician or hospital (to the extent such procedure is covered by the OWCP fee schedule). The Director's investigation may initially be conducted informally through contact of the medical care provider by the district director. If this informal investigation is unsuccessful further proceedings may be undertaken. These proceedings may include, but not be limited to: an informal conference involving all interested parties; agency interrogatories to the pertinent medical care provider; and issuance of subpoenas duces tecum for documents having a bearing on the dispute.

(1) A claim by the provider that the OWCP fee schedule does not represent the prevailing community rate will be considered only where the following circumstances are presented:

(i) where the actual procedure performed was incorrectly identified by medical procedure code;

(ii) that the presence of a severe or concomitant medical condition made treatment especially difficult;

(iii) the provider possessed unusual qualifications (board certification in a specialty is not sufficient evidence in itself of unusual qualifications); or

(iv) the provider or service is not one covered by the OWCP fee schedule as described by 20 CFR 10.805 *through 10.810*.

(2) The circumstances listed in paragraph (a)(1) of this section are the only ones which will justify reevaluation of the amount calculated under the OWCP fee schedule.

(b) The failure of any medical care provider to present any evidence required by the Director pursuant to this section without good cause shall not prevent the Director from making findings of fact.

(c) After any proceeding under this section the Director shall make specific findings on whether the fee exceeded the prevailing community charges (as established by the OWCP fee schedule, where appropriate) or the provider's customary charges and provide notice of these findings to the affected parties.

(d) The Director may suspend any such proceedings if after receipt of the written complaint the affected parties agree to withdraw the controversy from agency consideration on the basis that such controversy has been resolved by the affected parties. Such suspension, however, shall be at the discretion of the Director.

[51 FR 4286, Feb. 3, 1986, as amended at 60 FR 51348, Oct. 2, 1995; 77 FR 37286, June 21, 2012]

§ 702.415 Fees for medical services; unresolved disputes on charges; procedure.

After issuance of specific findings of fact and proposed action by the Director as provided in § 702.414 any affected provider employer or other interested party has the right to seek a hearing pursuant to section 556 of title 5, United States Code. Upon written request for such a hearing, the matter shall be referred by the District Director to the OALJ for formal hearing in accordance with the procedures in subpart C of this part. If no such request for a hearing is filed with the district director within thirty (30) days the findings issued pursuant to § 702.414 shall be final.

[51 FR 4286, Feb. 3, 1986]

§ 702.416 Fees for medical services; disputes; hearings; necessary parties.

At formal hearings held pursuant to § 702.415, the necessary parties shall be the person whose fee or cost charge is in question and the Director, or their representatives. The employer or carrier may also be represented, and other parties, or associations having an interest in the proceedings, may be heard, in the discretion of the administrative law judge.

§ 702.417 Fees for medical services; disputes; effect of adverse decision.

If the final decision and order upholds the finding of the Director that the fee or charge in dispute was not in accordance with prevailing community charges or the provider's customary charges, the person claiming such fee or cost charge shall be given thirty (30) days after filing of such decision and order to make the necessary adjustment. If such person still refuses to make the required readjustment, such person shall not be authorized to conduct any further treatments or examinations (if a physician) or to provide any other services or supplies (if by other than a physician). Any fee or cost charge subsequently incurred for services performed or supplies furnished shall not be a reimbursable medical expense under this subpart. This prohibition shall apply notwithstanding the fact that the services performed or supplies furnished were in all other respects necessary and appropriate within the provision of these regulations. However, the Director may direct reimbursement of medical claims for services rendered if such services were rendered in an emergency (see § 702.435(b)). At the termination of the proceedings provided for in this section the district director shall determine whether further proceedings under § 702.432 should be initiated.

[50 FR 403, Jan. 3, 1985]

MEDICAL PROCEDURES

§ 702.418 Procedure for requesting medical care; employee's duty to notify employer.

(a) As soon as practicable, but within 30 days after occurrence of an injury covered by the Act, or within 30 days after an employee becomes aware, or in the exercise of reasonable diligence should be aware, of the relationship between an injury or disease and his employment, the injured employee or someone on his behalf shall give written notice thereof to the district director having jurisdiction over the place where the injury occurred and to the employer. If a form has been prescribed for such purpose it shall be used, if available and practicable under the circumstances. Notices filed under subpart B of this part, if on the form prescribed by the Director for such purpose, satisfy the written notice requirements of this subpart.

(b) In the case of an occupational disease which does not immediately result in a disability or death, such notice shall be given within one year after the employee becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability. Notice shall be given: (1) To the district director in the compensation district in which the injury or death occurred, and (2) to the employer.

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 403, Jan. 3, 1985]

§ 702.419 Action by employer upon acquiring knowledge or being given notice of injury.

Whenever an employer acquires knowledge of an employee's injury, through receipt of a written notice or otherwise, said employer shall forthwith authorize, in writing, appropriate medical care. If a form is prescribed for this purpose it shall be used whenever practicable. Authorization shall also be given in cases where an employee's initial choice was not of a specialist whose services are necessary for and appropriate to the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.

[50 FR 403, Jan. 3, 1985]

§ 702.420 Issuance of authorization; binding effect upon insurance carrier.

The issuance of an authorization for treatment by the employer shall bind his insurance carrier to furnish and pay for such care and services.

§ 702.421 Effect of failure to obtain initial authorization.

An employee shall not be entitled to recover for medical services and supplies unless:

(a) The employer shall have refused or neglected a request to furnish such services and the employee has complied with sections 7 (b) and (c) of the Act, 33 U.S.C. 907 (b) and (c) and these regulations; or

(b) The nature of the injury required such treatment and services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize same.

[50 FR 403, Jan. 3, 1985]

§ 702.422 Effect of failure to report on medical care after initial authorization.

(a) Notwithstanding that medical care is properly obtained in accordance with these regulations, a finding by the Director that a medical care provider has failed to comply with the reporting requirements of the Act shall operate as a mandatory revocation of authorization of such medical care provider. The effect of a final finding to this effect operates to release the employer/carrier from liability of the expenses of such care. In addition to this, when such a finding is made by the Director, the claimant receiving treatment will be directed by the district director to seek authorization for medical care from another source.

(b) For good cause shown, the Director may excuse the failure to comply with the reporting requirements of the Act and further, may make an award

for the reasonable value of such medical care.

[50 FR 403, Jan. 3, 1985]

DEBARMENT OF PHYSICIANS AND OTHER PROVIDERS OF MEDICAL SERVICES AND SUPPLIERS AND CLAIMS REPRESENTATIVES

§ 702.431 Grounds for debarment.

A physician or health care provider shall be debarred if it is found, after appropriate investigation as described in § 702.414 and proceedings under §§ 702.432 and 702.433, that such physician or health care provider has:

(a) Knowingly and willfully made, or caused to be made, any false statement or misrepresentation of a material fact for use in a claim for compensation or claim for reimbursement of medical expenses under this Act;

(b) Knowingly and willfully submitted, or caused to be submitted, a bill or request for payment under this Act containing a charge which the Director finds to be substantially in excess of the charge for the service, appliance, or supply prevailing within the community or in excess of the provider's customary charges, unless the Director finds there is good cause for the bill or request containing the charge;

(c) Knowingly and willfully furnished a service, appliance, or supply which is determined by the Director to be substantially in excess of the need of the recipient thereof or to be of a quality which substantially fails to meet professionally recognized standards;

(d) Been convicted under any criminal statute, without regard to pending appeal thereof, for fraudulent activities in connection with federal or state program for which payments are made to physicians or providers of similar services, appliances, or supplies; or has otherwise been excluded from participation in such program.

(e) The fact that a physician or health care provider has been convicted of a crime previously described in (d), or excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any program as described in (d), shall be a prima facie finding of fact for purposes of section 7(j)(2) of the Act, 33 U.S.C. 907(j)(2).

[50 FR 404, Jan. 3, 1985]

§ 702.432 Debarment process.

(a) *Pertaining to health care providers.* Upon receipt of information indicating that a physician or health care provider has engaged in activities enumerated in subparagraphs (a) through (c) of § 702.431, the Director, through the Director's designees, may evaluate the information (as described in § 702.414) to ascertain whether proceedings should be initiated against the physician or health care provider to remove authorization to render medical care or service under the Longshore and Harbor Workers' Compensation Act.

(b) *Pertaining to health care providers and claims representatives.* If after appropriate investigation the Director determines that proceedings should be initiated, written notice thereof must be provided to the physician, health care provider or claims representative. Notice must contain the following:

(1) A concise statement of the grounds upon which debarment will be based;

(2) A summary of the information upon which the director has relied in reaching an initial decision that debarment proceedings should be initiated;

(3) An invitation to the physician, health care provider or claims representative to: (i) Resign voluntarily from participation in the program without admitting or denying the allegations presented in the written notice; or (ii) request a decision on debarment to be based upon the existing agency record and any other information the physician, health care provider or claims representative may wish to provide;

(4) A notice of the physician's, health care provider's or claims representative's right, in the event of an adverse ruling by the Director, to request a formal hearing before an administrative law judge;

(5) A notice that should the physician, health care provider or claims representative fail to provide written answer to the written notice described in this section within thirty (30) days of receipt, the Director may deem the allegations made therein to be true and

may order exclusion of the physician, health care provider or claims representative without conducting any further proceedings; and

(6) The name and address of the district director who will be responsible for receiving the answer from the physician, health care provider or claims representative.

(c) Should the physician, health care provider or claims representative fail to file a written answer to the notice described in this section within thirty (30) days of receipt thereof, the Director may deem the allegations made therein to be true and may order debarment of the physician, health care provider or claims representative.

(d) The physician, health care provider or claims representative may inspect or request copies of information in the agency records at any time prior to the Director's decision.

(e) The Director must issue a decision in writing, and must send a copy of the decision to the physician, health care provider or claims representative. The decision must advise the physician, health care provider or claims representative of the right to request, within thirty (30) days of the date of an adverse decision, a formal hearing before an administrative law judge under the procedures set forth herein. The filing of such a request for hearing within the time specified will operate to stay the effectiveness of the decision to debar.

[50 FR 404, Jan. 3, 1985, as amended at 80 FR 12932, Mar. 12, 2015]

§ 702.433 Requests for hearing.

(a) A request for hearing must be sent to the district director and contain a concise notice of the issues on which the physician, health care provider or claims representative desires to give evidence at the hearing with identification of witnesses and documents to be submitted at the hearing.

(b) If a request for hearing is timely received by the district director, the matter must be referred to the Chief Administrative Law Judge who must assign it for hearing with the assigned administrative law judge issuing a notice of hearing for the conduct of the hearing. A copy of the hearing notice must be served on the physician, health care provider or claims representative.

(c) If a request for hearing contains identification of witnesses or documents not previously considered by the Director, the Director may make application to the assigned administrative law judge for an offer of proof from the physician, health care provider or claims representative for the purpose of discovery prior to hearing. If the offer of proof indicates injection of new issues or new material evidence not previously considered by the Director, the Director may request a remand order for purposes of reconsideration of the decision made pursuant to § 702.432 of these regulations.

(d) The parties may make application for the issuance of subpoenas upon a showing of good cause therefore to the administrative law judge.

(e) The administrative law judge will issue a recommended decision after the termination of the hearing. The recommended decision must contain appropriate findings, conclusions and a recommended order and be forwarded, together with the record of the hearing, to the Administrative Review Board for a final decision. The recommended decision must be served upon all parties to the proceeding.

(f) Based upon a review of the record and the recommended decision of the administrative law judge, the Administrative Review Board will issue a final decision.

[50 FR 404, Jan. 3, 1985, as amended at 55 FR 28606, July 12, 1990; 61 FR 19984, May 3, 1996; 80 FR 12932, Mar. 12, 2015]

§ 702.434 Judicial review.

(a) Any physician, health care provider or claims representative, after any final decision of the Administrative Review Board made after a hearing to which such person was a party, irrespective of the amount of controversy, may obtain a review of such decision by a civil action commenced within sixty (60) days after the mailing to him or her of notice of such decision, but the pendency of such review shall not operate as a stay upon the effect of such decision. Such action shall be brought in the Court of Appeals of the United States for the judicial circuit in which the plaintiff resides or has his or

her principal place of business, or the Court of Appeals for the District of Columbia pursuant to section 7(j)(4) of the Act, 33 U.S.C. 907(j)(4).

(b) As part of the Administrative Review Board answer, he or she shall file a certified copy of the transcript of the record of the hearing, including all evidence submitted in connection therewith.

(c) The findings of fact of the Administrative Review Board, if based on substantial evidence in the record as a whole, shall be conclusive.

[50 FR 405, Jan. 3, 1985, as amended at 55 FR 28606, July 12, 1990; 61 FR 19984, May 3, 1996]

§ 702.435 Effects of debarment.

(a) The Director shall give notice of the debarment of a physician, hospital, or provider of medical support services or supplies to:

(1) All OWCP district offices;

(2) The Health Care Financing Administration;

(3) The State or Local authority responsible for licensing or certifying the debarred party;

(4) The employers and authorized insurers under the Act by means of an annual bulletin sent to them by the Director; and

(5) The general public by posting in the district office in the jurisdiction where the debarred party maintains a place of business.

If a claims representative is debarred, the Director shall give notice to those groups listed in paragraphs (a) (1), (3), (4), and (5) of this section.

(b) Notwithstanding any debarment under this subpart, the Director shall not refuse a claimant reimbursement for any otherwise reimbursable medical expense if the treatment, service or supply was rendered by debarred provider in an emergency situation. However, such claimant will be directed by the Director to select a duly qualified provider upon the earliest opportunity.

[50 FR 405, Jan. 3, 1985]

§ 702.436 Reinstatement.

(a) If a physician or health care provider has been debarred or pursuant to § 702.431(d) or if a claims representative has been debarred pursuant to § 702.131(c) (1) or (3) the person debarred will be automatically reinstated upon notice to the Director that the conviction or exclusion has been reversed or withdrawn. However, such reinstatement will not preclude the Director from instituting debarment proceedings based upon the subject matter involved.

(b) A physician, health care provider or claims representative otherwise debarred by the Director may apply for reinstatement to participate in the program by application to the Director after three years from the date of entry of the order of exclusion. Such application for reinstatement shall be addressed to the Associate Director for the Longshore program, and shall contain a statement of the basis of the application along with any supporting documentation.

(c) The Director may further investigate the merits of the reinstatement application by requiring special reporting procedures from the applicant for a probationary period not to exceed six months to be monitored by the district office where the provider maintains a place of business.

(d) At the end of aforesaid probationary period, the Director may order full reinstatement of the physician, health care provider or claims representative if such reinstatement is clearly consistent with the program goal to protect itself against fraud and abuse and, further, if the physician, health care provider or claims representative has given reasonable assurances that the basis for the debarment will not be repeated.

[50 FR 405, Jan. 3, 1985]

HEARING LOSS CLAIMS

§ 702.441 Claims for loss of hearing.

(a) Claims for hearing loss pending on or filed after September 28, 1984 (the date of enactment of Pub. L. 98–426) shall be adjudicated with respect to the determination of the degree of hearing impairment in accordance with these regulations.

(b) An audiogram shall be presumptive evidence of the amount of hearing loss on the date administered if the following requirements are met:

(1) The audiogram was administered by a licensed or certified audiologist, by a physician certified by the American Board of Otolaryngology, or by a technician, under an audiologist's or physician's supervision, certified by the Council of Accreditation on Occupational Hearing Conservation, or by any other person considered qualified by a hearing conservation program authorized pursuant to 29 CFR 1910.95(g)(3) promulgated under the Occupational Safety and Health Act of 1970 (29 U.S.C. 667). Thus, either a professional or trained technician may conduct audiometric testing. However, to be acceptable under this subsection, a licensed or certified audiologist or otolaryngologist, as defined, must ultimately interpret and certify the results of the audiogram. The accompanying report must set forth the testing standards used and describe the method of evaluating the hearing loss as well as providing an evaluation of the reliability of the test results.

(2) The employee was provided the audiogram and a report thereon at the time it was administered or within thirty (30) days thereafter.

(3) No one produces a contrary audiogram of equal probative value (meaning one performed using the standards described herein) made at the same time. ''Same time'' means within thirty (30) days thereof where noise exposure continues or within six (6) months where exposure to excessive noise levels does not continue. Audiometric tests performed prior to the enactment of Public Law 98–426 will be considered presumptively valid if the employer complied with the procedures in this section for administering audiograms.

(c) In determining the amount of preemployment hearing loss, an audiogram must be submitted which was performed prior to employment or within thirty (30) days of the date of the first employment-related noise exposure. Audiograms performed after December 27, 1984 must comply with the standards described in paragraph (d) of this section.

(d) In determining the loss of hearing under the Act, the evaluators shall use the criteria for measuring and calculating hearing impairment as published and modified from time-to-time by the American Medical Association in the *Guides to the Evaluation of Permanent Impairment*, using the most currently revised edition of this publication. In addition, the audiometer used for testing the individual's threshold of hearing must be calibrated according to current American National Standard Specifications for Audiometers. Audiometer testing procedures required by hearing conservation programs pursuant to the Occupational Safety and Health Act of 1970 should be followed (as described at 29 CFR 1910.95 and appendices).

(Approved by the Office of Management and Budget under control number 1215–0160)

[50 FR 405, Jan. 3, 1985]

Subpart E—Vocational Rehabilitation

§ 702.501 Vocational rehabilitation; objective.

The objective of vocational rehabilitation is the return of permanently disabled persons to gainful employment commensurate with their physical or mental impairments, or both, through a program of reevaluation or redirection of their abilities, or retraining in another occupation, or selective job placement assistance.

§ 702.502 Vocational rehabilitation; action by district directors.

All injury cases which are likely to result in, or have resulted in, permanent disability, and which are of a character likely to require review by a vocational rehabilitation adviser on the staff of the Director, shall promptly be referred to such adviser by the district director or his designee having charge of the case. A form has been prescribed for such purpose and shall be used. Medical data and other pertinent information shall accompany the referral.

(Approved by the Office of Management and Budget under control number 1215–0051)

(Pub. L. No. 96–511)

[38 FR 26861, Sept. 26, 1973, as amended at 49 FR 18294, Apr. 30, 1984]

§ 702.503 Vocational rehabilitation; action by adviser.

The vocational rehabilitation adviser, upon receipt of the referral, shall promptly consider the feasibility of a vocational referral or request for cooperative services from available resources or facilities, to include counseling, vocational survey, selective job placement assistance, and retraining. Public or private agencies may be utilized in arranging necessary vocational rehabilitation services under the Federal Vocational Rehabilitation Act, 29 U.S.C. 31 *et seq*.

§ 702.504 Vocational rehabilitation; referrals to State Employment Agencies.

Vocational rehabilitation advisers will arrange referral procedures with State Employment Service units within their assigned geographical districts for the purpose of securing employment counseling, job classification, and selective placement assistance. Referrals shall be made to State Employment Offices based upon the following:

(a) Vocational rehabilitation advisers will screen cases so as to refer only those disabled employees who are considered to have employment potential;

(b) Only employees will be referred who have permanent, compensable disabilities resulting in a significant vocational handicap and loss of wage earning capacity;

(c) Disabled employees, whose initial referral to former private employers did not result in a job reassignment or in a job retention, shall be referred for employment counseling and/or selective placement unless retraining services consideration is requested;

(d) The vocational rehabilitation advisers shall arrange for employees' referrals if it is ascertained that they may benefit from registering with the State Employment Service;

(e) Referrals will be made to appropriate State Employment Offices by letter, including all necessary information and a request for a report on the services provided the employee when he registers;

(f) The injured employee shall be advised of available job counseling services and informed that he is being referred for employment and selective placement;

(g) A followup shall be made within 60 days on all referrals to assure uniform reporting by State agencies on cases referred for a vocational survey.

§ 702.505 Vocational rehabilitation; referrals to other public and private agencies.

Referrals to such other public and private agencies providing assistance to disabled persons such as public welfare agencies, Public Health Services facilities, social services units of the Veterans Administration, the Social Security Administration, and other such agencies, shall be made by the vocational rehabilitation adviser, where appropriate, on an individual basis when requested by disabled employees. Such referrals do not provide for a service cost reimbursement by the Department of Labor.

§ 702.506 Vocational rehabilitation; training.

Vocational rehabilitation training shall be planned in anticipation of a short, realistic, attainable vocational objective terminating in remunerable employment, and in restoring wage-earning capacity or increasing it materially. The following procedures shall apply in arranging for or providing training:

(a) The vocational rehabilitation adviser shall arrange for and develop all vocational training programs.

(b) Training programs shall be developed to meet the varying needs of eligible beneficiaries, and may include courses at colleges, technical schools, training at rehabilitation centers, on-the-job training, or tutorial courses. The courses shall be pertinent to the occupation for which the employee is being trained.

(c) Training may be terminated if the injured employee fails to cooperate with the Department of Labor or with the agency supervising his course of training. The employee shall be counseled before training is terminated.

(d) Reports shall be required at periodic intervals on all persons in approved training programs.

§ 702.507 Vocational rehabilitation; maintenance allowance.

(a) An injured employee who, as a result of injury, is or may be expected to be totally or partially incapacitated for a remunerative occupation and who, under the direction of the Director is being rendered fit to engage in a remunerative occupation, shall be paid additional compensation necessary for this maintenance, not exceeding $25 a week. The expense shall be paid out of the special fund established in section 44 of the Act, 33 U.S.C. 944. The maximum maintenance allowance shall not be provided on an automatic basis, but shall be based on the recommendation of a State agency that a claimant is unable to meet additional costs by reason of being in training.

(b) When required by reason of personal illness or hardship, limited periods of absence from training may be allowed without terminating the maintenance allowance. A maintenance allowance shall be terminated when it is shown to the satisfaction of the Director that a trainee is not complying reasonably with the terms of the training plan or is absenting himself without good cause from training so as to materially interfere with the accomplishment of the training objective.

§ 702.508 Vocational rehabilitation; confidentiality of information.

The following safeguards will be observed to protect the confidential character of information released regarding an individual undergoing rehabilitation:

(a) Information will be released to other agencies from which an injured employee has requested services only if such agencies have established regulations assuring that such information will be considered confidential and will be used only for the purpose for which it is provided;

(b) Interested persons and agencies have been advised that any information concerning rehabilitation program employees is to be held confidential;

(c) A rehabilitation employee's written consent is secured for release of information regarding disability to a person, agency, or establishment seeking the information for purposes other than the approved rehabilitation planning with such employee.

Subpart F—Occupational Disease Which Does Not Immediately Result in Death or Disability

SOURCE: 50 FR 406, Jan. 3, 1985, unless otherwise noted.

§ 702.601 Definitions.

(a) *Time of injury*. For purposes of this subpart and with respect to an occupational disease which does not immediately result in death or disability, the time of injury shall be deemed to be the date on which the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability.

(b) *Disability*. With regard to an occupational disease for which the time of injury, as defined in § 702.601(a), occurs after the employee was retired, disability shall mean permanent impairment as determined according to the *Guides to the Evaluation of Permanent Impairment* which is prepared and modified from time-to-time by the American Medical Association, using the most currently revised edition of this publication. If this guide does not evaluate the impairment, other professionally recognized standards may be utilized. The disability described in this paragraph shall be limited to permanent partial disability. For that reason they are not subject to adjustments under section 10(f) of the Act, 33 U.S.C. 910(f).

(c) *Retirement*. For purposes of this subpart, retirement shall mean that the claimant, or decedent in cases involving survivor's benefits, has voluntarily withdrawn from the workforce and that there is no realistic expectation that such person will return to the workforce.

[50 FR 406, Jan. 3, 1985, as amended at 51 FR 4286, Feb. 3, 1986]

§ 702.602 Notice and claims.

(a) *Time for giving notice of injury or death*. Refer to § 702.207.

(b) *Time for filing of claims.* Refer to § 702.212.

§ 702.603 Determining the payrate for compensating occupational disease claims which become manifest after retirement.

(a) If the time of injury occurs within the first year after the employee has retired, the payrate for compensation purposes shall be one fifty-second part of the employee's average annual earnings during the fifty-two week period preceding retirement.

(b) If the time of injury occurs more than one year after the employee has retired the payrate for compensation purposes shall be the national average weekly wage, determined according to section 6(b)(3) of the Act, 33 U.S.C. 906(b)(3), at the time of injury.

§ 702.604 Determining the amount of compensation for occupational disease claims which become manifest after retirement.

(a) If the claim is for disability benefits and the time of injury occurs after the employee has retired, compensation shall be 66⅔ percent of the payrate, as determined under § 702.603, times the disability, as determined according to § 702.601(b).

(b) If the claim is for death benefits and the time of injury occurs after the decedent has retired, compensation shall be the percent specified in section 9 of the Act, 33 U.S.C. 909, times the payrate determined according to § 702.603. Total weekly death benefits shall not exceed one fifty-second part of the decedent's average annual earnings during the fifty-two week period preceding retirement, such benefits shall be subject to the limitation provided for in section 6(b)(1) of the Act, 33 U.S.C. 906(b)(1).

[50 FR 406, Jan. 3, 1985, as amended at 51 FR 4286, Feb. 3, 1986]

PART 703—INSURANCE REGULATIONS

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AUTHORITY: 5 U.S.C. 301, and 8171 *et seq.;* 33 U.S.C. 901 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1333; Reorganization Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 38 FR 26873, Sept. 26, 1973, unless otherwise noted.

Subpart A—General

SOURCE: 70 FR 43233, July 26, 2005, unless otherwise noted.

§ 703.1 Scope of part.

Part 703 governs insurance carrier authorizations, insurance carrier security deposits, self-insurer authorizations, and certificates of compliance with the insurance regulations. These provisions are required by the LHWCA and apply to the extensions of the LHWCA except as otherwise provided in part 704 of this subchapter.

§ 703.2 Forms.

(a) Any information required by the regulations in this part to be submitted to OWCP must be submitted on forms the Director authorizes from time to time for such purpose. Persons submitting forms may not modify the forms or use substitute forms without OWCP's approval. These forms must be submitted, sent, or filed in the manner prescribed by OWCP.

Form No.	Title
(1) LS–271	Application for Self-Insurance.
(2) LS–274	Report of Injury Experience.
(3) LS–275 SI	Self-Insurer's Agreement and Undertaking.
(4) LS–275 IC	Insurance Carrier's Agreement and Undertaking.
(5) LS–276	Application for Security Deposit Determination.
(6) LS–405	Indemnity Bond.
(7) LS–570	Card Report of Insurance.

(b) Copies of the forms listed in this section are available for public inspection at the Office of Workers' Compensation Programs, U.S. Department of Labor, Washington, DC 20210. They may also be obtained from OWCP district offices and on the Internet at *http://www.dol.gov/owcp/dlhwc*.

[70 FR 43233, July 26, 2005, as amended at 77 FR 37286, June 21, 2012; 80 FR 12932, Mar. 12, 2015]

§ 703.3 Failure to secure coverage; penalties.

(a) Each employer must secure the payment of compensation under the Act either through an authorized insurance carrier or by becoming an authorized self-insurer under section 32(a)(1) or (2) of the Act (33 U.S.C. 932(a)(1) or (2)). An employer who fails to comply with these provisions is subject, upon conviction, to a fine of not more than $10,000, or by imprisonment for not more than one year, or both. Where the employer is a corporation, the president, secretary and treasurer each will also be subject to this fine and/or imprisonment, in addition to the fine against the corporation, and each is severally personally liable,

jointly with the corporation, for all compensation or other benefits payable under the Act while the corporation fails to secure the payment of compensation.

(b) Any employer who willingly and knowingly transfers, sells, encumbers, assigns or in any manner disposes of, conceals, secretes, or destroys any property belonging to the employer after an employee sustains an injury covered by the Act, with the intent to avoid payment of compensation under the Act to that employee or his/her dependents, shall be guilty of a misdemeanor and punished, upon conviction, by a fine of not more than $10,000 and/or imprisonment for one year. Where the employer is a corporation, the president, secretary and treasurer are also severally liable to imprisonment and, along with the corporation, jointly liable for the fine.

Subpart B—Authorization of Insurance Carriers

§ 703.101 Types of companies which may be authorized by the OWCP.

The OWCP will consider for the granting of authority to write insurance under the Longshoremen's and Harbor Workers' Compensation Act and its extensions the application of any stock company, mutual company or association, or any other person or fund, while authorized under the laws of the United States or for any State to insure workmen's compensation. The term ''carrier'' as used in this part means any person or fund duly authorized to insure workmen's compensation benefits under said Act, or its extensions.

§ 703.102 Applications for authority to write insurance; how filed; evidence to be submitted; other requirements.

An application for authority to write insurance under this Act shall be made in writing, signed by an officer of the applicant duly authorized to make such application, and transmitted to the Office of Workmen's Compensation Programs, U.S. Department of Labor, Washington, DC 20210. Such application shall be accompanied by full and complete information regarding the history and experience of such applicant in the writing of workmen's compensation insurance, together with evidence that it has authority in its charter or form of organization to write such insurance, and evidence that the applicant is currently authorized to insure workmen's compensation liability under the laws of the United States or of any State. The statements of fact in each application and in the supporting evidence shall be verified by the oath of the officer of the applicant who signs such application. Each applicant shall state in its application the area or areas, in which it intends to do business. In connection with any such application the following shall be submitted, the Office reserving the right to call for such additional information as it may deem necessary in any particular case:

(a) A copy of the last annual report made by the applicant to the insurance department or other authority of the State in which it is incorporated, or the State in which its principal business is done.

(b) A certified copy from the proper State authorities of the paper purporting to show the action taken upon such report, or such other evidence as the applicant desires to submit in respect of such report, which may obviate delay caused by an inquiry of the OWCP of the State authorities relative to the standing and responsibility of the applicant.

(c) A full and complete statement of its financial condition, if not otherwise shown, and, if a stock company, shall show specifically its capital stock and surplus.

(d) A copy of its charter or other formal outline of its organization, its rules, its bylaws, and other documents, writings, or agreements by and under which it does business, and such other evidence as it may deem proper to make a full exposition of its affairs and financial condition.

[38 FR 26873, Sept. 26, 1973; 50 FR 406, Jan. 3, 1985]

§ 703.103 Stock companies holding Treasury certificates of authority.

A stock company furnishing evidence that it is authorized to write workmen's compensation insurance under the laws of the United States or of any

State, which holds a certificate of authority from the Secretary of the Treasury as an acceptable surety on Federal bonds, unless requested to do so, need not transmit to the Office with its application copies of such financial reports as are on file in the Department of the Treasury. The acceptance by that Department of such a company will be considered by the Office in conjunction with the application of such company, provided there has been compliance with the other requirements of the regulations in this part.

§ 703.104 Applicants currently authorized to write insurance under the extensions of the LHWCA.

Any applicant currently authorized by the Office to write insurance under any extension of the LHWCA need not support its application under the LHWCA or any other LHWCA extension with the evidence required by the regulations in this part, except the form of policy and endorsement which it proposes to use, unless specifically requested by the Office, but instead its application may refer to the fact that it has been so authorized.

§ 703.105 Copies of forms of policies to be submitted with application.

With each application for authority to write insurance there shall be submitted for the approval of the Office copies of the forms of policies which the applicant proposes to issue in writing insurance under the LHWCA, or its extensions, to which shall be attached the appropriate endorsement to be used in connection therewith.

§ 703.106 Certificate of authority to write insurance.

No corporation, company, association, person, or fund shall write insurance under this Act without first having received from the OWCP a certificate of authority to write such insurance. Any such certificate issued by the Office, after application therefor in accordance with these regulations, may authorize the applicant to write such insurance in a limited territory as determined by the Office. Any such certificate may be suspended or revoked by the Office prior to its expiration for good cause shown, but no suspension or revocation shall affect the liability of any carrier already incurred. Good cause shall include, without limitation, the failure to maintain in such limited territory a regular business office with full authority to act on all matters falling within the Act, and the failure to promptly and properly perform the carrier's responsibilities under the Act and these regulations, with special emphasis upon lack of promptness in making payments when due, upon failure to furnish appropriate medical care, and upon attempts to offer to, or urge upon, claimants inequitable settlements. A hearing may be requested by the aggrieved party and shall be held before the Director or his representative prior to the taking of any adverse action under this section.

§ 703.108 Period of authority to write insurance.

Effective with the end of the authorization period July 1, 1983, through June 30, 1984, annual reauthorization of authority to write insurance coverage under the Act is no longer necessary. Beginning July 1, 1984, and thereafter, newly issued Certificates of Authority will show no expiration date. Certificates of Authority will remain in force for so long as the carrier complies with the requirements of the OWCP.

[50 FR 406, Jan. 3, 1985]

§ 703.109 Longshoremen's endorsement; see succeeding parts for endorsements for extensions.

(a) The following form of endorsement application to the standard workmen's compensation and employer's liability policy, shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. _____,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, 33 U.S.C. 901 *et seq.*, and all laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of this Act, and all lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, U.S. Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Act.

This endorsement shall not be cancelled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to this employer.

All terms, conditions, requirements, and obligations, expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

§ 703.110 Other forms of endorsements and policies.

Where the form of endorsement prescribed by § 703.109 is not appropriate when used in conjunction with a form of policy approved for use by the Office no modification thereof shall be used unless specifically approved by the Office. Where the form of policy is designed to include therein the obligations of the insurer under said Act without the use of the appropriate endorsements, the policy shall contain the provisions required to be included in any of the endorsements. Such a policy, however, shall not be used until expressly approved by the Office.

§ 703.111 Submission of new forms of policies for approval; other endorsements.

No new forms of policies or modification of existing forms of policies shall be used by an insurer authorized by the Office under the regulations in this part to write insurance under said Act except after submission to and approval by the Office. No endorsement altering any provisions of a policy approved by the Office shall be used except after submission to and approval by the Office.

§ 703.112 Terms of policies.

A policy or contract of insurance shall be issued for the term of not less than 1 year from the date that it becomes effective, but if such insurance be not needed except for a particular contract or operation, the term of the policy may be limited to the period of such contract or operation.

§ 703.113 Marine insurance contracts.

A longshoremen's policy, or the longshoremen's endorsement provided for by § 703.109 for attachment to a marine policy, may specify the particular vessel or vessels in respect of which the policy applies and the address of the employer at the home port thereof. The report of the issuance of a policy or endorsement required by § 703.116 must be made to DLHWC and must show the name and address of the owner as well as the name or names of such vessel or vessels.

[80 FR 12933, Mar. 12, 2015]

§ 703.114 Notice of cancellation.

Cancellation of a contract or policy of insurance issued under authority of the Act will not become effective otherwise than as provided by 33 U.S.C. 936(b); 30 days before such cancellation is intended to be effective, notice of a proposed cancellation must be given to the district director and the employer in accordance with the provisions of 33 U.S.C. 912(c). The notice requirements of 33 U.S.C. 912(c) will be considered met when:

(a) Notice to the district director is given by a method specified in § 702.101(a) of this chapter or in the same manner that reports of issuance of policies and endorsements are reported under § 703.116; and

(b) Notice to the employer is given by a method specified in § 702.101(b) of this chapter.

[80 FR 12933, Mar. 12, 2015]

§ 703.115 Discharge by the carrier of obligations and duties of employer.

Every obligation and duty in respect of payment of compensation, the providing of medical and other treatment and care, the payment or furnishing of any other benefit required by said Act and in respect of the carrying out of the administrative procedure required or imposed by said Act or the regulations in this part upon an employer shall be discharged and carried out by the carrier except that the prescribed report of injury or death shall be sent

by the employer to the district director and to the insurance carrier as required by 33 U.S.C. 930. Such carrier shall be jointly responsible with the employer for the submission of all reports, notices, forms, and other administrative papers required by the district director or the Office in the administration of said Act to be submitted by the employer, but any form or paper so submitted where required therein shall contain in addition to the name and address of the carrier, the full name and address of the employer on whose behalf it is submitted. Notice to or knowledge of an employer of the occurrence of the injury or death shall be notice to or knowledge of such carrier. Jurisdiction of the employer by a district director, the Office, or appropriate appellate authority under said Act shall be jurisdiction of such carrier. Any requirement under any compensation order, finding, or decision shall be binding upon such carrier in the same manner and to the same extent as upon the employer.

§ 703.116 Report by carrier of issuance of policy or endorsement.

Each carrier must report to DLHWC each policy and endorsement issued by it to an employer whose employees are engaging in work subject to the Act and its extensions. Such reports must be made in a manner prescribed by OWCP. Reports made to an OWCP-authorized intermediary, such as an industry data collection organization, satisfy this reporting requirement.

[80 FR 12933, Mar. 12, 2015]

§ 703.117 Report; by whom sent.

The report of issuance of a policy and endorsement provided for in § 703.116 or notice of cancellation provided for in § 703.114 must be sent by the home office of the carrier, except that any carrier may authorize its agency or agencies in any compensation district to make such reports, provided the carrier notifies DLHWC of the agencies so duly authorized.

[80 FR 12933, Mar. 12, 2015]

§ 703.118 Agreement to be bound by report.

Every applicant for the authority to write insurance under the provisions of this Act, will be deemed to have included in its application an agreement that the acceptance by DLHWC of a report of insurance, as provided for by § 703.116, binds the carrier to full liability for the obligations under this Act of the employer named in said report, and every certificate of authority to write insurance under this Act will be deemed to have been issued by the Office upon consideration of the carrier's agreement to become so bound. It will be no defense to this agreement that the carrier failed or delayed to issue the policy to the employer covered by this report.

[80 FR 12933, Mar. 12, 2015]

§ 703.119 [Reserved]

§ 703.120 Name of one employer only in each report.

For policies that are reported to DLHWC on Form LS–570 (Carrier's Report of Issuance of Policy), a separate report of the issuance of a policy and endorsement, provided for by § 703.116, must be made for each employer covered by a policy. If a policy is issued insuring more than one employer, a separate form LS–570 for each employer so covered must be sent to DLHWC in the manner described in § 703.116, with the name of only one employer on each form.

[80 FR 12933, Mar. 12, 2015]

Subpart C—Insurance Carrier Security Deposit Requirements

SOURCE: 70 FR 43234, July 26, 2005, unless otherwise noted.

§ 703.201 Deposits of security by insurance carriers.

The regulations in this subpart require certain insurance carriers to deposit security in the form of indemnity bonds, letters of credit or negotiable securities (chosen at the option of the carrier) of a kind and in an amount determined by the Office, and prescribe the conditions under which deposits must be made. Security deposits secure

the payment of compensation and medical benefits when an insurance carrier defaults on any of its obligations under the LHWCA, regardless of the date such obligations arose. They also secure the payment of compensation and medical benefits when a carrier becomes insolvent and such obligations are not otherwise fully secured by a State guaranty fund. Any gap in State guaranty fund coverage will have a direct effect on the amount of security the Office will require a carrier to post. As used in this subpart, the terms ''obligations under the Act'' and ''LHWCA obligations'' mean a carrier's liability for compensation payments and medical benefits arising under the Longshore and Harbor Workers' Compensation Act and any of its extensions.

§ 703.202 Identification of significant gaps in State guaranty fund coverage for LHWCA obligations.

(a) In determining the amount of a carrier's required security deposit, the Office will consider the extent to which a State guaranty fund secures the insurance carrier's LHWCA obligations in that State. When evaluating State guaranty funds, the Office may consider a number of factors including, but not limited to—

(1) Limits on weekly benefit amounts;

(2) Limits on aggregate maximum benefit amounts;

(3) Time limits on coverage;

(4) Ocean marine exclusions;

(5) Employer size and viability provisions; and

(6) Financial strength of the State guaranty fund itself.

(b) OWCP will identify States without guaranty funds and States with guaranty funds that do not fully and immediately secure LHWCA obligations and will post its findings on the Internet at *http://www.dol.gov/owcp/dlhwc*. These findings will indicate the extent of any partial or total gap in coverage provided by a State guaranty fund, and they will be open for inspection and comment by all interested parties. If the extent of coverage a particular State guaranty fund provides either cannot be determined or is ambiguous, OWCP will deem one third (33⅓ percent) of a carrier's LHWCA obligations in that State to be unsecured. OWCP will revise its findings from time to time, in response to substantiated public comments it receives or for any other reasons it considers relevant.

[70 FR 43234, July 26, 2005, as amended at 77 FR 37286, June 21, 2012]

§ 703.203 Application for security deposit determination; information to be submitted; other requirements.

(a) Each insurance carrier authorized by OWCP to write insurance under the LHWCA or any of its extensions, and each insurance carrier seeking initial authorization to write such insurance, must apply annually, on a schedule set by OWCP, for a determination of the extent of its unsecured obligations and the security deposit required. The application must be addressed to the Branch of Financial Management and Insurance (Branch) within OWCP's Division of Longshore and Harbor Workers' Compensation, and be made on a form provided by OWCP. The application must contain the following:

(1) Any carrier seeking an exemption from the security deposit requirements based on its financial standing (*see* § 703.204(c)(1)) must submit documentation establishing the carrier's current rating and its rating for the immediately preceding year from each insurance rating service designated by the Branch and posted on the Internet at *http://www.dol.gov/owcp/dlhwc*.

(2) All other carriers, and any carrier whose exemption request under paragraph (a)(1) of this section has been denied, must provide—

(i) A statement of the carrier's outstanding liabilities under the LHWCA or any of its extensions for its LHWCA obligations for each State in which the obligations arise; and

(ii) Any other information the Branch requests to enable it to give the application adequate consideration including, but not limited to, the reports set forth at § 703.212.

(b) If the carrier disagrees with any of OWCP's findings regarding State guaranty funds made under § 703.202(b) as they exist when it submits its application, the carrier may submit a statement of its unsecured obligations based

on a different conclusion regarding the extent of coverage afforded by one or more State guaranty funds. The carrier must submit evidence and/or argument with its application sufficient to establish that such conclusion is correct.

(c) The carrier must sign and swear to the application. If the carrier is not an individual, the carrier's duly authorized officer must sign and swear to the application and list his or her official designation. If the carrier is a corporation, the officer must also affix the corporate seal.

(d) At any time after filing an application, the carrier must inform the Branch immediately of any material changes that may have rendered its application incomplete, inaccurate or misleading.

(e) By filing an application, the carrier consents to be bound by and to comply with the regulations and requirements in this part.

[70 FR 43234, July 26, 2005, as amended at 77 FR 37286, June 21, 2012]

§ 703.204 Decision on insurance carrier's application; minimum amount of deposit.

(a) The Branch will issue a decision on the application determining the extent of an insurance carrier's unsecured LHWCA obligations and fixing the amount of security the carrier must deposit to fully secure payment of its unsecured obligations. The Branch will transmit its decision to the applicant in a way it considers appropriate.

(b) The Branch may consider a number of factors in setting the security deposit amount including, but not limited to, the—

(1) Financial strength of the carrier as determined by private insurance rating organizations;

(2) Financial strength of the carrier's insureds in the Longshore industry;

(3) Extent to which State guaranty funds secure the carrier's LHWCA obligations in the event the carrier defaults on its obligations or becomes insolvent;

(4) Carrier's longevity in writing LHWCA or other workers' compensation coverage;

(5) Extent of carrier's exposure for LHWCA coverage; and

(6) Carrier's payment history in satisfying its LHWCA obligations.

(c) In setting the security deposit amount, the Branch will follow these criteria:

(1) Carriers who hold the highest rating awarded by each of the three insurance rating services designated by the Branch and posted on the Internet at *http://www.dol.gov/owcp/dlhwc* for both the current rating year and the immediately preceding year will not be required to deposit security.

(2) Carriers whose LHWCA obligations are fully secured by one or more State guaranty funds, as evaluated by OWCP under § 703.202 of this subpart, will not be required to deposit security.

(3) The Branch will require all carriers not meeting the requirements of paragraphs (c)(1) or (2) of this section to deposit security for their LHWCA obligations not secured by a State guaranty fund, as evaluated by OWCP under § 703.202 of this subpart. For carriers that write only an insignificant or incidental amount of LHWCA insurance, the Branch will require a deposit in an amount determined by the Branch from time to time. For all other carriers, the Branch will require a minimum deposit of one third (33⅓ percent) of a carrier s outstanding LHWCA obligations not secured by a State guaranty fund, but may require a deposit up to an amount equal to the carrier's total outstanding LHWCA obligations (100 percent) not secured by a State guaranty fund.

(d) If a carrier believes that a lesser deposit would fully secure its LHWCA obligations, the carrier may request a hearing before the Director of the Division of Longshore and Harbor Workers' Compensation (Longshore Director) or the Longshore Director's representative. Requests for hearing must be in writing and sent to the Branch within 10 days of the date of the Branch's decision. The carrier may submit new evidence and/or argument in support of its challenge to the Branch's decision and must provide any additional documentation OWCP requests. The Longshore Director or his representative will notify the carrier of the hearing date within 10 days of receiving the request. The Longshore Director or his representative will issue the final

agency decision on the application within 60 days of the hearing date, or, where evidence is submitted after the hearing, within 60 days of the receipt of such evidence, but no later than 180 days after receiving the carrier's request for a hearing.

[70 FR 43234, July 26, 2005, as amended at 77 FR 37286, June 21, 2012]

§ 703.205 Filing of Agreement and Undertaking; deposit of security.

Within 45 days of the date on which the insurance carrier receives the Branch's decision (or, if the carrier requests a hearing, a period set by the Longshore Director or the Longshore Director's representative) determining the extent of its unsecured LHWCA obligations and fixing the required security deposit amount (*see* § 703.204), the carrier must:

(a) Execute and file with the Branch an Agreement and Undertaking, in a form prescribed and provided by OWCP, in which the carrier shall agree to—

(1) Deposit with the Branch indemnity bonds or letters of credit in the amount fixed by the Office, or deposit negotiable securities under §§ 703.207 and 703.208 in that amount;

(2) Authorize the Branch, at its discretion, to bring suit under any deposited indemnity bond or to draw upon any deposited letters of credit, as appropriate under the terms of the security instrument, or to collect the interest and principal as they become due on any deposited negotiable securities and to sell or otherwise liquidate such negotiable securities or any part thereof when—

(i) The carrier defaults on any of its LHWCA obligations;

(ii) The carrier fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(iii) The carrier fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place;

(iv) State insolvency proceedings are initiated against the carrier; or

(v) The carrier fails to comply with any of the terms of the Agreement and Undertaking; and

(3) Authorize the Branch, at its discretion, to pay such ongoing claims of the carrier as it may find to be due and payable from the proceeds of the deposited security;

(b) Give security in the amount fixed in the Office's decision:

(1) In the form of an indemnity bond with sureties satisfactory to the Branch and in such form, and containing such provisions, as the Branch may prescribe: *Provided*, That only surety companies approved by the United States Treasury Department under the laws of the United States and the rules and regulations governing bonding companies may act as sureties on such indemnity bonds (*see* Department of Treasury's Circular–570), and that a surety company that is a corporate subsidiary of an insurance carrier may not act as surety on such carrier's indemnity bond;

(2) In the form of letters of credit issued by a financial institution satisfactory to the Branch and upon which the Branch may draw; or

(3) By a deposit of negotiable securities with a Federal Reserve Bank or the Treasurer of the United States in compliance with §§ 703.207 and 703.208.

§ 703.206 [Reserved]

§ 703.207 Kinds of negotiable securities that may be deposited; conditions of deposit; acceptance of deposits.

An insurance carrier electing to deposit negotiable securities to secure its obligations under the Act in the amount fixed by the Office under the regulations in this part shall deposit any negotiable securities acceptable as security for the deposit of public monies of the United States under regulations issued by the Secretary of the Treasury. (*See* 31 CFR part 225.) The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States.

§ 703.208 Deposits of negotiable securities with Federal Reserve banks or the Treasurer of the United States; interest thereon.

Deposits of negotiable securities provided for by the regulations in this part must be made with any Federal

Reserve bank or any branch of a Federal Reserve bank designated by the Branch, or the Treasurer of the United States, and must be held subject to the order of the Branch. The Branch will authorize the insurance carrier to collect interest on the securities it deposits unless any of the conditions set forth at § 703.211(a) occur.

§ 703.209 Substitution and withdrawal of indemnity bond, letters of credit or negotiable securities.

(a) A carrier may not substitute other security for any indemnity bond or letters of credit deposited under the regulations in this part except when authorized by the Branch. A carrier may, however, substitute negotiable securities acceptable under the regulations in this part for previously-deposited negotiable securities without the Branch's prior approval.

(b) A carrier that has ceased to write insurance under the Act may apply to the Branch for withdrawal of its security deposit. The carrier must file with its application a sworn statement setting forth—

(1) A list of all cases in each State in which the carrier is paying compensation, together with the names of the employees and other beneficiaries, a description of causes of injury or death, and a statement of the amount of compensation paid;

(2) A similar list of all pending cases in which the carrier has not yet paid compensation; and

(3) A similar list of all cases in which injury or death has occurred within one year before such application or in which the last payment of compensation was made within one year before such application.

(c) The Branch may authorize withdrawal of previously-deposited indemnity bonds, letters of credit and negotiable securities that, in the opinion of the Branch, are not necessary to provide adequate security for the payment of the carrier's outstanding and potential LHWCA liabilities. No withdrawals will be authorized unless there has been no claim activity involving the carrier for a minimum of five years, and the Branch is reasonably certain that no further claims will arise.

§ 703.210 Increase or reduction in security deposit amount.

(a) Whenever the Office considers the security deposited by an insurance carrier insufficient to fully secure the carrier's LHWCA obligations, the carrier must, upon demand by the Branch, deposit additional security in accordance with the regulations in this part in an amount fixed by the Branch. The Branch will issue its decision requiring additional security in accordance with § 703.204, and the procedures set forth at §§ 703.204(d) and 703.205 for requesting a hearing and complying with the Office's decision will apply as appropriate.

(b) The Branch may reduce the required security at any time on its own initiative, or upon application of a carrier, when in the Branch's opinion the facts warrant a reduction. A carrier seeking a reduction must furnish any information the Office requests regarding its outstanding LHWCA obligations for any State in which it does business, its obligations not secured by a State guaranty fund in each of these States, and any other evidence as the Branch considers necessary.

§ 703.211 Authority to seize security deposit; use and/or return of proceeds.

(a) The Office may take any of the actions set forth in paragraph (b) of this section when an insurance carrier—

(1) Defaults on any of its LHWCA obligations;

(2) Fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(3) Fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place;

(4) Has State insolvency proceedings initiated against it; or

(5) Fails to comply with any of the terms of the Agreement and Undertaking.

(b) When any of the conditions set forth in paragraph (a) of this section occur, the Office may, within its discretion and as appropriate to the security instrument—

(1) Bring suit under any indemnity bond;

(2) Draw upon any letters of credit;

(3) Seize any negotiable securities, collect the interest and principal as they may become due, and sell or otherwise liquidate the negotiable securities or any part thereof.

(c) When the Office, within its discretion, determines that it no longer needs to collect the interest and principal of any negotiable securities seized pursuant to paragraphs (a) and (b) of this section, or to retain the proceeds of their sale, it must return any of the carrier's negotiable securities still in its possession and any remaining proceeds of their sale.

§ 703.212 Required reports; examination of insurance carrier accounts.

(a) Upon the Office's request, each insurance carrier must submit the following reports:

(1) A certified financial statement of the carrier's assets and liabilities, or a balance sheet.

(2) A sworn statement showing the extent of the carrier's unsecured LHWCA obligations for each State in which it is authorized to write insurance under the LHWCA or any of its extensions.

(3) A sworn statement reporting the carrier's open cases as of the date of such report, listing by State all death and injury cases, together with a report of the status of all outstanding claims.

(b) Whenever it considers necessary, the Office may inspect or examine a carrier's books of account, records, and other papers to verify any financial statement or other information the carrier furnished to the Office in any statement or report required by this section, or any other section of the regulations in this part. The carrier must permit the Office or its duly authorized representative to make the inspection or examination. Alternatively, the Office may accept an adequate independent audit by a certified public accountant.

§ 703.213 Failure to comply.

The Office may suspend or revoke a carrier's certificate of authority to write LHWCA insurance under § 703.106 when the carrier fails to comply with any of the requirements of this part.

Subpart D—Authorization of Self-Insurers

SOURCE: 70 FR 43234, July 26, 2005, unless otherwise noted.

§ 703.301 Employers who may be authorized as self-insurers.

The regulations in this subpart set forth procedures for authorizing employers to self-insure the payment of compensation under the Longshore and Harbor Workers' Compensation Act, or its extensions. The Office may authorize any employer to self-insure who, pursuant to the regulations in this part, furnishes to the Office satisfactory proof of its ability to pay compensation directly, and who agrees to immediately cancel any existing insurance policy covering its Longshore obligations (except for excess or catastrophic workers' compensation insurance, *see* §§ 703.302(a)(6), 703.304(a)(6)) when OWCP approves the employer's application to be self-insured. The regulations require self-insurers to deposit security in the form of an indemnity bond, letters of credit or negotiable securities (at the option of the employer) of a kind and in an amount determined by the Office, and prescribe the conditions under which such deposits shall be made. The term ''self-insurer'' as used in these regulations means any employer securing the payment of compensation under the LHWCA or its extensions in accordance with the provisions of 33 U.S.C. 932(a)(2) and these regulations.

§ 703.302 Application for authority to become a self-insurer; how filed; information to be submitted; other requirements.

(a) Any employer may apply to become an authorized self-insurer. The application must be addressed to the Branch of Financial Management and Insurance (Branch) within OWCP's Division of Longshore and Harbor Workers' Compensation, and be made on a form provided by OWCP. The application must contain—

(1) A statement of the employer's total payroll for the 12 months before the application date;

(2) A statement of the average number of employees engaged in employment within the purview of the LHWCA or any of its extensions for the 12 months before the application date;

(3) A statement of the number of injuries to such employees resulting in disability of more than 7 days' duration, or in death, during each of the 5 years before the application date;

(4) A certified financial report for each of the three years before the application date;

(5) A description of the facilities maintained or the arrangements made for the medical and hospital care of injured employees;

(6) A statement describing the provisions and maximum amount of any excess or catastrophic insurance; and

(7) Any other information the Branch requests to enable it to give the application adequate consideration including, but not limited to, the reports set forth at § 703.310.

(b) The employer must sign and swear to the application. If the employer is not an individual, the employer's duly authorized officer must sign and swear to the application and list his or her official designation. If the employer is a corporation, the officer must also affix the corporate seal.

(c) At any time after filing an application, the employer must inform the Branch immediately of any material changes that may have rendered its application incomplete, inaccurate or misleading.

(d) By filing an application, the employer consents to be bound by and to comply with the regulations and requirements in this part.

§ 703.303 Decision on employer's application.

(a) The Branch will issue a decision granting or denying the employer's application to be an authorized self-insurer. If the Branch grants the application, the decision will fix the amount of security the employer must deposit. The Branch will transmit its decision to the employer in a way it considers appropriate.

(b) The employer is authorized to self-insure beginning with the date of the Branch's decision. Each grant of authority to self-insure is conditioned, however, upon the employer's execution and filing of an Agreement and Undertaking and deposit of the security fixed in the decision in the form and within the time limits required by § 703.304. In the event the employer fails to comply with the requirements set forth in § 703.304, its authorization to self-insure will be considered never to have been effective, and the employer will be subject to appropriate penalties for failure to secure its LHWCA obligations.

(c) The Branch will require security in the amount it considers necessary to fully secure the employer's LHWCA obligations. When fixing the amount of security, the Branch may consider a number of factors including, but not limited to, the—

(1) Employer's overall financial standing;

(2) Nature of the employer's work;

(3) Hazard of the work in which the employees are employed;

(4) Employer's payroll amount for employees engaged in employment within the purview of the Act; and

(5) Employer's accident record as shown in the application and the Office's records.

(d) If an employer believes that the Branch incorrectly denied its application to self-insure, or that a lesser security deposit would fully secure its LHWCA obligations, the employer may request a hearing before the Director of the Division of Longshore and Harbor Workers' Compensation (Longshore Director) or the Longshore Director's representative. Requests for hearing must be in writing and sent to the Branch within ten days of the date of the Branch's decision. The employer may submit new evidence and/or argument in support of its challenge to the Branch's decision and must provide any additional documentation OWCP requests. The Longshore Director or his representative will notify the employer of the hearing date within 10 days of receiving the request. The Longshore Director or his representative will issue the final agency decision on the application within 60 days of the

hearing date, or, where evidence is submitted after the hearing, within 60 days of the receipt of such evidence, but no later than 180 days after receiving the employer's request for a hearing.

§ 703.304 Filing of Agreement and Undertaking; deposit of security.

Within 45 days of the date on which the employer receives the Branch's decision (or, if the employer requests a hearing, a period set by the Longshore Director or the Longshore Director's representative) granting its application to self-insure and fixing the required security deposit amount (*see* § 703.303), the employer must:

(a) Execute and file with the Branch an Agreement and Undertaking, in a form prescribed and provided by OWCP, in which the employer shall agree to:

(1) Pay when due, as required by the provisions of the Act, all compensation payable on account of injury or death of any of its employees injured within the purview of the Act;

(2) Furnish medical, surgical, hospital, and other attendance, treatment and care as required by the Act;

(3) Deposit with the Branch indemnity bonds or letters of credit in the amount fixed by the Office, or deposit negotiable securities under §§ 703.306 and 703.307 in that amount;

(4) Authorize the Branch, at its discretion, to bring suit under any deposited indemnity bond or to draw upon any deposited letters of credit, as appropriate under the terms of the security instrument, or to collect the interest and principal as they become due on any deposited negotiable securities and to seize and sell or otherwise liquidate such negotiable securities or any part thereof when the employer:

(i) Defaults on any of its LHWCA obligations;

(ii) Fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(iii) Fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place; or

(iv) Fails to comply with any of the terms of the Agreement and Undertaking;

(5) Authorize the Branch, at its discretion, to pay such compensation, medical, and other expenses and any accrued penalties imposed by law as it may find to be due and payable from the proceeds of the deposited security; and

(6) Obtain and maintain, if required by the Office, excess or catastrophic insurance in amounts to be determined by the Office.

(b) Give security in the amount fixed in the Office's decision:

(1) In the form of an indemnity bond with sureties satisfactory to the Office, and in such form and containing such provisions as the Office may prescribe: *Provided*, That only surety companies approved by the United States Treasury Department under the laws of the United States and the rules and regulations governing bonding companies may act as sureties on such indemnity bonds (*see* Department of Treasury's Circular–570);

(2) In the form of letters of credit issued by a financial institution satisfactory to the Branch and upon which the Branch may draw; or,

(3) By a deposit of negotiable securities with a Federal Reserve Bank or the Treasurer of the United States in compliance with §§ 703.306 and 703.307.

§ 703.305 [Reserved]

§ 703.306 Kinds of negotiable securities that may be deposited; conditions of deposit; acceptance of deposits.

A self-insurer or a self-insurer applicant electing to deposit negotiable securities to secure its obligations under the Act in the amount fixed by the Office under the regulations in this part shall deposit any negotiable securities acceptable as security for the deposit of public monies of the United States under regulations issued by the Secretary of the Treasury. (*See* 31 CFR part 225.) The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States.

§ 703.307 Deposits of negotiable securities with Federal Reserve banks or the Treasurer of the United States; interest thereon.

Deposits of negotiable securities provided for by the regulations in this part shall be made with any Federal Reserve bank or any branch of a Federal Reserve bank designated by the Office, or the Treasurer of the United States, and shall be held subject to the order of the Office. The Office will authorize the self-insurer to collect interest on the securities deposited by it unless any of the conditions set forth at § 703.304(a)(4) occur.

§ 703.308 Substitution and withdrawal of indemnity bond, letters of credit or negotiable securities.

(a) A self-insurer may not substitute other security for any indemnity bond or letters of credit deposited under the regulations in this part except when authorized by the Office. A self-insurer may, however, substitute negotiable securities acceptable under the regulations in this part for previously-deposited negotiable securities without the Office's prior approval.

(b) A self-insurer discontinuing business, discontinuing operations within the purview of the Act, or securing the payment of compensation by commercial insurance under the provisions of the Act may apply to the Office for the withdrawal of the security it provided under the regulations in this part. The self-insurer must file with its application a sworn statement setting forth—

(1) A list of all cases in each compensation district in which the self-insurer is paying compensation, together with the names of the employees and other beneficiaries, a description of causes of injury or death, and a statement of the amount of compensation paid;

(2) A similar list of all pending cases in which the self-insurer has not yet paid compensation; and

(3) A similar list of all cases in which injury or death has occurred within one year before such application or in which the last payment of compensation was made within one year before such application.

(c) The Office may authorize withdrawal of previously-deposited indemnity bonds, letters of credit and negotiable securities that, in the opinion of the Office, are not necessary to provide adequate security for the payment of the self-insurer's outstanding and potential LHWCA obligations. No withdrawals will be authorized unless there has been no claim activity involving the self-insurer for a minimum of five years, and the Office is reasonably certain no further claims will arise.

§ 703.309 Increase or reduction in the amount of indemnity bond, letters of credit or negotiable securities.

(a) Whenever the Office considers the principal sum of the indemnity bond or letters of credit filed or the amount of the negotiable securities deposited by a self-insurer insufficient to fully secure the self-insurer's LHWCA obligations, the self-insurer must, upon demand by the Office, deposit additional security in accordance with the regulations in this part in an amount fixed by the Branch. The Branch will issue its decision requiring additional security in accordance with § 703.303, and the procedures set forth at §§ 703.303(d) and 703.304 for requesting a hearing and complying with the Office's decision will apply as appropriate.

(b) The Office may reduce the required security at any time on its own initiative, or upon application of a self-insurer, when in the Office's opinion the facts warrant a reduction. A self-insurer seeking a reduction must furnish any information the Office requests regarding its current affairs, the nature and hazard of the work of its employees, the amount of its payroll for employees engaged in maritime employment within the purview of the Act, its financial condition, its accident experience, a record of compensation payments it has made, and any other evidence the Branch considers necessary.

§ 703.310 Authority to seize security deposit; use and/or return of proceeds.

(a) The Office may take any of the actions set forth in paragraph (b) of this section when a self-insurer—

(1) Defaults on any of its LHWCA obligations;

(2) Fails to renew any deposited letter of credit or substitute a new letter of credit, indemnity bond or acceptable negotiable securities in its place;

(3) Fails to renew any deposited negotiable securities at maturity or substitute a letter of credit, indemnity bond or acceptable negotiable securities in their place; or

(4) Fails to comply with any of the terms of the Agreement and Undertaking.

(b) When any of the conditions set forth in paragraph (a) of this section occur, the Office may, within its discretion and as appropriate to the security instrument—

(1) Bring suit under any indemnity bond;

(2) Draw upon any letters of credit;

(3) Seize any negotiable securities, collect the interest and principal as they may become due, and sell or otherwise liquidate the negotiable securities or any part thereof.

(c) When the Office, within its discretion, determines that it no longer needs to collect the interest and principal of any negotiable securities seized pursuant to paragraphs (a) and (b) of this section, or to retain the proceeds of their sale, it must return any of the employer's negotiable securities still in its possession and any remaining proceeds of their sale.

§ 703.311 Required reports; examination of self-insurer accounts.

(a) Upon the Office's request, each self-insurer must submit the following reports:

(1) A certified financial statement of the self-insurer's assets and liabilities, or a balance sheet.

(2) A sworn statement showing by classifications the payroll of employees of the self-insurer who are engaged in employment within the purview of the LHWCA or any of its extensions.

(3) A sworn statement covering the six-month period preceding the date of such report, listing by compensation districts all death and injury cases which have occurred during such period, together with a report of the status of all outstanding claims showing the particulars of each case.

(b) Whenever it considers necessary, the Office may inspect or examine a self-insurer's books of account, records, and other papers to verify any financial statement or other information the self-insurer furnished to the Office in any report required by this section, or any other section of the regulations in this part. The self-insurer must permit the Office or its duly authorized representative to make the inspection or examination. Alternatively, the Office may accept an adequate report of a certified public accountant.

§ 703.312 Period of authorization as self-insurer.

(a) Self-insurance authorizations will remain in effect for so long as the self-insurer complies with the requirements of the Act, the regulations in this part, and OWCP.

(b) A self-insurer who has secured its liability by depositing an indemnity bond with the Office will, on or about May 10 of each year, receive from the Office a form for executing a bond that will continue its self-insurance authorization. The submission of such bond, duly executed in the amount indicated by the Office, will be deemed a condition of the continuing authorization.

§ 703.313 Revocation of authorization to self-insure.

The Office may for good cause shown suspend or revoke the authorization of any self-insurer. Failure by a self-insurer to comply with any provision or requirement of law or of the regulations in this part, or with any lawful order or communication of the Office, or the failure or insolvency of the surety on its indemnity bond, or impairment of financial responsibility of such self-insurer, shall be deemed good cause for suspension or revocation.

Subpart E—Issuance of Certificates of Compliance

§ 703.501 Issuance of certificates of compliance.

Every employer who has secured the payment of compensation as required by 33 U.S.C. 932 and by the regulations in this part may request a certificate from the district director in the compensation district in which he has operations, and for which a certificate is required by 33 U.S.C. 937, showing that

such employer has secured the payment of compensation. Only one such certificate will be issued to an employer in a compensation district, and it will be valid only during the period for which such employer has secured such payment. An employer so desiring may have photocopies of such a certificate made for use in different places within the compensation district. Two forms of such certificates have been provided by the Office, one form for use where the employer has obtained insurance generally under these regulations, and one for use where the employer has been authorized as a self-insurer.

§ 703.502 [Reserved]

§ 703.503 Return of certificates of compliance.

Upon the termination by expiration, cancellation or otherwise, of a policy of insurance issued under the provisions of law and these regulations, or the revocation or termination of the privilege of self-insurance granted by the Office, all certificates of compliance issued on the basis of such insurance or self-insurance shall be void and shall be returned by the employer to the district director issuing them with a statement of the reason for such return. An employer holding certificate of compliance under an insurance policy which has expired, pending renewal of such insurance need not return such certificate of compliance if such expired insurance is promptly replaced. An employer who has secured renewal of insurance upon the expiration of policy under said Act or whose self-insurance thereunder is reauthorized without a break in the continuity thereof need not return an expired certificate of compliance.

PART 704—SPECIAL PROVISIONS FOR LHWCA EXTENSIONS

Sec.

704.001 Extensions covered by this part.
704.002 Scope of part.

DEFENSE BASE ACT

704.101 Administration; compensation districts.
704.102 Commutation of payments to aliens and nonresidents.
704.103 Removal of certain minimums when computing or paying compensation.
704.151 DBA endorsement.

DISTRICT OF COLUMBIA WORKMEN'S COMPENSATION ACT

704.201 Administration; compensation districts.
704.251 DCCA endorsement.

OUTER CONTINENTAL SHELF LANDS ACT

704.301 Administration; compensation districts.
704.351 OCSLA endorsement.

NONAPPROPRIATED FUND INSTRUMENTALITIES ACT

704.401 Administration; compensation districts.
704.451 NFIA endorsement.

AUTHORITY: 5 U.S.C. 301; Reorg. Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; 33 U.S.C. 939; 36 D.C. Code 501 *et seq.;* 42 U.S.C. 1651 *et seq.;* 43 U.S.C. 1331; 5 U.S.C. 6171 *et seq.;* Secretary's Order 1–89; Employment Standards Order No. 90–02.

SOURCE: 38 FR 26877, Sept. 26, 1973, unless otherwise noted.

§ 704.001 Extensions covered by this part.

(a) Defense Base Act (DBA).

(b) District of Columbia Workmen's Compensation Act (DCCA).

(c) Outer Continental Shelf Lands Act (OCSLA).

(d) Nonappropriated Fund Instrumentalities Act (NFIA).

§ 704.002 Scope of part.

The regulations governing the administration of the LHWCA as set forth in parts 702 and 703 of this subchapter govern the administration of the LHWCA extensions (see § 704.001) in nearly every respect, and are not repeated in this part 704. Such special provisions as are necessary to the proper administration of each of the extensions are set forth in this part. To the extent of any inconsistency between regulations in parts 702 and 703 of this subchapter and those in this part, the latter supersedes those in parts 702 and 703 of this subchapter.

DEFENSE BASE ACT

§ 704.101 Administration; compensation districts.

For the purpose of administration of this Act areas assigned to the compensation districts established for administration of the Longshoremen's and Harbor Workers' Compensation Act as set forth in part 702 of this subchapter shall be extended in the following manner to include:

(a) Canada, east of the 75th degree west longitude, Newfoundland, and Greenland are assigned to District No. 1.

(b) Canada, west of the 75th degree and east of the 110th degree west longitude, is assigned to District No. 10.

(c) Canada, west of the 110th degree west longitude, and all areas in the Pacific Ocean north of the 45th degree north latitude are assigned to District No. 14.

(d) All areas west of the continents of North and South America (except coastal islands) to the 60th degree east longitude, except for Iran, are assigned to District No. 15.

(e) Mexico, Central and South America (including coastal islands); areas east of the continents of North and South America to the 60th degree east longitude, including Iran, and any other areas or locations not covered under any other district office, are assigned to District No. 2.

§ 704.102 Commutation of payments to aliens and nonresidents.

Authority to commute payments to aliens and nonnationals who are not residents of the United States and Canada, section 2(b) of the Defense Base Act, 42 U.S.C. 1652(b), though separately stated in this Act, is identical in language to section 9(g) of the Longshoremen's Act. Thus, except for the different statutory citation, the LHWCA regulation at § 702.142 of this subchapter shall apply.

§ 704.103 Removal of certain minimums when computing or paying compensation.

The minimum limitation on weekly compensation for disability established by section 6 of the LHWCA, 33 U.S.C. 906, and the minimum limit on the average weekly wages on which death benefits are to be computed under section 9 of the LHWCA, 33 U.S.C. 909, shall not apply in computing compensation and death benefits under this Act; section 2(a), 42 U.S.C. 1652(a).

§ 704.151 DBA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employers' liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. ____,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, as extended by the provisions of the Defense Base Act, and all laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The Company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the Company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The Company agrees to abide by all the provisions of said Acts and all lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Acts.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to this employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

DISTRICT OF COLUMBIA WORKMEN'S COMPENSATION ACT

§ 704.201 Administration; compensation districts.

For the purpose of administration of this Act, the District of Columbia shall be the compensation district and is designated as District No. 40.

§ 704.251 DCCA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employer's liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. ____,

The obligations of the policy include the District of Columbia Workmen's Compensation Act, and the applicable provisions of the Longshoremen's and Harbor Workers' Compensation Act, and all laws amendatory of either of said Acts or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of said District of Columbia Workmen's Compensation Act and all lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Act.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director for the District of Columbia and to this employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

OUTER CONTINENTAL SHELF LANDS ACT

§ 704.301 Administration; compensation districts.

For the purpose of administration of this Act, the compensation districts established under the Longshoremen's and Harbor Workers' Compensation Act as set forth in part 702 of this subchapter shall administer this Act, and their jurisdiction for this purpose is extended, where appropriate, to include those parts of the Outer Continental Shelf adjacent to the State or States in such districts having adjacent shelf areas.

§ 704.351 OCSLA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employer's liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. ____,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, as extended by the Outer Continental Shelf Lands Act, and all the laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C. 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of said laws and all the lawful rules, regulations, orders and decisions of the Office of Workmen's Compensation Programs, Department of Labor, until set aside, modified, or reversed by appropriate appellate authority as provided for by said Acts.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to his employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

NONAPPROPRIATED FUND INSTRUMENTALITIES ACT

§ 704.401 Administration; compensation districts.

For the purpose of administration of this Act within the continental United States, Hawaii, and Alaska, the compensation districts established for administration of the Longshoremen's and Harbor Workers' Compensation Act as set forth in part 702 of this subchapter are established as the administrative districts under this Act. For the purpose of administration of this Act outside the continental United States, Alaska, and Hawaii, the compensation districts established for such

overseas administration of the Defense Base Act as set forth in § 704.101 are established as the administrative districts under this Act.

§ 704.451 NFIA endorsement.

The following form of endorsement applicable to the standard workmen's compensation and employer's liability policy shall be used, if required by the OWCP, with the form of policy approved by the Office for use by an authorized carrier:

For attachment to Policy No. ____,

The obligations of the policy include the Longshoremen's and Harbor Workers' Compensation Act, as extended by the Nonappropriated Fund Instrumentalities Act, and all of the laws amendatory thereof or supplementary thereto which may be or become effective while this policy is in force.

The company will be subject to the provisions of 33 U.S.C 935. Insolvency or bankruptcy of the employer and/or discharge therein shall not relieve the company from payment of compensation and other benefits lawfully due for disability or death sustained by an employee during the life of the policy.

The company agrees to abide by all the provisions of said Acts and all the lawful rules, regulations, orders, and decisions of the Office of Workmen's Compensation Programs, Department of Labor, unless and until set aside, modified, or reversed by appropriate appellate authority as provided for by said Acts.

This endorsement shall not be canceled prior to the date specified in this policy for its expiration until at least 30 days have elapsed after a notice of cancellation has been sent to the District Director and to the within named employer.

All terms, conditions, requirements, and obligations expressed in this policy or in any other endorsement attached thereto which are not inconsistent with or inapplicable to the provisions of this endorsement are hereby made a part of this endorsement as fully and completely as if wholly written herein.

SUBCHAPTER B—FEDERAL COAL MINE HEALTH AND SAFETY ACT OF 1969, AS AMENDED

PART 718—STANDARDS FOR DETERMINING COAL MINERS' TOTAL DISABILITY OR DEATH DUE TO PNEUMOCONIOSIS

Subpart A—General

Sec.
718.1 Statutory provisions.
718.2 Applicability of this part.
718.3 Scope and intent of this part.
718.4 Definitions and use of terms.
718.5 Incorporations by reference.

Subpart B—Criteria for the Development of Medical Evidence

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718.102 Chest radiographs (X-rays).
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718.201 Definition of pneumoconiosis.
718.202 Determining the existence of pneumoconiosis.
718.203 Establishing relationship of pneumoconiosis to coal mine employment.
718.204 Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis.
718.205 Death due to pneumoconiosis.
718.206 Effect of findings by persons or agencies.

Subpart D—Presumptions Applicable to Eligibility Determinations

718.301 Establishing length of employment as a miner.
718.302 Relationship of pneumoconiosis to coal mine employment.
718.303 [Reserved]
718.304 Irrebuttable presumption of total disability or death due to pneumoconiosis.
718.305 Presumption of pneumoconiosis.
718.306 [Reserved]

APPENDIX A TO PART 718—STANDARDS FOR ADMINISTRATION AND INTERPRETATION OF CHEST RADIOGRAPHS (X-RAYS)

APPENDIX B TO PART 718—STANDARDS FOR ADMINISTRATION AND INTERPRETATION OF PULMONARY FUNCTION TESTS. TABLES B1, B2, B3, B4, B5, B6

APPENDIX C TO PART 718—BLOOD-GAS TABLES

AUTHORITY: 5 U.S.C. 301; Reorganization Plan No. 6 of 1950, 15 FR 3174; 30 U.S.C. 901 *et seq.*, 902(f), 934, 936; 33 U.S.C. 901 *et seq.*; 42 U.S.C. 405; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 45 FR 13678, Feb. 29, 1980, unless otherwise noted.

Subpart A—General

SOURCE: 65 FR 80045, Dec. 20, 2000, unless otherwise noted.

§ 718.1 Statutory provisions.

Section 402(f) of the Act authorizes the Secretary of Labor to establish criteria for determining total disability or death due to pneumoconiosis to be applied in the processing and adjudication of claims filed under Part C of the Act. Section 402(f) further authorizes the Secretary of Labor, in consultation with the National Institute for Occupational Safety and Health, to establish criteria for all appropriate medical tests administered in connection with a claim for benefits. Section 413(b) of the Act authorizes the Secretary of Labor to establish criteria for the techniques used to take chest roentgenograms (x-rays) in connection with a claim for benefits under the Act.

[78 FR 59114, Sept. 25, 2013]

§ 718.2 Applicability of this part.

(a) With the exception of the second sentence of § 718.204(a), this part is applicable to the adjudication of all claims filed on or after June 30, 1982 under Part C of the Act. It provides standards for establishing entitlement to benefits under the Act and describes the criteria for the development of medical evidence used in establishing such entitlement. The second sentence of § 718.204(a) is applicable to the adjudication of all claims filed after January 19, 2001.

(b) Publication of certain provisions or parts of certain provisions that apply only to claims filed prior to June 30, 1982, or to claims subject to Section

435 of the Act, has been discontinued because those provisions affect an increasingly smaller number of claims. The version of Part 718 set forth in 20 CFR, parts 500 to end, edition revised as of April 1, 2010, applies to the adjudication of all claims filed prior to June 30, 1982, as appropriate.

(c) The provisions of this part must, to the extent appropriate, be construed together in the adjudication of claims.

[78 FR 59114, Sept. 25, 2013]

§ 718.3 Scope and intent of this part.

(a) This part sets forth the standards to be applied in determining whether a coal miner is or was totally disabled due to pneumoconiosis or died due to pneumoconiosis. It also specifies the procedures and requirements to be followed in conducting medical examinations and in administering various tests relevant to such determinations.

(b) This part is designed to interpret the presumptions contained in section 411(c) of the Act, evidentiary standards and criteria contained in section 413(b) of the Act and definitional requirements and standards contained in section 402(f) of the Act within a coherent framework for the adjudication of claims. It is intended that these enumerated provisions of the Act be construed as provided in this part.

[65 FR 80045, Dec. 20, 2000, as amended at 78 FR 59114, Sept. 25, 2013]

§ 718.4 Definitions and use of terms.

Except as is otherwise provided by this part, the definitions and usages of terms contained in § 725.101 of subpart A of part 725 of this title shall be applicable to this part.

§ 718.5 Incorporations by reference.

(a) The materials listed in paragraphs (b) through (f) of this section are incorporated by reference in this part. The Director of the Federal Register has approved these incorporations by reference under 5 U.S.C. 522(a) and 1 CFR part 51. To enforce any edition other than that specified in these regulations, OWCP must publish notice of change in the FEDERAL REGISTER. All approved material is available from the sources listed below. You may inspect a copy of the approved material at the Division of Coal Mine Workers' Compensation, OWCP, U.S. Department of Labor, Washington, DC. To arrange for an inspection at OWCP, call 202–693–0046. These materials are also available for inspection at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030 or go to *http://www.archives.gov/federalregister/codeoffederalregulations/ibrlocations.html*.

(b) American Association of Physicists in Medicine, Order Department, Medical Physics Publishing, 4513 Vernon Blvd., Madison, WI 53705, *http://www.aapm.org/pubs/reports:*

(1) AAPM On-Line Report No. 03, Assessment of Display Performance for Medical Imaging Systems, April 2005, IBR approved for Appendix A to part 718, paragraph (d).

(2) AAPM Report No. 93, Acceptance Testing and Quality Control of Photostimulable Storage Phosphor Imaging Systems, October 2006, IBR approved for Appendix A to part 718, paragraph (d).

(c) American College of Radiology, 1891 Preston White Dr., Reston, VA 20191, *http://www.acr.org/~/media/ACR/Documents/PGTS/guidelines/Reference_Levels.pdf:*

(1) ACR Practice Guideline for Diagnostic Reference Levels in Medical X-Ray Imaging, Revised 2008 (Resolution 3), IBR approved for Appendix A to part 718, paragraph (d).

(2) [Reserved]

(d) International Labour Office, CH–1211 Geneva 22, Switzerland, *http://www.ilo.org/publns:* (1) Occupational Safety and Health Series No. 22, Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, Revised edition 2011, IBR approved for § 718.102(d) and Appendix A to part 718, paragraph (d).

(2) Occupational Safety and Health Series No. 22 (Rev. 2000), Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, Revised edition 2000, IBR approved for § 718.102(d).

(3) Occupational Safety and Health Series No. 22 (Rev. 80), Guidelines for the Use of ILO International Classification of Radiographs of

Pneumoconioses, Revised edition 1980, IBR approved for § 718.102(d).

(e) National Council on Radiation Protection and Measurements, NCRP Publications, 7910 Woodmont Avenue, Suite 400, Bethesda, MD 20814–3095, Telephone (800) 229–2652, *http://www.ncrppublications.org:*

(1) NCRP Report No. 102, Medical X–Ray, Electron Beam, and Gamma–Ray Protection for Energies Up to 50 MeV (Equipment Design, Performance, and Use), issued June 30, 1989, IBR approved for Appendix A to part 718, paragraph (b).

(2) NCRP Report No. 105, Radiation Protection for Medical and Allied Health Personnel, issued October 30, 1989, IBR approved for Appendix A to part 718, paragraph (b).

(3) NCRP Report No. 147, Structural Shielding Design for Medical X–Ray Imaging Facilities, revised March 18, 2005, IBR approved for Appendix A to part 718, paragraph (b).

(f) National Electrical Manufacturers Association, 1300 N. 17th Street, Rosslyn, VA 22209, *http://medical.nema.org:*

(1) DICOM Standard PS 3.3–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 3: Information Object Definitions, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(2) DICOM Standard PS 3.4–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 4: Service Class Specifications, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(3) DICOM Standard PS 3.10–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 10: Media Storage and File Format for Media Interchange, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(4) DICOM Standard PS 3.11–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 11: Media Storage Application Profiles, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(5) DICOM Standard PS 3.12–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 12: Media Formats and Physical Media for Media Interchange, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(6) DICOM Standard PS 3.14–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 14: Grayscale Standard Display Function, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

(7) DICOM Standard PS 3.16–2011, Digital Imaging and Communications in Medicine (DICOM) standard, Part 16: Content Mapping Resource, copyright 2011, IBR approved for Appendix A to part 718, paragraph (d).

[79 FR 21611, Apr. 17, 2014]

Subpart B—Criteria for the Development of Medical Evidence

SOURCE: 65 FR 80045, Dec. 20, 2000, unless otherwise noted.

§ 718.101 General.

(a) The Office of Workers' Compensation Programs (hereinafter OWCP or the Office) must develop the medical evidence necessary to determine each claimant's entitlement to benefits. Each miner who files a claim for benefits under the Act must be provided an opportunity to substantiate his or her claim by means of a complete pulmonary evaluation including, but not limited to, a chest radiograph (X-ray), physical examination, pulmonary function tests, and a blood-gas study.

(b) The standards for the administration of clinical tests and examinations contained in this subpart shall apply to all evidence developed by any party after January 19, 2001 in connection with a claim governed by this part (see §§ 725.406(b), 725.414(a), 725.456(d)). These standards shall also apply to claims governed by part 727 (see 20 CFR 725.4(d)), but only for clinical tests or examinations conducted after January 19, 2001. Any clinical test or examination subject to these standards shall be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. Unless otherwise provided, any evidence which is not in substantial

compliance with the applicable standard is insufficient to establish the fact for which it is proffered.

[65 FR 80045, Dec. 20, 2000, as amended at 78 FR 35555, June 13, 2013; 79 FR 21611, Apr. 17, 2014]

§ 718.102 Chest radiographs (X-rays).

(a) A chest radiograph (X-ray) must be of suitable quality for proper classification of pneumoconiosis and must conform to the standards for administration and interpretation of chest X-rays as described in Appendix A.

(b) Chest X-rays may be produced by either film or digital radiography systems as defined in Appendix A to this part.

(c) The images described in paragraphs (c)(1) and (2) of this section will not be considered of suitable quality for proper classification of pneumoconiosis under this section:

(1) Digital images derived from film screen chest X-rays (e.g., by scanning or digital photography); and

(2) Images that were acquired using digital systems and then printed on transparencies for back-lighted display (e.g., using traditional view boxes).

(d) Standards for classifying radiographs:

(1) To establish the existence of pneumoconiosis, a film chest X-ray must be classified as Category 1, 2, 3, A, B, or C, in accordance with the International Labour Organization (ILO) classification system established in one of the following:

(i) Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, revised edition 2011 (incorporated by reference, *see* § 718.5).

(ii) Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, revised edition 2000 (incorporated by reference, *see* § 718.5).

(iii) Guidelines for the Use of ILO International Classification of Radiographs of Pneumoconioses, revised edition 1980 (incorporated by reference, *see* § 718.5).

(2) To establish the existence of pneumoconiosis, a digital chest radiograph must be classified as Category 1, 2, 3, A, B, or C, in accordance with the ILO classification system established in Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses, revised edition 2011.

(3) A chest radiograph classified under any of the foregoing ILO classification systems as Category 0, including subcategories 0-, 0/0, or 0/1, does not constitute evidence of pneumoconiosis.

(e) An X-ray report must include the following:

(1) The name and qualifications of the person who took the X-ray.

(2) The name and qualifications of the physician who interpreted the X-ray. The interpreting physician must indicate whether he or she was a Board-certified radiologist, a Board-eligible radiologist, or a Certified B Reader as defined below on the date the interpretation was made.

(i) *Board-certified radiologist* means that the physician is certified in radiology or diagnostic radiology by the American Board of Radiology, Inc., or the American Osteopathic Association.

(ii) *Board-eligible radiologist* means that the physician has successfully completed a formal accredited residency program in radiology or diagnostic radiology.

(iii) *Certified B Reader* means that the physician has demonstrated ongoing proficiency in evaluating chest radiographs for radiographic quality and in the use of the ILO classification for interpreting chest radiographs for pneumoconiosis and other diseases by taking and passing a specially designed proficiency examination given on behalf of or by the National Institute for Occupational Safety and Health (NIOSH), and has maintained that certification through the date the interpretation is made. *See* 42 CFR 37.52(b).

(3) A description and interpretation of the findings in terms of the ILO classification described in paragraph (d) of this section.

(4) A statement that the X-ray was interpreted in compliance with this section.

(f) Radiograph Submission: For film X-rays, the original film on which the X-ray report is based must be supplied to OWCP. For digital X-rays, a copy of the original digital object upon which the X-ray report is based, formatted to meet the standards for transmission of

diagnostic chest images set forth in Appendix A, paragraph (d), must be provided to OWCP on a DVD or other media specified by OWCP. In cases where the law prohibits the parties or a physician from supplying the original film or a copy of the digital image, the report will be considered as evidence only if the original film or digital image is otherwise available to OWCP and the other parties.

(g) Where the chest X-ray of a deceased miner has been lost or destroyed, or is otherwise unavailable, a report of the chest X-ray submitted by any party may be considered in connection with the claim.

(h) Except as provided in this paragraph (h), no chest X-ray may constitute evidence of the presence or absence of pneumoconiosis unless it is conducted and reported in accordance with the requirements of this section and Appendix A. In the absence of evidence to the contrary, compliance with the requirements of Appendix A must be presumed. In the case of a deceased miner where the only available X-ray does not substantially comply with paragraphs (a) through (e) of this section, the X-ray may form the basis for a finding of the presence or absence of pneumoconiosis if it is of sufficient quality for determining whether pneumoconiosis is present and it was interpreted by a Board-certified radiologist, Board-eligible radiologist, or Certified B Reader.

[79 FR 21612, Apr. 17, 2014]

§ 718.103 Pulmonary function tests.

(a) Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop). The instrument shall simultaneously provide records of volume versus time (spirometric tracing). The report shall provide the results of the forced expiratory volume in one second (FEV1) and the forced vital capacity (FVC). The report shall also provide the FEV1/FVC ratio, expressed as a percentage. If the maximum voluntary ventilation (MVV) is reported, the results of such test shall be obtained independently rather than calculated from the results of the FEV1.

(b) All pulmonary function test results submitted in connection with a claim for benefits shall be accompanied by three tracings of the flow versus volume and the electronically derived volume versus time tracings. If the MVV is reported, two tracings of the MVV whose values are within 10% of each other shall be sufficient. Pulmonary function test results developed in connection with a claim for benefits shall also include a statement signed by the physician or technician conducting the test setting forth the following:

(1) Date and time of test;

(2) Name, DOL claim number, age, height, and weight of claimant at the time of the test;

(3) Name of technician;

(4) Name and signature of physician supervising the test;

(5) Claimant's ability to understand the instructions, ability to follow directions and degree of cooperation in performing the tests. If the claimant is unable to complete the test, the person executing the report shall set forth the reasons for such failure;

(6) Paper speed of the instrument used;

(7) Name of the instrument used;

(8) Whether a bronchodilator was administered. If a bronchodilator is administered, the physician's report must detail values obtained both before and after administration of the bronchodilator and explain the significance of the results obtained; and

(9) That the requirements of paragraphs (b) and (c) of this section have been complied with.

(c) Except as provided in this paragraph, no results of a pulmonary function study shall constitute evidence of the presence or absence of a respiratory or pulmonary impairment unless it is conducted and reported in accordance with the requirements of this section and Appendix B to this part. In the absence of evidence to the contrary, compliance with the requirements of Appendix B shall be presumed. In the case of a deceased miner, where no pulmonary function tests are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for

a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner.

§ 718.104 Report of physical examinations.

(a) A report of any physical examination conducted in connection with a claim shall be prepared on a medical report form supplied by the Office or in a manner containing substantially the same information. Any such report shall include the following information and test results:

(1) The miner's medical and employment history;

(2) All manifestations of chronic respiratory disease;

(3) Any pertinent findings not specifically listed on the form;

(4) If heart disease secondary to lung disease is found, all symptoms and significant findings;

(5) The results of a chest X-ray conducted and interpreted as required by § 718.102; and

(6) The results of a pulmonary function test conducted and reported as required by § 718.103. If the miner is physically unable to perform a pulmonary function test or if the test is medically contraindicated, in the absence of evidence establishing total disability pursuant to § 718.304, the report must be based on other medically acceptable clinical and laboratory diagnostic techniques, such as a blood gas study.

(b) In addition to the requirements of paragraph (a), a report of physical examination may be based on any other procedures such as electrocardiogram, blood-gas studies conducted and reported as required by § 718.105, and other blood analyses which, in the physician's opinion, aid in his or her evaluation of the miner.

(c) In the case of a deceased miner, where no report is in substantial compliance with paragraphs (a) and (b), a report prepared by a physician who is unavailable may nevertheless form the basis for a finding if, in the opinion of the adjudication officer, it is accompanied by sufficient indicia of reliability in light of all relevant evidence.

(d) *Treating physician.* In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) *Nature of relationship.* The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) *Duration of relationship.* The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) *Frequency of treatment.* The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) *Extent of treatment.* The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

§ 718.105 Arterial blood-gas studies.

(a) Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. No blood-gas study shall be performed if medically contraindicated.

(b) A blood-gas study shall initially be administered at rest and in a sitting position. If the results of the blood-gas test at rest do not satisfy the requirements of Appendix C to this part, an exercise blood-gas test shall be offered to the miner unless medically contraindicated. If an exercise blood-gas test is administered, blood shall be drawn during exercise.

(c) Any report of a blood-gas study submitted in connection with a claim shall specify:

(1) Date and time of test;

(2) Altitude and barometric pressure at which the test was conducted;

(3) Name and DOL claim number of the claimant;

(4) Name of technician;

(5) Name and signature of physician supervising the study;

(6) The recorded values for PC02, P02, and PH, which have been collected simultaneously (specify values at rest and, if performed, during exercise);

(7) Duration and type of exercise;

(8) Pulse rate at the time the blood sample was drawn;

(9) Time between drawing of sample and analysis of sample; and

(10) Whether equipment was calibrated before and after each test.

(d) If one or more blood-gas studies producing results which meet the appropriate table in Appendix C is administered during a hospitalization which ends in the miner's death, then any such study must be accompanied by a physician's report establishing that the test results were produced by a chronic respiratory or pulmonary condition. Failure to produce such a report will prevent reliance on the blood-gas study as evidence that the miner was totally disabled at death. (e) In the case of a deceased miner, where no blood gas tests are in substantial compliance with paragraphs (a), (b), and (c), noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the only available tests demonstrate technically valid results. This provision shall not excuse compliance with the requirements in paragraph (d) for any blood gas study administered during a hospitalization which ends in the miner's death.

§ 718.106 Autopsy; biopsy.

(a) A report of an autopsy or biopsy submitted in connection with a claim shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure has been performed to obtain a portion of a lung, the evidence shall include a copy of the surgical note and the pathology report of the gross and microscopic examination of the surgical specimen. If an autopsy has been performed, a complete copy of the autopsy report shall be submitted to the Office.

(b) In the case of a miner who died prior to March 31, 1980, an autopsy or biopsy report shall be considered even when the report does not substantially comply with the requirements of this section. A noncomplying report concerning a miner who died prior to March 31, 1980, shall be accorded the appropriate weight in light of all relevant evidence.

(c) A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis.

§ 718.107 Other medical evidence.

(a) The results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or absence of pneumoconiosis, the sequelae of pneumoconiosis or a respiratory or pulmonary impairment, may be submitted in connection with a claim and shall be given appropriate consideration.

(b) The party submitting the test or procedure pursuant to this section bears the burden to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits.

Subpart C—Determining Entitlement to Benefits

SOURCE: 65 FR 80045, Dec. 20, 2000, unless otherwise noted.

§ 718.201 Definition of pneumoconiosis.

(a) For the purpose of the Act, ''pneumoconiosis'' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or ''clinical'', pneumoconiosis and statutory, or ''legal'', pneumoconiosis.

(1) *Clinical Pneumoconiosis.* ''Clinical pneumoconiosis'' consists of those diseases recognized by the medical community as pneumoconioses, *i.e.,* the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* ''Legal pneumoconiosis'' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease ''arising out of coal mine employment'' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, ''pneumoconiosis'' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§ 718.202 Determining the existence of pneumoconiosis.

(a) A finding of the existence of pneumoconiosis may be made as follows in paragraphs (a)(1) through (4) of this section:

(1) A chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. Except as otherwise provided in this section, where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration must be given to the radiological qualifications of the physicians interpreting such X-rays (*see* § 718.102(d)).

(2) A biopsy or autopsy conducted and reported in compliance with § 718.106 may be the basis for a finding of the existence of pneumoconiosis. A finding in an autopsy or biopsy of anthracotic pigmentation, however, must not be considered sufficient, by itself, to establish the existence of pneumoconiosis. A report of autopsy must be accepted unless there is evidence that the report is not accurate or that the claim has been fraudulently represented.

(3) If the presumptions described in § 718.304 or § 718.305 are applicable, it must be presumed that the miner is or was suffering from pneumoconiosis.

(4) A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding must be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding must be supported by a reasoned medical opinion.

(b) A claim for benefits must not be denied solely on the basis of a negative chest X-ray.

(c) A determination of the existence of pneumoconiosis must not be made—

(1) Solely on the basis of a living miner's statements or testimony; or

(2) In a claim involving a deceased miner, solely on the basis of the affidavit(s) (or equivalent testimony) of

the claimant and/or his or her dependents who would be eligible for augmentation of the claimant's benefits if the claim were approved.

[79 FR 21612, Apr. 17, 2014]

§ 718.203 Establishing relationship of pneumoconiosis to coal mine employment.

(a) In order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment. The provisions in this section set forth the criteria to be applied in making such a determination.

(b) If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

(c) If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship.

§ 718.204 Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis.

(a) *General.* Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

(b)(1) *Total disability defined.* A miner shall be considered totally disabled if the irrebuttable presumption described in § 718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner:

(i) From performing his or her usual coal mine work; and

(ii) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time.

(2) *Medical criteria.* In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:

(i) Pulmonary function tests showing values equal to or less than those listed in Table B1 (Males) or Table B2 (Females) in Appendix B to this part for an individual of the miner's age, sex, and height for the FEV1 test; if, in addition, such tests also reveal the values specified in either paragraph (b)(2)(i)(A) or (B) or (C) of this section:

(A) Values equal to or less than those listed in Table B3 (Males) or Table B4 (Females) in Appendix B of this part, for an individual of the miner's age, sex, and height for the FVC test, or

(B) Values equal to or less than those listed in Table B5 (Males) or Table B6 (Females) in Appendix B to this part, for an individual of the miner's age, sex, and height for the MVV test, or

(C) A percentage of 55 or less when the results of the FEV1 test are divided by the results of the FVC test (FEV1/FVC equal to or less than 55%), or

(ii) Arterial blood-gas tests show the values listed in Appendix C to this part, or

(iii) The miner has pneumoconiosis and has been shown by the medical evidence to be suffering from cor pulmonale with right-sided congestive heart failure, or

(iv) Where total disability cannot be shown under paragraphs (b)(2)(i), (ii), or (iii) of this section, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may nevertheless be

found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b)(1) of this section.

(c)(1) *Total disability due to pneumoconiosis defined.* A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a ''substantially contributing cause'' of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

(2) Except as provided in § 718.305 and paragraph (b)(2)(iii) of this section, proof that the miner suffers or suffered from a totally disabling respiratory or pulmonary impairment as defined in paragraphs (b)(2)(i), (b)(2)(ii), (b)(2)(iv) and (d) of this section shall not, by itself, be sufficient to establish that the miner's impairment is or was due to pneumoconiosis. Except as provided in paragraph (d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report.

(d) *Lay evidence.* In establishing total disability, lay evidence may be used in the following cases:

(1) In a case involving a deceased miner in which the claim was filed prior to January 1, 1982, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition shall be sufficient to establish total (or under § 718.306 partial) disability due to pneumoconiosis if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition.

(2) In a case involving a survivor's claim filed on or after January 1, 1982, but prior to June 30, 1982, which is subject to § 718.306, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition shall be sufficient to establish total or partial disability due to pneumoconiosis if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition; however, such a determination shall not be based solely upon the affidavits or testimony of the claimant and/or his or her dependents who would be eligible for augmentation of the claimant's benefits if the claim were approved.

(3) In a case involving a deceased miner whose claim was filed on or after January 1, 1982, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition shall be sufficient to establish total disability due to pneumoconiosis if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition; however, such a determination shall not be based solely upon the affidavits or testimony of any person who would be eligible for benefits (including augmented benefits) if the claim were approved.

(4) Statements made before death by a deceased miner about his or her physical condition are relevant and shall be considered in making a determination as to whether the miner was totally disabled at the time of death.

(5) In the case of a living miner's claim, a finding of total disability due to pneumoconiosis shall not be made solely on the miner's statements or testimony.

(e) In determining total disability to perform usual coal mine work, the following shall apply in evaluating the miner's employment activities:

(1) In the case of a deceased miner, employment in a mine at the time of death shall not be conclusive evidence that the miner was not totally disabled. To disprove total disability, it must be shown that at the time the miner died, there were no changed circumstances of employment indicative of his or her reduced ability to perform his or her usual coal mine work.

(2) In the case of a living miner, proof of current employment in a coal mine

shall not be conclusive evidence that the miner is not totally disabled unless it can be shown that there are no changed circumstances of employment indicative of his or her reduced ability to perform his or her usual coal mine work.

(3) Changed circumstances of employment indicative of a miner's reduced ability to perform his or her usual coal mine work may include but are not limited to:

(i) The miner's reduced ability to perform his or her customary duties without help; or

(ii) The miner's reduced ability to perform his or her customary duties at his or her usual levels of rapidity, continuity or efficiency; or

(iii) The miner's transfer by request or assignment to less vigorous duties or to duties in a less dusty part of the mine.

§ 718.205 Death due to pneumoconiosis.

(a) Benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. In order to receive benefits based on a showing of death due to pneumoconiosis, a claimant must prove that:

(1) The miner had pneumoconiosis (*see* § 718.202);

(2) The miner's pneumoconiosis arose out of coal mine employment (*see* § 718.203); and

(3) The miner's death was due to pneumoconiosis as provided by this section.

(b) Death will be considered to be due to pneumoconiosis if any of the following criteria is met:

(1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or

(2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

(3) Where the presumption set forth at § 718.304 is applicable, or

(4) For survivors' claims filed after January 1, 2005, and pending on or after March 23, 2010, where the presumption at § 718.305 is invoked and not rebutted.

(5) However, except where the § 718.304 presumption is invoked, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury (including suicide) or the principal cause of death was a medical condition not related to pneumoconiosis, unless the claimant establishes (by proof or presumption) that pneumoconiosis was a substantially contributing cause of death.

(6) Pneumoconiosis is a ''substantially contributing cause'' of a miner's death if it hastens the miner's death.

[78 FR 59114, Sept. 25, 2013]

§ 718.206 Effect of findings by persons or agencies.

Decisions, statements, reports, opinions, or the like, of agencies, organizations, physicians or other individuals, about the existence, cause, and extent of a miner's disability, or the cause of a miner's death, are admissible. If properly submitted, such evidence shall be considered and given the weight to which it is entitled as evidence under all the facts before the adjudication officer in the claim.

Subpart D—Presumptions Applicable to Eligibility Determinations

SOURCE: 65 FR 80045, Dec. 20, 2000, unless otherwise noted.

§ 718.301 Establishing length of employment as a miner.

The presumptions set forth in §§ 718.302 and 718.305 apply only if a miner worked in one or more coal mines for the number of years required to invoke the presumption. The length of the miner's coal mine work history must be computed as provided by 20 CFR 725.101(a)(32).

[78 FR 59114, Sept. 25, 2013]

§ 718.302 Relationship of pneumoconiosis to coal mine employment.

If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. (See § 718.203.)

§ 718.303 [Reserved]

§ 718.304 Irrebuttable presumption of total disability or death due to pneumoconiosis.

There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis, that a miner's death was due to pneumoconiosis or that a miner was totally disabled due to pneumoconiosis at the time of death, if such miner is suffering or suffered from a chronic dust disease of the lung which:

(a) When diagnosed by chest X-ray (*see* § 718.202 concerning the standards for X-rays and the effect of interpretations of X-rays by physicians) yields one or more large opacities (greater than one centimeter in diameter) and would be classified in Category A, B, or C in accordance with the classification system established in Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses as provided in § 718.102(d); or

(b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or

(c) When diagnosed by means other than those specified in paragraphs (a) and (b) of this section, would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described: *Provided, however,* that any diagnosis made under this paragraph must accord with acceptable medical procedures.

[79 FR 21613, Apr. 17, 2014]

§ 718.305 Presumption of pneumoconiosis.

(a) *Applicability*. This section applies to all claims filed after January 1, 2005, and pending on or after March 23, 2010.

(b) *Invocation*. (1) The claimant may invoke the presumption by establishing that—

(i) The miner engaged in coal-mine employment for fifteen years, either in one or more underground coal mines, or in coal mines other than underground mines in conditions substantially similar to those in underground mines, or in any combination thereof; and

(ii) The miner or survivor cannot establish entitlement under § 718.304 by means of chest x-ray evidence; and

(iii) The miner has, or had at the time of his death, a totally disabling respiratory or pulmonary impairment established pursuant to § 718.204, except that § 718.204(d) does not apply.

(2) The conditions in a mine other than an underground mine will be considered ''substantially similar'' to those in an underground mine if the claimant demonstrates that the miner was regularly exposed to coal-mine dust while working there.

(3) In a claim involving a living miner, a miner's affidavit or testimony, or a spouse's affidavit or testimony, may not be used by itself to establish the existence of a totally disabling respiratory or pulmonary impairment.

(4) In the case of a deceased miner, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition must be considered sufficient to establish total disability due to a respiratory or pulmonary impairment if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition; however, such a determination must not be based solely upon the affidavits or testimony of any person who would be eligible for benefits (including augmented benefits) if the claim were approved.

(c) *Facts presumed*. Once invoked, there will be rebuttable presumption—

(1) In a miner's claim, that the miner is totally disabled due to pneumoconiosis, or was totally disabled due to pneumoconiosis at the time of death; or

(2) In a survivor's claim, that the miner's death was due to pneumoconiosis.

(d) *Rebuttal*—(1) *Miner's claim*. In a claim filed by a miner, the party opposing entitlement may rebut the presumption by—

(i) Establishing both that the miner does not, or did not, have:

(A) Legal pneumoconiosis as defined in § 718.201(a)(2); and

(B) Clinical pneumoconiosis as defined in § 718.201(a)(1), arising out of coal mine employment (*see* § 718.203); or

(ii) Establishing that no part of the miner's respiratory or pulmonary total disability was caused by pneumoconiosis as defined in § 718.201.

(2) *Survivor's claim.* In a claim filed by a survivor, the party opposing entitlement may rebut the presumption by—

(i) Establishing both that the miner did not have:

(A) Legal pneumoconiosis as defined in § 718.201(a)(2); and

(B) Clinical pneumoconiosis as defined in § 718.201(a)(1), arising out of coal mine employment (*see* § 718.203); or

(ii) Establishing that no part of the miner's death was caused by pneumoconiosis as defined in § 718.201.

(3) The presumption must not be considered rebutted on the basis of evidence demonstrating the existence of a totally disabling obstructive respiratory or pulmonary disease of unknown origin.

[78 FR 59114, Sept. 25, 2013]

§ 718.306 [Reserved]

APPENDIX A TO PART 718—STANDARDS FOR ADMINISTRATION AND INTERPRETATION OF CHEST RADIOGRAPHS (X-RAYS)

The following standards are established in accordance with sections 402(f)(1)(D) and 413(b) of the Act. They were developed in consultation with the National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention in the Department of Health and Human Services. These standards are promulgated for the guidance of physicians and medical technicians to ensure that uniform procedures are used in administering and interpreting X-rays and that the best available medical evidence will be submitted in connection with a claim for black lung benefits. If it is established that one or more standards have not been met, the claims adjudicator may consider such fact in determining the evidentiary weight to be assigned to the physician's report of an X-ray.

(a) *Definitions.* (1) *Digital radiography systems,* as used in this context, include both digital radiography (DR) and computed radiography (CR). Digital radiography is the term used for digital X-ray image acquisition systems in which the X-ray signals received by the image detector are converted nearly instantaneously to electronic signals without moveable cassettes. Computed radiography is the term for digital X-ray image acquisition systems that detect X-ray signals using a cassette-based photostimulable storage phosphor. Subsequently, the cassette is processed using a stimulating laser beam to convert the latent radiographic image to electronic signals which are then processed and stored so they can be displayed.

(2) *Qualified medical physicist* means an individual who is trained in evaluating the performance of radiographic equipment including radiation controls and facility quality assurance programs, and has the relevant current certification by a competent U.S. national board, or unrestricted license or approval from a U.S. State or Territory.

(3) *Radiographic technique chart* means a table that specifies the types of cassette, intensifying screen, film or digital detector, grid, filter, and lists X-ray machine settings (timing, kVp, mA) that enables the radiographer to select the correct settings based on the body habitus or the thickness of the chest tissue.

(4) *Radiologic technologist* means an individual who has met the requirements for privileges to perform general radiographic procedures and for competence in using the equipment and software employed by the examining facility to obtain chest images as specified by the State or Territory and examining facility in which such services are provided. Optimally, such an individual will have completed a formal training program in radiography leading to a certificate, an associate's degree, or a bachelor's degree and participated in the voluntary initial certification and annual renewal of registration for radiologic technologists offered by the American Registry of Radiologic Technologists.

(5) *Soft copy* means the image of a coal miner's chest radiograph acquired using a digital radiography system, viewed at the full resolution of the image acquisition system using an electronic medical image display device.

(b) *General provisions.* (1) Facilities must maintain ongoing licensure and certification under relevant local, State, and Federal laws and regulations for all digital equipment and related processes covered by this Appendix. Radiographic equipment, its use and the facilities (including mobile facilities) in which such equipment is used must conform to applicable State or Territorial and Federal regulations. Where no applicable regulations exist regarding reducing the risk from ionizing radiation exposure in the clinical setting, radiographic equipment, its use and the facilities (including mobile facilities) in which such equipment is used should conform to the recommendations in NCRP Report No. 102, NCRP Report No. 105, and NCRP Report No. 147 (incorporated by reference, *see* § 718.5).

(2) Chest radiographs of miners must be performed:

(i) By or under the supervision of a physician who makes chest radiographs in the

normal course of practice and who has demonstrated ability to make chest radiographs of a quality to best ascertain the presence of pneumoconiosis; or

(ii) By a radiologic technologist.

(3) Miners must be disrobed from the waist up at the time the radiograph is given. The facility must provide a dressing area and for those miners who wish to use one, the facility will provide a clean gown. Facilities must be heated to a comfortable temperature.

(4) Before the miner is advised that the examination is concluded, the radiograph must be processed and inspected and accepted for quality standards by the physician, or if the physician is not available, acceptance may be made by the radiologic technologist. In a case of a substandard radiograph, another must be made immediately.

(c) *Chest radiograph specifications—film.* (1) Every chest radiograph must be a single posteroanterior projection at full inspiration on a film being no less than 14 by 17 inch film. Additional chest films or views must be obtained if they are necessary for clarification and classification. The film and cassette must be capable of being positioned both vertically and horizontally so that the chest radiograph will include both apices and costophrenic angles. If a miner is too large to permit the above requirements, then a projection with minimum loss of costophrenic angle must be made.

(2) Radiographs must be made with a diagnostic X-ray machine having a rotating anode tube with a maximum of a 2 mm source (focal spot).

(3) Except as provided in paragraph (c)(4) of this appendix, radiographs must be made with units having generators that comply with the following:

(i) Generators of existing radiographic units acquired by the examining facility prior to July 27, 1973, must have a minimum rating of 200 mA at 100 kVp;

(ii) Generators of units acquired subsequent to that date must have a minimum rating of 300 mA at 125 kVp. A generator with a rating of 150 kVp is recommended.

(4) Radiographs made with battery-powered mobile or portable equipment must be made with units having a minimum rating of 100 mA at 110 kVp at 500 Hz, or 200 mA at 110 kVp at 60 Hz.

(5) Capacitor discharge and field emission units may be used.

(6) Radiographs must be given only with equipment having a beam-limiting device that does not cause large unexposed boundaries. The use of such a device must be discernible from an examination of the radiograph.

(7) To ensure high quality chest radiographs:

(i) The maximum exposure time must not exceed 50 milliseconds except that with single phase units with a rating less than 300 mA at 125 kVp and subjects with chests over 28 cm postero-anterior, the exposure may be increased to not more than 100 milliseconds;

(ii) The source or focal spot to film distance must be at least 6 feet.

(iii) Medium-speed film and medium-speed intensifying screens are recommended. However, any film-screen combination, the rated ''speed'' of which is at least 100 and does not exceed 300, which produces radiographs with spatial resolution, contrast, latitude and quantum mottle similar to those of systems designated as ''medium speed'' may be employed;

(iv) Film-screen contact must be maintained and verified at 6-month or shorter intervals.

(v) Intensifying screens must be inspected at least once a month and cleaned when necessary by the method recommended by the manufacturer;

(vi) All intensifying screens in a cassette must be of the same type and made by the same manufacturer;

(vii) When using over 90 kV, a suitable grid or other means of reducing scattered radiation must be used;

(viii) The geometry of the radiographic system must ensure that the central axis (ray) of the primary beam is perpendicular to the plane of the film surface and impinges on the center of the film.

(8) Radiographic processing:

(i) Either automatic or manual film processing is acceptable. A constant time-temperature technique must be meticulously employed for manual processing.

(ii) If mineral or other impurities in the processing water introduce difficulty in obtaining a high-quality radiograph, a suitable filter or purification system must be used.

(9) An electric power supply must be used that complies with the voltage, current, and regulation specified by the manufacturer of the machine.

(10) A test object may be required on each radiograph for an objective evaluation of film quality at the discretion of the Department of Labor.

(11) Each radiograph made under this Appendix must be permanently and legibly marked with the name and address of the facility at which it is made, the miner's DOL claim number, the date of the radiograph, and left and right side of the film. No other identifying markings may be recorded on the radiograph.

(d) *Chest radiograph specifications—digital radiography systems.* (1) Every digital chest radiograph must be a single posteroanterior projection at full inspiration on a digital detector with sensor area being no less than 1505 square centimeters with a minimum width of 35 cm. The imaging plate must have a maximum pixel pitch of 200 μm, with a minimum bit depth of 10. Spatial resolution

must be at least 2.5 line pairs per millimeter. The storage phosphor cassette or digital image detector must be positioned either vertically or horizontally so that the image includes the apices and costophrenic angles of both right and left lungs. If the detector cannot include the apices and costophrenic angles of both lungs as described, then the two side-by-side images can be obtained that together include the apices and costophrenic angles of both right and left lungs.

(2) Radiographs must be made with a diagnostic X-ray machine with a maximum actual (not nominal) source (focal spot) of 2 mm, as measured in two orthogonal directions.

(3) Radiographs must be made with units having generators which have a minimum rating of 300 mA at 125 kVp. Exposure kilovoltage must be at least the minimum as recommended by the manufacturer for chest radiography.

(4) An electric power supply must be used that complies with the voltage, current, and regulation specified by the manufacturer of the machine. If the manufacturer or installer of the radiographic equipment recommends equipment for control of electrical power fluctuations, such equipment must be used as recommended.

(5) Radiographs must be obtained only with equipment having a beam-limiting device that does not cause large unexposed boundaries. The beam limiting device must provide rectangular collimation. Electronic post-image acquisition ''shutters'' available on some CR or DR systems that limit the size of the final image and that simulate collimator limits must not be used. The use and effect of the beam limiting device must be discernible on the resulting image.

(6) Radiographic technique charts must be used that are developed specifically for the X-ray system and detector combinations used, indicating exposure parameters by anatomic measurements.

(7) To ensure high quality chest radiographs:

(i) The maximum exposure time must not exceed 50 milliseconds except for subjects with chests over 28 cm posteroanterior, for whom the exposure time must not exceed 100 milliseconds.

(ii) The distance from source or focal spot to detector must be at least 70 inches (or 180 centimeters if measured in centimeters).

(iii) The exposure setting for chest images must be within the range of 100–300 equivalent exposure speeds and must comply with ACR Practice Guidelines for Diagnostic Reference Levels in Medical X-ray Imaging, Section V—Diagnostic Reference Levels for Imaging with Ionizing Radiation and Section VII-Radiation Safety in Imaging (incorporated by reference, *see* §718.5). Radiation exposures should be periodically measured and patient radiation doses estimated by the medical physicist to assure doses are as low as reasonably achievable.

(iv) Digital radiography system performance, including resolution, modulation transfer function (MTF), image signal-to-noise and detective quantum efficiency must be evaluated and judged acceptable by a qualified medical physicist using the specifications in AAPM Report No. 93, pages 1–68 (incorporated by reference, *see* §718.5). Image management software and settings for routine chest imaging must be used, including routine amplification of digital detector signal as well as standard image post-processing functions. Image or edge enhancement software functions must not be employed unless they are integral to the digital radiography system (not elective); in such cases, only the minimum image enhancement permitted by the system may be employed.

(v)(A) The image object, transmission and associated data storage, film format, and transmissions of associated information must conform to the following components of the Digital Imaging and Communications in Medicine (DICOM) standard (incorporated by reference, *see* §718.5):

(*1*) DICOM Standard PS 3.3–2011, Annex A—Composite Information Object Definitions, sections: Computed Radiographic Image Information Object Definition; Digital X-Ray Image Information Object Definition; X-Ray Radiation Dose SR Information Object Definition; and Grayscale Softcopy Presentation State Information Object Definition.

(*2*) DICOM Standard PS 3.4–2011: Annex B—Storage Service Class; Annex N—Softcopy Presentation State Storage SOP Classes; Annex O—Structured Reporting Storage SOP Classes.

(*3*) DICOM Standard PS 3.10–2011.

(*4*) DICOM Standard PS 3.11–2011.

(*5*) DICOM Standard PS 3.12–2011.

(*6*) DICOM Standard PS 13.14–2011.

(*7*) DICOM Standard PS 3.16–2011.

(B) Identification of each miner, chest image, facility, date and time of the examination must be encoded within the image information object, according to DICOM Standard PS 3.3–2011, Information Object Definitions, for the DICOM ''DX'' object. If data compression is performed, it must be lossless. Exposure parameters (kVp, mA, time, beam filtration, scatter reduction, radiation exposure) must be stored in the DX information object.

(C) Exposure parameters as defined in the DICOM Standard PS 3.16–2011 must additionally be provided when such parameters are available from the facility digital image acquisition system or recorded in a written report or electronic file and transmitted to OWCP.

(8) A specific test object may be required on each radiograph for an objective evaluation of image quality at the Department of Labor's discretion.

(9) CR imaging plates must be inspected at least once a month and cleaned when necessary by the method recommended by the manufacturer.

(10) A grid or air gap for reducing scattered radiation must be used; grids must not be used that cause Moiré interference patterns in either horizontal or vertical images.

(11) The geometry of the radiographic system must ensure that the central axis (ray) of the primary beam is perpendicular to the plane of the CR imaging plate or DR detector and is correctly aligned to the grid.

(12) Radiographs must not be made when the environmental temperatures and humidity in the facility are outside the manufacturer's recommended range of the CR and DR equipment to be used.

(13) All interpreters, whenever classifying digitally acquired chest radiographs, must have immediately available for reference a complete set of ILO standard digital chest radiographic images provided for use with the Guidelines for the Use of the ILO International Classification of Radiographs of Pneumoconioses (2011 Revision) (incorporated by reference, *see* §718.5). Modification of the appearance of the standard images using software tools is not permitted.

(14) Viewing systems should enable readers to display the coal miner's chest image at the full resolution of the image acquisition system, side-by-side with the selected ILO standard images for comparison.

(i)(A) Image display devices must be flat panel monitors displaying at least 3 MP at 10 bit depth. Image displays and associated graphics cards must meet the calibration and other specifications of the Digital Imaging and Communications in Medicine (DICOM) standard PS 3.14–2011 (incorporated by reference, *see* §718.5).

(B) Image displays and associated graphics cards must not deviate by more than 10 percent from the grayscale standard display function (GSDF) when assessed according to the AAPM On-Line Report No. 03, pages 1–146 (incorporated by reference, *see* §718.5).

(ii) Display system luminance (maximum and ratio), relative noise, linearity, modulation transfer function (MTF), frequency, and glare should meet or exceed recommendations listed in AAPM On-Line Report No. 03, pages 1–146 (incorporated by reference, *see* §718.5). Viewing displays must have a maximum luminance of at least 171 cd/m^2, a ratio of maximum luminance to minimum luminance of at least 250, and a glare ratio greater than 400. The contribution of ambient light reflected from the display surface, after light sources have been minimized, must be included in luminance measurements.

(iii) Displays must be situated so as to minimize front surface glare. Readers must minimize reflected light from ambient sources during the performance of classifications.

(iv) Measurements of the width and length of pleural shadows and the diameter of opacities must be taken using calibrated software measuring tools. If permitted by the viewing software, a record must be made of the presentation state(s), including any noise reduction and edge enhancement or restoration functions that were used in performing the classification, including any annotations and measurements.

(15) Quality control procedures for devices used to display chest images for classification must comply with the recommendations of the American Association of Physicists in Medicine AAPM On-Line Report No. 03, pages 1–146 (incorporated by reference, *see* §718.5). If automatic quality assurance systems are used, visual inspection must be performed using one or more test patterns recommended by the medical physicist every 6 months, or more frequently, to check for defects that automatic systems may not detect.

(16) Classification of CR and DR digitally-acquired chest radiographs under this Part must be performed based on the viewing images displayed as soft copies using the viewing workstations specified in this section. Classification of radiographs must not be based on the viewing of hard copy printed transparencies of images that were digitally-acquired.

(17) The classification of chest radiographs based on digitized copies of chest radiographs that were originally acquired using film-screen techniques is not permissible.

[79 FR 21613, Apr. 17, 2014]

APPENDIX B TO PART 718—STANDARDS FOR ADMINISTRATION AND INTERPRETATION OF PULMONARY FUNCTION TESTS. TABLES B1, B2, B3, B4, B5, B6.

The following standards are established in accordance with section 402(f)(1)(D) of the Act. They were developed in consultation with the National Institute for Occupational Safety and Health (NIOSH). These standards are promulgated for the guidance of physicians and medical technicians to insure that uniform procedures are used in administering and interpreting ventilatory function tests and that the best available medical evidence will be submitted in support of a claim for black lung benefits. If it is established that one or more standards have not been met, the claims adjudicator may consider such fact in determining the evidentiary weight to be given to the results of the ventilatory function tests.

(1) Instruments to be used for the administration of pulmonary function tests shall be approved by NIOSH and shall conform to the following criteria:

(i) The instrument shall be accurate within ±50 ml or within ±3 percent of reading, whichever is greater.

(ii) The instrument shall be capable of measuring vital capacity from 0 to 7 liters BTPS.

(iii) The instrument shall have a low inertia and offer low resistance to airflow such that the resistance to airflow at 12 liters per second must be less than 1.5 cm H20/liter/sec.

(iv) The instrument or user of the instrument must have a means of correcting volumes to body temperature saturated with water vapor (BTPS) under conditions of varying ambient spirometer temperatures and barometric pressures.

(v) The instrument used shall provide a tracing of flow versus volume (flow-volume loop) which displays the entire maximum inspiration and the entire maximum forced expiration. The instrument shall, in addition, provide tracings of the volume versus time tracing (spirogram) derived electronically from the flow-volume loop. Tracings are necessary to determine whether maximum inspiratory and expiratory efforts have been obtained during the FVC maneuver. If maximum voluntary ventilation is measured, the tracing shall record the individual breaths volumes versus time.

(vi) The instrument shall be capable of accumulating volume for a minimum of 10 seconds after the onset of exhalation.

(vii) The instrument must be capable of being calibrated in the field with respect to the FEV1. The volume calibration shall be accomplished with a 3 L calibrating syringe and should agree to within 1 percent of a 3 L calibrating volume. The linearity of the instrument must be documented by a record of volume calibrations at three different flow rates of approximately 3 L/6 sec, 3 L/3 sec, and 3 L/sec.

(viii) For measuring maximum voluntary ventilation (MVV) the instrument shall have a response which is flat within ±10 percent up to 4 Hz at flow rates up to 12 liters per second over the volume range.

(ix) The spirogram shall be recorded at a speed of at least 20 mm/sec and a volume excursion of at least 10mm/L. Calculation of the FEVl from the flow-volume loop is not acceptable. Original tracings shall be submitted.

(2) The administration of pulmonary function tests shall conform to the following criteria:

(i) Tests shall not be performed during or soon after an acute respiratory illness.

(ii) For the FEV1 and FVC, use of a nose clip is required. The procedures shall be explained in simple terms to the patient who shall be instructed to loosen any tight clothing and stand in front of the apparatus. The subject may sit, or stand, but care should be taken on repeat testing that the same position be used. Particular attention shall be given to insure that the chin is slightly elevated with the neck slightly extended. The subject shall be instructed to expire completely, momentarily hold his breath, place the mouthpiece in his mouth and close the mouth firmly about the mouthpiece to ensure no air leak. The subject will than make a maximum inspiration from the instrument and when maximum inspiration has been attained, without interruption, blow as hard, fast and completely as possible for at least 7 seconds or until a plateau has been attained in the volume-time curve with no detectable change in the expired volume during the last 2 seconds of maximal expiratory effort. A minimum of three flow-volume loops and derived spirometric tracings shall be carried out. The patient shall be observed throughout the study for compliance with instructions. Inspiration and expiration shall be checked visually for reproducibility. The effort shall be judged unacceptable when the patient:

(A) Has not reached full inspiration preceding the forced expiration; or

(B) Has not used maximal effort during the entire forced expiration; or

(C) Has not continued the expiration for least 7 sec. or until an obvious plateau for at least 2 sec. in the volume-time curve has occurred; or

(D) Has coughed or closed his glottis; or

(E) Has an obstructed mouthpiece or a leak around the mouthpiece (obstruction due to tongue being placed in front of mouthpiece, false teeth falling in front of mouthpiece, etc.); or

(F) Has an unsatisfactory start of expiration, one characterized by excessive hesitation (or false starts). Peak flow should be attained at the start of expiration and the volume-time tracing (spirogram) should have a smooth contour revealing gradually decreasing flow throughout expiration; or

(G) Has an excessive variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve this degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test.

(iii) For the MVV, the subject shall be instructed before beginning the test that he or she will be asked to breathe as deeply and as rapidly as possible for approximately 15 seconds. The test shall be performed with the subject in the standing position, if possible. Care shall be taken on repeat testing that the same position be used. The subject shall breathe normally into the mouthpiece of the

apparatus for 10 to 15 seconds to become accustomed to the system. The subject shall then be instructed to breathe as deeply and as rapidly as possible, and shall be continually encouraged during the remainder of the maneuver. Subject shall continue the maneuver for 15 seconds. At least 5 minutes of rest shall be allowed between maneuvers. At least three MVV's shall be carried out. (*But see* §718.103(b).) During the maneuvers the patient shall be observed for compliance with instructions. The effort shall be judged unacceptable when the patient:

(A) Has not maintained consistent effort for at least 12 to 15 seconds; or

(B) Has coughed or closed his glottis; or

(C) Has an obstructed mouthpiece or a leak around the mouthpiece (obstruction due to tongue being placed in front of mouthpiece, false teeth falling in front of mouthpiece, etc.); or

(D) Has an excessive variability between the three acceptable curves. The variation between the two largest MVVs of the three satisfactory tracings shall not exceed 10 percent.

(iv) A calibration check shall be performed on the instrument each day before use, using a volume source of at least three liters, accurate to within ±1 percent of full scale. The volume calibration shall be performed in accordance with the method described in paragraph (1)(vii) of this Appendix. Accuracy of the time measurement used in determining the FEV1 shall be checked using the manufacturer's stated procedure and shall be within ±3 percent of actual. The procedure described in the Appendix shall be performed as well as any other procedures suggested by the manufacturer of the spirometer being used.

(v)(A) The first step in evaluating a spirogram for the FVC and FEV1 shall be to determine whether or not the patient has performed the test properly or as described in (2)(ii) of this Appendix. The largest recorded FVC and FEV1, corrected to BTPS, shall be used in the analysis.

(B) Only MVV maneuvers which demonstrate consistent effort for at least 12 seconds shall be considered acceptable. The largest accumulated volume for a 12 second period corrected to BTPS and multiplied by five or the largest accumulated volume for a 15 second period corrected to BTPS and multiplied by four is to be reported as the MVV.

PREDICTION EQUATIONS FOR FEV1 MALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
59.1	1.85	1.88	1.90	1.75	1.74	1.72	1.70	1.69	1.67	1.66	1.64	1.62	1.61	1.59	1.58	1.56	1.54	1.53	1.51	1.49	1.48	1.46	1.45	1.43	1.41
59.4	1.88	1.90	1.93	1.78	1.77	1.75	1.74	1.72	1.70	1.69	1.67	1.65	1.64	1.62	1.61	1.59	1.57	1.56	1.54	1.53	1.51	1.49	1.48	1.46	1.44
59.8	1.90	1.93	1.96	1.82	1.80	1.78	1.77	1.75	1.73	1.72	1.70	1.69	1.67	1.65	1.64	1.62	1.61	1.59	1.57	1.56	1.54	1.52	1.51	1.49	1.48
60.2	1.93	1.96	1.99	1.85	1.83	1.81	1.80	1.78	1.77	1.75	1.73	1.72	1.70	1.68	1.67	1.65	1.64	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51
60.6	1.96	1.99	2.01	1.88	1.86	1.85	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.72	1.70	1.68	1.67	1.65	1.64	1.62	1.60	1.59	1.57	1.55	1.54
61.0	1.99	2.01	2.04	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67	1.65	1.63	1.62	1.60	1.59	1.57
61.4	2.01	2.04	2.07	1.94	1.92	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67	1.65	1.63	1.62	1.60
61.8	2.04	2.07	2.10	1.97	1.96	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.83	1.81	1.79	1.78	1.76	1.74	1.73	1.71	1.70	1.68	1.66	1.65	1.63
62.2	2.07	2.10	2.12	2.00	1.99	1.97	1.95	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.74	1.73	1.71	1.70	1.68	1.66
62.6	2.10	2.12	2.15	2.03	2.02	2.00	1.99	1.97	1.95	1.94	1.92	1.90	1.89	1.87	1.86	1.84	1.82	1.81	1.79	1.77	1.76	1.74	1.73	1.71	1.69
63.0	2.13	2.15	2.18	2.07	2.05	2.03	2.02	2.00	1.98	1.97	1.95	1.94	1.92	1.90	1.89	1.87	1.85	1.84	1.82	1.81	1.79	1.77	1.76	1.74	1.73
63.4	2.15	2.18	2.21	2.10	2.08	2.06	2.05	2.03	2.02	2.00	1.98	1.97	1.95	1.93	1.92	1.90	1.89	1.87	1.85	1.84	1.82	1.80	1.79	1.77	1.76
63.8	2.18	2.21	2.23	2.13	2.11	2.10	2.08	2.06	2.05	2.03	2.01	2.00	1.98	1.97	1.95	1.93	1.92	1.90	1.88	1.87	1.85	1.84	1.82	1.80	1.79
64.2	2.21	2.24	2.26	2.16	2.14	2.13	2.11	2.09	2.08	2.06	2.05	2.03	2.01	2.00	1.98	1.96	1.95	1.93	1.92	1.90	1.88	1.87	1.85	1.83	1.82
64.6	2.24	2.26	2.29	2.19	2.17	2.16	2.14	2.13	2.11	2.09	2.08	2.06	2.04	2.03	2.01	2.00	1.98	1.96	1.95	1.93	1.91	1.90	1.88	1.87	1.85
65.0	2.26	2.29	2.32	2.22	2.20	2.19	2.17	2.16	2.14	2.12	2.11	2.09	2.08	2.06	2.04	2.03	2.01	1.99	1.98	1.96	1.95	1.93	1.91	1.90	1.88
65.4	2.29	2.32	2.34	2.25	2.24	2.22	2.20	2.19	2.17	2.16	2.14	2.12	2.11	2.09	2.07	2.06	2.04	2.03	2.01	1.99	1.98	1.96	1.94	1.93	1.91
65.7	2.32	2.35	2.37	2.28	2.27	2.25	2.24	2.22	2.20	2.19	2.17	2.15	2.14	2.12	2.11	2.09	2.07	2.06	2.04	2.02	2.01	1.99	1.98	1.96	1.94
66.1	2.35	2.37	2.40	2.31	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.19	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.06	2.04	2.02	2.01	1.99	1.97
66.5	2.37	2.40	2.43	2.35	2.33	2.31	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.18	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.05	2.04	2.02	2.01
66.9	2.40	2.43	2.46	2.38	2.36	2.34	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.22	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.09	2.07	2.05	2.04
67.3	2.43	2.46	2.48	2.41	2.39	2.38	2.36	2.34	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.08	2.07
67.7	2.46	2.48	2.51	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.33	2.31	2.29	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.16	2.15	2.13	2.12	2.10
68.1	2.48	2.51	2.54	2.47	2.45	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.33	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.20	2.18	2.16	2.15	2.13
68.5	2.51	2.54	2.57	2.50	2.49	2.47	2.45	2.44	2.42	2.40	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.19	2.18	2.16
68.9	2.54	2.57	2.59	2.53	2.52	2.50	2.48	2.47	2.45	2.44	2.42	2.40	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.27	2.26	2.24	2.23	2.21	2.19
69.3	2.57	2.59	2.62	2.56	2.55	2.53	2.52	2.50	2.48	2.47	2.45	2.43	2.42	2.40	2.39	2.37	2.35	2.34	2.32	2.31	2.29	2.27	2.26	2.24	2.22
69.7	2.59	2.62	2.65	2.60	2.58	2.56	2.55	2.53	2.51	2.50	2.48	2.47	2.45	2.43	2.42	2.40	2.39	2.37	2.35	2.34	2.32	2.30	2.29	2.27	2.26
70.1	2.62	2.65	2.68	2.63	2.61	2.59	2.58	2.56	2.55	2.53	2.51	2.50	2.48	2.46	2.45	2.43	2.42	2.40	2.38	2.37	2.35	2.34	2.32	2.30	2.29
70.5	2.65	2.68	2.70	2.66	2.64	2.63	2.61	2.59	2.58	2.56	2.54	2.53	2.51	2.50	2.48	2.46	2.45	2.43	2.42	2.40	2.38	2.37	2.35	2.33	2.32
70.9	2.68	2.70	2.73	2.69	2.67	2.66	2.64	2.62	2.61	2.59	2.58	2.56	2.54	2.53	2.51	2.49	2.48	2.46	2.45	2.43	2.41	2.40	2.38	2.37	2.35
71.3	2.70	2.73	2.76	2.72	2.70	2.69	2.67	2.66	2.64	2.62	2.61	2.59	2.57	2.56	2.54	2.53	2.51	2.49	2.48	2.46	2.45	2.43	2.41	2.40	2.38
71.7	2.73	2.76	2.79	2.75	2.74	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.61	2.59	2.57	2.56	2.54	2.52	2.51	2.49	2.48	2.46	2.44	2.43	2.41
72.0	2.76	2.79	2.81	2.78	2.77	2.75	2.73	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.56	2.54	2.52	2.51	2.49	2.47	2.46	2.44
72.4	2.79	2.81	2.84	2.81	2.80	2.78	2.77	2.75	2.73	2.72	2.70	2.68	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.55	2.54	2.52	2.51	2.49	2.47
72.8	2.82	2.84	2.87	2.85	2.83	2.81	2.80	2.78	2.76	2.75	2.73	2.72	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.59	2.57	2.55	2.54	2.52	2.50
73.2	2.84	2.87	2.90	2.88	2.86	2.84	2.83	2.81	2.80	2.78	2.76	2.75	2.73	2.71	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.58	2.57	2.55	2.54
73.6	2.87	2.90	2.92	2.91	2.89	2.88	2.86	2.84	2.83	2.81	2.79	2.78	2.76	2.75	2.73	2.71	2.70	2.68	2.66	2.65	2.63	2.62	2.60	2.58	2.57
74.0	2.90	2.93	2.95	2.94	2.92	2.91	2.89	2.87	2.86	2.84	2.83	2.81	2.79	2.78	2.76	2.74	2.73	2.71	2.70	2.68	2.66	2.65	2.63	2.61	2.60
74.4	2.93	2.95	2.98	2.97	2.95	2.94	2.92	2.91	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.78	2.76	2.74	2.73	2.71	2.69	2.68	2.66	2.65	2.63
74.8	2.95	2.98	3.01	3.00	2.99	2.97	2.95	2.94	2.92	2.90	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.77	2.76	2.74	2.73	2.71	2.69	2.68	2.66
75.2	2.98	3.01	3.03	3.03	3.02	3.00	2.98	2.97	2.95	2.94	2.92	2.90	2.89	2.87	2.85	2.84	2.82	2.81	2.79	2.77	2.76	2.74	2.72	2.71	2.69
75.6	3.01	3.04	3.06	3.06	3.05	3.03	3.02	3.00	2.98	2.97	2.95	2.93	2.92	2.90	2.89	2.87	2.85	2.84	2.82	2.80	2.79	2.77	2.76	2.74	2.72
76.0	3.04	3.06	3.09	3.09	3.08	3.06	3.05	3.03	3.01	3.00	2.98	2.97	2.95	2.93	2.92	2.90	2.88	2.87	2.85	2.84	2.82	2.80	2.79	2.77	2.75
76.4	3.06	3.09	3.12	3.13	3.11	3.09	3.08	3.06	3.05	3.03	3.01	3.00	2.98	2.96	2.95	2.93	2.92	2.90	2.88	2.87	2.85	2.83	2.82	2.80	2.79
76.8	3.09	3.12	3.15	3.16	3.14	3.12	3.11	3.09	3.08	3.06	3.04	3.03	3.01	3.00	2.98	2.96	2.95	2.93	2.91	2.90	2.88	2.87	2.85	2.83	2.82
77.2	3.12	3.15	3.17	3.19	3.17	3.16	3.14	3.12	3.11	3.09	3.08	3.06	3.04	3.03	3.01	2.99	2.98	2.96	2.95	2.93	2.91	2.90	2.88	2.86	2.85
77.6	3.15	3.17	3.20	3.22	3.20	3.19	3.17	3.15	3.14	3.12	3.11	3.09	3.07	3.06	3.04	3.03	3.01	2.99	2.98	2.96	2.94	2.93	2.91	2.90	2.88
78.0	3.17	3.20	3.23	3.25	3.23	3.22	3.20	3.19	3.17	3.15	3.14	3.12	3.11	3.09	3.07	3.06	3.04	3.02	3.01	2.99	2.98	2.96	2.94	2.93	2.91
78.3	3.20	3.23	3.26	3.28	3.27	3.25	3.23	3.22	3.20	3.18	3.17	3.15	3.14	3.12	3.10	3.09	3.07	3.06	3.04	3.02	3.01	2.99	2.97	2.96	2.94
78.7	3.23	3.26	3.28	3.31	3.30	3.28	3.26	3.25	3.23	3.22	3.20	3.18	3.17	3.15	3.14	3.12	3.10	3.09	3.07	3.05	3.04	3.02	3.01	2.99	2.97
79.1	3.26	3.28	3.31	3.34	3.33	3.31	3.30	3.28	3.26	3.25	3.23	3.21	3.20	3.18	3.17	3.15	3.13	3.12	3.10	3.09	3.07	3.05	3.04	3.02	3.00
79.5	3.28	3.31	3.34	3.38	3.36	3.34	3.33	3.31	3.29	3.28	3.26	3.25	3.23	3.21	3.20	3.18	3.17	3.15	3.13	3.12	3.10	3.08	3.07	3.05	3.04
79.9	3.31	3.34	3.37	3.41	3.39	3.37	3.36	3.34	3.33	3.31	3.29	3.28	3.26	3.24	3.23	3.21	3.20	3.18	3.16	3.15	3.13	3.12	3.10	3.08	3.07
80.3	3.34	3.37	3.39	3.44	3.42	3.41	3.39	3.37	3.36	3.34	3.32	3.31	3.29	3.28	3.26	3.24	3.23	3.21	3.19	3.18	3.16	3.15	3.13	3.11	3.10
80.7	3.37	3.39	3.42	3.47	3.45	3.44	3.42	3.40	3.39	3.37	3.36	3.34	3.32	3.31	3.29	3.27	3.26	3.24	3.23	3.21	3.19	3.18	3.16	3.15	3.13
81.1	3.39	3.42	3.45	3.50	3.48	3.47	3.45	3.44	3.42	3.40	3.39	3.37	3.35	3.34	3.32	3.31	3.29	3.27	3.26	3.24	3.22	3.21	3.19	3.18	3.16
81.5	3.42	3.45	3.48	3.53	3.52	3.50	3.48	3.47	3.45	3.43	3.42	3.40	3.39	3.37	3.35	3.34	3.32	3.30	3.29	3.27	3.26	3.24	3.22	3.21	3.19
81.9	3.45	3.48	3.50	3.56	3.55	3.53	3.51	3.50	3.48	3.47	3.45	3.43	3.42	3.40	3.38	3.37	3.35	3.34	3.32	3.30	3.29	3.27	3.25	3.24	3.22
82.3	3.48	3.50	3.53	3.59	3.58	3.56	3.55	3.53	3.51	3.50	3.48	3.46	3.45	3.43	3.42	3.40	3.38	3.37	3.35	3.33	3.32	3.30	3.29	3.27	3.25
82.7	3.51	3.53	3.56	3.63	3.61	3.59	3.58	3.56	3.54	3.53	3.51	3.50	3.48	3.46	3.45	3.43	3.41	3.40	3.38	3.37	3.35	3.33	3.32	3.30	3.29

PREDICTION EQUATIONS FOR FEV1 MALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
59.1	1.40	1.38	1.36	1.35	1.33	1.32	1.30	1.28	1.27	1.25	1.23	1.22	1.20	1.19	1.17	1.15	1.14	1.12	1.11	1.09	1.07	1.06	1.04	1.02	1.01
59.4	1.43	1.41	1.40	1.38	1.36	1.35	1.33	1.31	1.30	1.28	1.27	1.25	1.23	1.22	1.20	1.18	1.17	1.15	1.14	1.12	1.10	1.09	1.07	1.06	1.04
59.8	1.46	1.44	1.43	1.41	1.39	1.38	1.36	1.35	1.33	1.31	1.30	1.28	1.26	1.25	1.23	1.22	1.20	1.18	1.17	1.15	1.14	1.12	1.10	1.09	1.07
60.2	1.49	1.47	1.46	1.44	1.43	1.41	1.39	1.38	1.36	1.34	1.33	1.31	1.30	1.28	1.26	1.25	1.23	1.22	1.20	1.18	1.17	1.15	1.13	1.12	1.10
60.6	1.52	1.51	1.49	1.47	1.46	1.44	1.42	1.41	1.39	1.38	1.36	1.34	1.33	1.31	1.29	1.28	1.26	1.25	1.23	1.21	1.20	1.18	1.17	1.15	1.13
61.0	1.55	1.54	1.52	1.50	1.49	1.47	1.46	1.44	1.42	1.41	1.39	1.37	1.36	1.34	1.33	1.31	1.29	1.28	1.26	1.25	1.23	1.21	1.20	1.18	1.16
61.4	1.58	1.57	1.55	1.54	1.52	1.50	1.49	1.47	1.45	1.44	1.42	1.41	1.39	1.37	1.36	1.34	1.32	1.31	1.29	1.28	1.26	1.24	1.23	1.21	1.20
61.8	1.62	1.60	1.58	1.57	1.55	1.53	1.52	1.50	1.49	1.47	1.45	1.44	1.42	1.40	1.39	1.37	1.36	1.34	1.32	1.31	1.29	1.28	1.26	1.24	1.23
62.2	1.65	1.63	1.61	1.60	1.58	1.57	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.44	1.42	1.40	1.39	1.37	1.35	1.34	1.32	1.31	1.29	1.27	1.26
62.6	1.68	1.66	1.65	1.63	1.61	1.60	1.58	1.56	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.43	1.42	1.40	1.39	1.37	1.35	1.34	1.32	1.31	1.29
63.0	1.71	1.69	1.68	1.66	1.64	1.63	1.61	1.60	1.58	1.56	1.55	1.53	1.51	1.50	1.48	1.47	1.45	1.43	1.42	1.40	1.38	1.37	1.35	1.34	1.32
63.4	1.74	1.72	1.71	1.69	1.68	1.66	1.64	1.63	1.61	1.59	1.58	1.56	1.55	1.53	1.51	1.50	1.48	1.46	1.45	1.43	1.42	1.40	1.38	1.37	1.35
63.8	1.77	1.75	1.74	1.72	1.71	1.69	1.67	1.66	1.64	1.63	1.61	1.59	1.58	1.56	1.54	1.53	1.51	1.50	1.48	1.46	1.45	1.43	1.41	1.40	1.38
64.2	1.80	1.79	1.77	1.75	1.74	1.72	1.71	1.69	1.67	1.66	1.64	1.62	1.61	1.59	1.58	1.56	1.54	1.53	1.51	1.49	1.48	1.46	1.45	1.43	1.41
64.6	1.83	1.82	1.80	1.78	1.77	1.75	1.74	1.72	1.70	1.69	1.67	1.66	1.64	1.62	1.61	1.59	1.57	1.56	1.54	1.53	1.51	1.49	1.48	1.46	1.44
65.0	1.86	1.85	1.83	1.82	1.80	1.78	1.77	1.75	1.74	1.72	1.70	1.69	1.67	1.65	1.64	1.62	1.61	1.59	1.57	1.56	1.54	1.52	1.51	1.49	1.48
65.4	1.90	1.88	1.86	1.85	1.83	1.81	1.80	1.78	1.77	1.75	1.73	1.72	1.70	1.69	1.67	1.65	1.64	1.62	1.60	1.59	1.57	1.56	1.54	1.52	1.51
65.7	1.93	1.91	1.89	1.88	1.86	1.85	1.83	1.81	1.80	1.78	1.77	1.75	1.73	1.72	1.70	1.68	1.67	1.65	1.64	1.62	1.60	1.59	1.57	1.55	1.54
66.1	1.96	1.94	1.93	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.72	1.70	1.68	1.67	1.65	1.63	1.62	1.60	1.59	1.57
66.5	1.99	1.97	1.96	1.94	1.92	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.80	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.67	1.65	1.63	1.62	1.60
66.9	2.02	2.00	1.99	1.97	1.96	1.94	1.92	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.79	1.78	1.76	1.75	1.73	1.71	1.70	1.68	1.66	1.65	1.63
67.3	2.05	2.04	2.02	2.00	1.99	1.97	1.95	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.83	1.81	1.79	1.78	1.76	1.74	1.73	1.71	1.70	1.68	1.66
67.7	2.08	2.07	2.05	2.03	2.02	2.00	1.99	1.97	1.95	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.82	1.81	1.79	1.78	1.76	1.74	1.73	1.71	1.69
68.1	2.11	2.10	2.08	2.07	2.05	2.03	2.02	2.00	1.98	1.97	1.95	1.94	1.92	1.90	1.89	1.87	1.86	1.84	1.82	1.81	1.79	1.77	1.76	1.74	1.73
68.5	2.15	2.13	2.11	2.10	2.08	2.06	2.05	2.03	2.02	2.00	1.98	1.97	1.95	1.94	1.92	1.90	1.89	1.87	1.85	1.84	1.82	1.81	1.79	1.77	1.76
68.9	2.18	2.16	2.14	2.13	2.11	2.10	2.08	2.06	2.05	2.03	2.01	2.00	1.98	1.97	1.95	1.93	1.92	1.90	1.89	1.87	1.85	1.84	1.82	1.80	1.79
69.3	2.21	2.19	2.18	2.16	2.14	2.13	2.11	2.09	2.08	2.06	2.05	2.03	2.01	2.00	1.98	1.97	1.95	1.93	1.92	1.90	1.88	1.87	1.85	1.84	1.82
69.7	2.24	2.22	2.21	2.19	2.17	2.16	2.14	2.13	2.11	2.09	2.08	2.06	2.04	2.03	2.01	2.00	1.98	1.96	1.95	1.93	1.92	1.90	1.88	1.87	1.85
70.1	2.27	2.25	2.24	2.22	2.21	2.19	2.17	2.16	2.14	2.12	2.11	2.09	2.08	2.06	2.04	2.03	2.01	2.00	1.98	1.96	1.95	1.93	1.91	1.90	1.88
70.5	2.30	2.29	2.27	2.25	2.24	2.22	2.20	2.19	2.17	2.16	2.14	2.12	2.11	2.09	2.07	2.06	2.04	2.03	2.01	1.99	1.98	1.96	1.95	1.93	1.91
70.9	2.33	2.32	2.30	2.28	2.27	2.25	2.24	2.22	2.20	2.19	2.17	2.15	2.14	2.12	2.11	2.09	2.07	2.06	2.04	2.03	2.01	1.99	1.98	1.96	1.94
71.3	2.36	2.35	2.33	2.32	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.19	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.06	2.04	2.02	2.01	1.99	1.98
71.7	2.40	2.38	2.36	2.35	2.33	2.31	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.18	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.05	2.04	2.02	2.01
72.0	2.43	2.41	2.39	2.38	2.36	2.35	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.22	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.09	2.07	2.05	2.04
72.4	2.46	2.44	2.43	2.41	2.39	2.38	2.36	2.34	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.17	2.15	2.13	2.12	2.10	2.08	2.07
72.8	2.49	2.47	2.46	2.44	2.42	2.41	2.39	2.38	2.36	2.34	2.33	2.31	2.29	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.16	2.15	2.13	2.12	2.10
73.2	2.52	2.50	2.49	2.47	2.46	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.33	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.20	2.18	2.16	2.15	2.13
73.6	2.55	2.54	2.52	2.50	2.49	2.47	2.45	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.19	2.18	2.16
74.0	2.58	2.57	2.55	2.53	2.52	2.50	2.49	2.47	2.45	2.44	2.42	2.40	2.39	2.37	2.36	2.34	2.32	2.31	2.29	2.27	2.26	2.24	2.23	2.21	2.19
74.4	2.61	2.60	2.58	2.57	2.55	2.53	2.52	2.50	2.48	2.47	2.45	2.44	2.42	2.40	2.39	2.37	2.35	2.34	2.32	2.31	2.29	2.27	2.26	2.24	2.22
74.8	2.64	2.63	2.61	2.60	2.58	2.56	2.55	2.53	2.52	2.50	2.48	2.47	2.45	2.43	2.42	2.40	2.39	2.37	2.35	2.34	2.32	2.30	2.29	2.27	2.26
75.2	2.68	2.66	2.64	2.63	2.61	2.60	2.58	2.56	2.55	2.53	2.51	2.50	2.48	2.47	2.45	2.43	2.42	2.40	2.38	2.37	2.35	2.34	2.32	2.30	2.29
75.6	2.71	2.69	2.67	2.66	2.64	2.63	2.61	2.59	2.58	2.56	2.55	2.53	2.51	2.50	2.48	2.46	2.45	2.43	2.42	2.40	2.38	2.37	2.35	2.33	2.32
76.0	2.74	2.72	2.71	2.69	2.67	2.66	2.64	2.63	2.61	2.59	2.58	2.56	2.54	2.53	2.51	2.50	2.48	2.46	2.45	2.43	2.41	2.40	2.38	2.37	2.35
76.4	2.77	2.75	2.74	2.72	2.70	2.69	2.67	2.66	2.64	2.62	2.61	2.59	2.58	2.56	2.54	2.53	2.51	2.49	2.48	2.46	2.45	2.43	2.41	2.40	2.38
76.8	2.80	2.78	2.77	2.75	2.74	2.72	2.70	2.69	2.67	2.66	2.64	2.62	2.61	2.59	2.57	2.56	2.54	2.53	2.51	2.49	2.48	2.46	2.44	2.43	2.41
77.2	2.83	2.82	2.80	2.78	2.77	2.75	2.73	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.61	2.59	2.57	2.56	2.54	2.52	2.51	2.49	2.48	2.46	2.44
77.6	2.86	2.85	2.83	2.81	2.80	2.78	2.77	2.75	2.73	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.56	2.54	2.52	2.51	2.49	2.47
78.0	2.89	2.88	2.86	2.85	2.83	2.81	2.80	2.78	2.76	2.75	2.73	2.72	2.70	2.68	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.55	2.54	2.52	2.51
78.3	2.93	2.91	2.89	2.88	2.86	2.84	2.83	2.81	2.80	2.78	2.76	2.75	2.73	2.72	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.59	2.57	2.55	2.54
78.7	2.96	2.94	2.92	2.91	2.89	2.88	2.86	2.84	2.83	2.81	2.79	2.78	2.76	2.75	2.73	2.71	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.58	2.57
79.1	2.99	2.97	2.96	2.94	2.92	2.91	2.89	2.87	2.86	2.84	2.83	2.81	2.79	2.78	2.76	2.75	2.73	2.71	2.70	2.68	2.66	2.65	2.63	2.62	2.60
79.5	3.02	3.00	2.99	2.97	2.95	2.94	2.92	2.91	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.78	2.76	2.74	2.73	2.71	2.70	2.68	2.66	2.65	2.63
79.9	3.05	3.03	3.02	3.00	2.99	2.97	2.95	2.94	2.92	2.90	2.89	2.87	2.86	2.84	2.82	2.81	2.79	2.77	2.76	2.74	2.73	2.71	2.69	2.68	2.66
80.3	3.08	3.07	3.05	3.03	3.02	3.00	2.98	2.97	2.95	2.94	2.92	2.90	2.89	2.87	2.85	2.84	2.82	2.81	2.79	2.77	2.76	2.74	2.73	2.71	2.69
80.7	3.11	3.10	3.08	3.06	3.05	3.03	3.02	3.00	2.98	2.97	2.95	2.93	2.92	2.90	2.89	2.87	2.85	2.84	2.82	2.80	2.79	2.77	2.76	2.74	2.72
81.1	3.14	3.13	3.11	3.10	3.08	3.06	3.05	3.03	3.01	3.00	2.98	2.97	2.95	2.93	2.92	2.90	2.88	2.87	2.85	2.84	2.82	2.80	2.79	2.77	2.76
81.5	3.18	3.16	3.14	3.13	3.11	3.09	3.08	3.06	3.05	3.03	3.01	3.00	2.98	2.96	2.95	2.93	2.92	2.90	2.88	2.87	2.85	2.84	2.82	2.80	2.79
81.9	3.21	3.19	3.17	3.16	3.14	3.13	3.11	3.09	3.08	3.06	3.04	3.03	3.01	3.00	2.98	2.96	2.95	2.93	2.91	2.90	2.88	2.87	2.85	2.83	2.82
82.3	3.24	3.22	3.21	3.19	3.17	3.16	3.14	3.12	3.11	3.09	3.08	3.06	3.04	3.03	3.01	2.99	2.98	2.96	2.95	2.93	2.91	2.90	2.88	2.86	2.85
82.7	3.27	3.25	3.24	3.22	3.20	3.19	3.17	3.16	3.14	3.12	3.11	3.09	3.07	3.06	3.04	3.03	3.01	2.99	2.98	2.96	2.94	2.93	2.91	2.90	2.88

PREDICTION EQUATIONS FOR FEV1 FEMALES * 80% OF PREDICTED **

HEIGHT	AGE (YEARS)																										
(IN)	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
51.2	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.18	1.16	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05
51.6	1.37	1.36	1.34	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.12	1.10	1.09	1.08	1.07
52.0	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.25	1.23	1.22	1.21	1.20	1.18	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08
52.4	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.14	1.12	1.11	1.10
52.8	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.32	1.30	1.29	1.28	1.27	1.25	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.11
53.1	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18	1.17	1.16	1.14	1.13
53.5	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15
53.9	1.47	1.45	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.18	1.16
54.3	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.39	1.38	1.37	1.36	1.34	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18
54.7	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.25	1.23	1.22	1.21	1.20
55.1	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.22	1.21
55.5	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.32	1.30	1.29	1.28	1.27	1.25	1.24	1.23
55.9	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24
56.3	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26
56.7	1.58	1.57	1.55	1.54	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.28
57.1	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.39	1.38	1.37	1.36	1.34	1.33	1.32	1.31	1.29
57.5	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.52	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31
57.9	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.33
58.3	1.64	1.63	1.62	1.61	1.59	1.58	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34
58.7	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.43	1.42	1.41	1.40	1.38	1.37	1.36
59.1	1.68	1.66	1.65	1.64	1.63	1.61	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.37
59.4	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.57	1.55	1.54	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.40	1.39
59.8	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.41
60.2	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.52	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42
60.6	1.74	1.73	1.72	1.70	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.48	1.46	1.45	1.44
61.0	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.59	1.58	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48	1.47	1.46
61.4	1.77	1.76	1.75	1.74	1.72	1.71	1.70	1.69	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47
61.8	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.61	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49
62.2	1.81	1.79	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.57	1.55	1.54	1.53	1.52	1.50
62.6	1.82	1.81	1.80	1.78	1.77	1.76	1.75	1.73	1.72	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52
63.0	1.84	1.83	1.81	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.54
63.4	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55
63.8	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.59	1.58	1.57
64.2	1.89	1.87	1.86	1.85	1.84	1.82	1.81	1.80	1.79	1.77	1.76	1.75	1.74	1.72	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.58
64.6	1.90	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.61	1.60
65.0	1.92	1.91	1.89	1.88	1.87	1.86	1.84	1.83	1.82	1.81	1.79	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.63	1.62
65.4	1.94	1.92	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.75	1.73	1.72	1.71	1.70	1.68	1.67	1.66	1.65	1.63
65.7	1.95	1.94	1.93	1.91	1.90	1.89	1.88	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65
66.1	1.97	1.96	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68	1.67
66.5	1.98	1.97	1.96	1.95	1.93	1.92	1.91	1.90	1.88	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68
66.9	2.00	1.99	1.98	1.96	1.95	1.94	1.92	1.91	1.90	1.89	1.87	1.86	1.85	1.84	1.82	1.81	1.80	1.79	1.77	1.76	1.75	1.74	1.72	1.71	1.70
67.3	2.02	2.00	1.99	1.98	1.97	1.95	1.94	1.93	1.92	1.90	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71
67.7	2.03	2.02	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.86	1.84	1.83	1.82	1.81	1.79	1.78	1.77	1.76	1.74	1.73
68.1	2.05	2.04	2.02	2.01	2.00	1.99	1.97	1.96	1.95	1.94	1.92	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.75
68.5	2.07	2.05	2.04	2.03	2.01	2.00	1.99	1.98	1.96	1.95	1.94	1.93	1.91	1.90	1.89	1.88	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.78	1.76
68.9	2.08	2.07	2.06	2.04	2.03	2.02	2.01	1.99	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78
69.3	2.10	2.09	2.07	2.06	2.05	2.03	2.02	2.01	2.00	1.98	1.97	1.96	1.95	1.93	1.92	1.91	1.90	1.88	1.87	1.86	1.85	1.83	1.82	1.81	1.80
69.7	2.11	2.10	2.09	2.08	2.06	2.05	2.04	2.03	2.01	2.00	1.99	1.98	1.96	1.95	1.94	1.92	1.91	1.90	1.89	1.87	1.86	1.85	1.84	1.82	1.81
70.1	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04	2.03	2.02	2.00	1.99	1.98	1.97	1.95	1.94	1.93	1.92	1.90	1.89	1.88	1.87	1.85	1.84	1.83
70.5	2.15	2.13	2.12	2.11	2.10	2.08	2.07	2.06	2.05	2.03	2.02	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.86	1.84
70.9	2.16	2.15	2.14	2.12	2.11	2.10	2.09	2.07	2.06	2.05	2.04	2.02	2.01	2.00	1.99	1.97	1.96	1.95	1.94	1.92	1.91	1.90	1.89	1.87	1.86
71.3	2.18	2.17	2.15	2.14	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04	2.03	2.01	2.00	1.99	1.98	1.96	1.95	1.94	1.93	1.91	1.90	1.89	1.88
71.7	2.19	2.18	2.17	2.16	2.14	2.13	2.12	2.11	2.09	2.08	2.07	2.06	2.04	2.03	2.02	2.01	1.99	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.89
72.0	2.21	2.20	2.19	2.17	2.16	2.15	2.14	2.12	2.11	2.10	2.09	2.07	2.06	2.05	2.03	2.02	2.01	2.00	1.98	1.97	1.96	1.95	1.93	1.92	1.91
72.4	2.23	2.21	2.20	2.19	2.18	2.16	2.15	2.14	2.13	2.11	2.10	2.09	2.08	2.06	2.05	2.04	2.03	2.01	2.00	1.99	1.98	1.96	1.95	1.94	1.92
72.8	2.24	2.23	2.22	2.21	2.19	2.18	2.17	2.16	2.14	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04	2.03	2.02	2.00	1.99	1.98	1.97	1.95	1.94
73.2	2.26	2.25	2.23	2.22	2.21	2.20	2.18	2.17	2.16	2.15	2.13	2.12	2.11	2.10	2.08	2.07	2.06	2.05	2.03	2.02	2.01	2.00	1.98	1.97	1.96
73.6	2.28	2.26	2.25	2.24	2.23	2.21	2.20	2.19	2.18	2.16	2.15	2.14	2.12	2.11	2.10	2.09	2.07	2.06	2.05	2.04	2.02	2.01	2.00	1.99	1.97
74.0	2.29	2.28	2.27	2.25	2.24	2.23	2.22	2.20	2.19	2.18	2.17	2.15	2.14	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04	2.03	2.01	2.00	1.99
74.4	2.31	2.30	2.28	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.16	2.14	2.13	2.12	2.11	2.09	2.08	2.07	2.06	2.04	2.03	2.02	2.01
74.8	2.32	2.31	2.30	2.29	2.27	2.26	2.25	2.24	2.22	2.21	2.20	2.19	2.17	2.16	2.15	2.14	2.12	2.11	2.10	2.09	2.07	2.06	2.05	2.03	2.02

PREDICTION EQUATIONS FOR FEV1 FEMALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
51.2	1.04	1.02	1.01	1.00	0.99	0.97	0.96	0.95	0.94	0.92	0.91	0.90	0.89	0.87	0.86	0.85	0.84	0.82	0.81	0.80	0.79	0.77	0.76	0.75	0.73
51.6	1.05	1.04	1.03	1.02	1.00	0.99	0.98	0.97	0.95	0.94	0.93	0.92	0.90	0.89	0.88	0.86	0.85	0.84	0.83	0.81	0.80	0.79	0.78	0.76	0.75
52.0	1.07	1.06	1.04	1.03	1.02	1.01	0.99	0.98	0.97	0.96	0.94	0.93	0.92	0.91	0.89	0.88	0.87	0.86	0.84	0.83	0.82	0.81	0.79	0.78	0.77
52.4	1.09	1.07	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.97	0.96	0.95	0.93	0.92	0.91	0.90	0.88	0.87	0.86	0.85	0.83	0.82	0.81	0.80	0.78
52.8	1.10	1.09	1.08	1.06	1.05	1.04	1.03	1.01	1.00	0.99	0.98	0.96	0.95	0.94	0.93	0.91	0.90	0.89	0.88	0.86	0.85	0.84	0.83	0.81	0.80
53.1	1.12	1.11	1.09	1.08	1.07	1.06	1.04	1.03	1.02	1.00	0.99	0.98	0.97	0.95	0.94	0.93	0.92	0.90	0.89	0.88	0.87	0.85	0.84	0.83	0.82
53.5	1.13	1.12	1.11	1.10	1.08	1.07	1.06	1.05	1.03	1.02	1.01	1.00	0.98	0.97	0.96	0.95	0.93	0.92	0.91	0.90	0.88	0.87	0.86	0.84	0.83
53.9	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.97	0.96	0.95	0.94	0.92	0.91	0.90	0.89	0.87	0.86	0.85
54.3	1.17	1.15	1.14	1.13	1.12	1.10	1.09	1.08	1.07	1.05	1.04	1.03	1.02	1.00	0.99	0.98	0.97	0.95	0.94	0.93	0.92	0.90	0.89	0.88	0.86
54.7	1.18	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08	1.07	1.06	1.04	1.03	1.02	1.01	0.99	0.98	0.97	0.96	0.94	0.93	0.92	0.91	0.89	0.88
55.1	1.20	1.19	1.17	1.16	1.15	1.14	1.12	1.11	1.10	1.09	1.07	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.97	0.96	0.95	0.93	0.92	0.91	0.90
55.5	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05	1.04	1.03	1.01	1.00	0.99	0.98	0.96	0.95	0.94	0.93	0.91
55.9	1.23	1.22	1.21	1.19	1.18	1.17	1.16	1.14	1.13	1.12	1.11	1.09	1.08	1.07	1.06	1.04	1.03	1.02	1.00	0.99	0.98	0.97	0.95	0.94	0.93
56.3	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08	1.07	1.06	1.05	1.03	1.02	1.01	1.00	0.98	0.97	0.96	0.95
56.7	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.18	1.16	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05	1.04	1.02	1.01	1.00	0.99	0.97	0.96
57.1	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.12	1.10	1.09	1.08	1.07	1.05	1.04	1.03	1.02	1.00	0.99	0.98
57.5	1.30	1.28	1.27	1.26	1.25	1.23	1.22	1.21	1.20	1.18	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08	1.07	1.06	1.04	1.03	1.02	1.01	0.99
57.9	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.14	1.12	1.11	1.10	1.09	1.07	1.06	1.05	1.04	1.02	1.01
58.3	1.33	1.32	1.30	1.29	1.28	1.27	1.25	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06	1.05	1.04	1.03
58.7	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18	1.17	1.16	1.14	1.13	1.12	1.11	1.09	1.08	1.07	1.06	1.04
59.1	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.10	1.08	1.07	1.06
59.4	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.18	1.16	1.15	1.14	1.13	1.11	1.10	1.09	1.08
59.8	1.39	1.38	1.37	1.36	1.34	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14	1.13	1.12	1.10	1.09
60.2	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.25	1.23	1.22	1.21	1.20	1.18	1.17	1.16	1.15	1.13	1.12	1.11
60.6	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.14	1.12
61.0	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.32	1.30	1.29	1.28	1.27	1.25	1.24	1.23	1.22	1.20	1.19	1.18	1.17	1.15	1.14
61.4	1.46	1.45	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.21	1.19	1.18	1.17	1.16
61.8	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17
62.2	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19
62.6	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.39	1.38	1.37	1.36	1.34	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.20
63.0	1.52	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.30	1.28	1.27	1.26	1.25	1.23	1.22
63.4	1.54	1.53	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26	1.25	1.24
63.8	1.56	1.54	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.32	1.30	1.29	1.28	1.27	1.25
64.2	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27
64.6	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.30	1.29
65.0	1.60	1.59	1.58	1.57	1.55	1.54	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30
65.4	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.39	1.38	1.37	1.36	1.34	1.33	1.32
65.7	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.52	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33
66.1	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35
66.5	1.67	1.66	1.64	1.63	1.62	1.61	1.59	1.58	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.37
66.9	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.45	1.43	1.42	1.41	1.40	1.38
67.3	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.61	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40
67.7	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.57	1.55	1.54	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.42
68.1	1.73	1.72	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43
68.5	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.52	1.51	1.50	1.49	1.47	1.46	1.45
68.9	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51	1.50	1.49	1.48	1.46
69.3	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.59	1.58	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48
69.7	1.80	1.79	1.77	1.76	1.75	1.74	1.72	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.50
70.1	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.68	1.66	1.65	1.64	1.63	1.61	1.60	1.59	1.58	1.56	1.55	1.54	1.53	1.51
70.5	1.83	1.82	1.81	1.79	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.57	1.55	1.54	1.53
70.9	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.75	1.73	1.72	1.71	1.70	1.68	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.55
71.3	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56
71.7	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58
72.0	1.90	1.88	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.59
72.4	1.91	1.90	1.89	1.87	1.86	1.85	1.84	1.82	1.81	1.80	1.79	1.77	1.76	1.75	1.74	1.72	1.71	1.70	1.69	1.67	1.66	1.65	1.63	1.62	1.61
72.8	1.93	1.92	1.90	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.68	1.66	1.65	1.64	1.63
73.2	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.86	1.84	1.83	1.82	1.81	1.79	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64
73.6	1.96	1.95	1.94	1.92	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.75	1.73	1.72	1.71	1.70	1.68	1.67	1.66
74.0	1.98	1.96	1.95	1.94	1.93	1.91	1.90	1.89	1.88	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.78	1.76	1.75	1.74	1.73	1.71	1.70	1.69	1.67
74.4	1.99	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.77	1.75	1.74	1.73	1.72	1.70	1.69
74.8	2.01	2.00	1.98	1.97	1.96	1.95	1.93	1.92	1.91	1.90	1.88	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.71

PREDICTION EQUATIONS FOR FVC MALES * 60% OF PREDICTED **

HEIGHT	AGE (YEARS)																										
(IN)	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
59.1	2.22	2.27	2.32	2.14	2.12	2.10	2.09	2.07	2.05	2.04	2.02	2.00	1.98	1.97	1.95	1.93	1.91	1.90	1.88	1.86	1.84	1.83	1.81	1.79	1.77
59.4	2.25	2.30	2.35	2.18	2.16	2.14	2.13	2.11	2.09	2.07	2.06	2.04	2.02	2.00	1.99	1.97	1.95	1.93	1.92	1.90	1.88	1.87	1.85	1.83	1.81
59.8	2.28	2.33	2.38	2.22	2.20	2.18	2.17	2.15	2.13	2.11	2.10	2.08	2.06	2.04	2.03	2.01	1.99	1.97	1.96	1.94	1.92	1.90	1.89	1.87	1.85
60.2	2.31	2.36	2.41	2.26	2.24	2.22	2.20	2.19	2.17	2.15	2.13	2.12	2.10	2.08	2.07	2.05	2.03	2.01	2.00	1.98	1.96	1.94	1.93	1.91	1.89
60.6	2.34	2.39	2.44	2.30	2.28	2.26	2.24	2.23	2.21	2.19	2.17	2.16	2.14	2.12	2.10	2.09	2.07	2.05	2.03	2.02	2.00	1.98	1.96	1.95	1.93
61.0	2.37	2.42	2.47	2.33	2.32	2.30	2.28	2.26	2.25	2.23	2.21	2.20	2.18	2.16	2.14	2.13	2.11	2.09	2.07	2.06	2.04	2.02	2.00	1.99	1.97
61.4	2.40	2.45	2.50	2.37	2.36	2.34	2.32	2.30	2.29	2.27	2.25	2.23	2.22	2.20	2.18	2.16	2.15	2.13	2.11	2.10	2.08	2.06	2.04	2.03	2.01
61.8	2.43	2.48	2.53	2.41	2.40	2.38	2.36	2.34	2.33	2.31	2.29	2.27	2.26	2.24	2.22	2.20	2.19	2.17	2.15	2.13	2.12	2.10	2.08	2.06	2.05
62.2	2.46	2.51	2.56	2.45	2.43	2.42	2.40	2.38	2.36	2.35	2.33	2.31	2.29	2.28	2.26	2.24	2.23	2.21	2.19	2.17	2.16	2.14	2.12	2.10	2.09
62.6	2.49	2.54	2.59	2.49	2.47	2.46	2.44	2.42	2.40	2.39	2.37	2.35	2.33	2.32	2.30	2.28	2.26	2.25	2.23	2.21	2.19	2.18	2.16	2.14	2.13
63.0	2.52	2.57	2.62	2.53	2.51	2.49	2.48	2.46	2.44	2.43	2.41	2.39	2.37	2.36	2.34	2.32	2.30	2.29	2.27	2.25	2.23	2.22	2.20	2.18	2.16
63.4	2.55	2.60	2.65	2.57	2.55	2.53	2.52	2.50	2.48	2.46	2.45	2.43	2.41	2.39	2.38	2.36	2.34	2.32	2.31	2.29	2.27	2.26	2.24	2.22	2.20
63.8	2.58	2.63	2.68	2.61	2.59	2.57	2.56	2.54	2.52	2.50	2.49	2.47	2.45	2.43	2.42	2.40	2.38	2.36	2.35	2.33	2.31	2.29	2.28	2.26	2.24
64.2	2.61	2.66	2.71	2.65	2.63	2.61	2.59	2.58	2.56	2.54	2.52	2.51	2.49	2.47	2.46	2.44	2.42	2.40	2.39	2.37	2.35	2.33	2.32	2.30	2.28
64.6	2.64	2.69	2.74	2.69	2.67	2.65	2.63	2.62	2.60	2.58	2.56	2.55	2.53	2.51	2.49	2.48	2.46	2.44	2.42	2.41	2.39	2.37	2.36	2.34	2.32
65.0	2.67	2.72	2.77	2.72	2.71	2.69	2.67	2.65	2.64	2.62	2.60	2.59	2.57	2.55	2.53	2.52	2.50	2.48	2.46	2.45	2.43	2.41	2.39	2.38	2.36
65.4	2.70	2.75	2.80	2.76	2.75	2.73	2.71	2.69	2.68	2.66	2.64	2.62	2.61	2.59	2.57	2.55	2.54	2.52	2.50	2.49	2.47	2.45	2.43	2.42	2.40
65.7	2.73	2.78	2.83	2.80	2.79	2.77	2.75	2.73	2.72	2.70	2.68	2.66	2.65	2.63	2.61	2.59	2.58	2.56	2.54	2.52	2.51	2.49	2.47	2.45	2.44
66.1	2.76	2.81	2.86	2.84	2.82	2.81	2.79	2.77	2.75	2.74	2.72	2.70	2.68	2.67	2.65	2.63	2.62	2.60	2.58	2.56	2.55	2.53	2.51	2.49	2.48
66.5	2.79	2.84	2.89	2.88	2.86	2.85	2.83	2.81	2.79	2.78	2.76	2.74	2.72	2.71	2.69	2.67	2.65	2.64	2.62	2.60	2.58	2.57	2.55	2.53	2.52
66.9	2.82	2.87	2.92	2.92	2.90	2.88	2.87	2.85	2.83	2.82	2.80	2.78	2.76	2.75	2.73	2.71	2.69	2.68	2.66	2.64	2.62	2.61	2.59	2.57	2.55
67.3	2.85	2.90	2.95	2.96	2.94	2.92	2.91	2.89	2.87	2.85	2.84	2.82	2.80	2.78	2.77	2.75	2.73	2.71	2.70	2.68	2.66	2.65	2.63	2.61	2.59
67.7	2.88	2.93	2.98	3.00	2.98	2.96	2.95	2.93	2.91	2.89	2.88	2.86	2.84	2.82	2.81	2.79	2.77	2.75	2.74	2.72	2.70	2.68	2.67	2.65	2.63
68.1	2.91	2.96	3.01	3.04	3.02	3.00	2.98	2.97	2.95	2.93	2.91	2.90	2.88	2.86	2.85	2.83	2.81	2.79	2.78	2.76	2.74	2.72	2.71	2.69	2.67
68.5	2.94	2.99	3.04	3.08	3.06	3.04	3.02	3.01	2.99	2.97	2.95	2.94	2.92	2.90	2.88	2.87	2.85	2.83	2.81	2.80	2.78	2.76	2.74	2.73	2.71
68.9	2.97	3.02	3.07	3.11	3.10	3.08	3.06	3.05	3.03	3.01	2.99	2.98	2.96	2.94	2.92	2.91	2.89	2.87	2.85	2.84	2.82	2.80	2.78	2.77	2.75
69.3	3.00	3.05	3.10	3.15	3.14	3.12	3.10	3.08	3.07	3.05	3.03	3.01	3.00	2.98	2.96	2.94	2.93	2.91	2.89	2.88	2.86	2.84	2.82	2.81	2.79
69.7	3.03	3.08	3.13	3.19	3.18	3.16	3.14	3.12	3.11	3.09	3.07	3.05	3.04	3.02	3.00	2.98	2.97	2.95	2.93	2.91	2.90	2.88	2.86	2.84	2.83
70.1	3.06	3.11	3.16	3.23	3.21	3.20	3.18	3.16	3.14	3.13	3.11	3.09	3.07	3.06	3.04	3.02	3.01	2.99	2.97	2.95	2.94	2.92	2.90	2.88	2.87
70.5	3.09	3.14	3.19	3.27	3.25	3.24	3.22	3.20	3.18	3.17	3.15	3.13	3.11	3.10	3.08	3.06	3.04	3.03	3.01	2.99	2.97	2.96	2.94	2.92	2.91
70.9	3.12	3.17	3.22	3.31	3.29	3.27	3.26	3.24	3.22	3.21	3.19	3.17	3.15	3.14	3.12	3.10	3.08	3.07	3.05	3.03	3.01	3.00	2.98	2.96	2.94
71.3	3.15	3.20	3.25	3.35	3.33	3.31	3.30	3.28	3.26	3.24	3.23	3.21	3.19	3.17	3.16	3.14	3.12	3.10	3.09	3.07	3.05	3.04	3.02	3.00	2.98
71.7	3.18	3.23	3.28	3.39	3.37	3.35	3.34	3.32	3.30	3.28	3.27	3.25	3.23	3.21	3.20	3.18	3.16	3.14	3.13	3.11	3.09	3.07	3.06	3.04	3.02
72.0	3.21	3.26	3.31	3.43	3.41	3.39	3.37	3.36	3.34	3.32	3.30	3.29	3.27	3.25	3.24	3.22	3.20	3.18	3.17	3.15	3.13	3.11	3.10	3.08	3.06
72.4	3.24	3.29	3.34	3.47	3.45	3.43	3.41	3.40	3.38	3.36	3.34	3.33	3.31	3.29	3.27	3.26	3.24	3.22	3.20	3.19	3.17	3.15	3.13	3.12	3.10
72.8	3.27	3.32	3.37	3.50	3.49	3.47	3.45	3.43	3.42	3.40	3.38	3.37	3.35	3.33	3.31	3.30	3.28	3.26	3.24	3.23	3.21	3.19	3.17	3.16	3.14
73.2	3.30	3.35	3.40	3.54	3.53	3.51	3.49	3.47	3.46	3.44	3.42	3.40	3.39	3.37	3.35	3.33	3.32	3.30	3.28	3.27	3.25	3.23	3.21	3.20	3.18
73.6	3.33	3.38	3.43	3.58	3.57	3.55	3.53	3.51	3.50	3.48	3.46	3.44	3.43	3.41	3.39	3.37	3.36	3.34	3.32	3.30	3.29	3.27	3.25	3.23	3.22
74.0	3.36	3.41	3.46	3.62	3.60	3.59	3.57	3.55	3.53	3.52	3.50	3.48	3.46	3.45	3.43	3.41	3.40	3.38	3.36	3.34	3.33	3.31	3.29	3.27	3.26
74.4	3.39	3.44	3.49	3.66	3.64	3.63	3.61	3.59	3.57	3.56	3.54	3.52	3.50	3.49	3.47	3.45	3.43	3.42	3.40	3.38	3.36	3.35	3.33	3.31	3.30
74.8	3.42	3.47	3.52	3.70	3.68	3.66	3.65	3.63	3.61	3.60	3.58	3.56	3.54	3.53	3.51	3.49	3.47	3.46	3.44	3.42	3.40	3.39	3.37	3.35	3.33
75.2	3.45	3.50	3.55	3.74	3.72	3.70	3.69	3.67	3.65	3.63	3.62	3.60	3.58	3.56	3.55	3.53	3.51	3.50	3.48	3.46	3.44	3.43	3.41	3.39	3.37
75.6	3.48	3.53	3.58	3.78	3.76	3.74	3.73	3.71	3.69	3.67	3.66	3.64	3.62	3.60	3.59	3.57	3.55	3.53	3.52	3.50	3.48	3.46	3.45	3.43	3.41
76.0	3.51	3.56	3.61	3.82	3.80	3.78	3.76	3.75	3.73	3.71	3.69	3.68	3.66	3.64	3.63	3.61	3.59	3.57	3.56	3.54	3.52	3.50	3.49	3.47	3.45
76.4	3.54	3.59	3.64	3.86	3.84	3.82	3.80	3.79	3.77	3.75	3.73	3.72	3.70	3.68	3.66	3.65	3.63	3.61	3.59	3.58	3.56	3.54	3.52	3.51	3.49
76.8	3.57	3.62	3.67	3.89	3.88	3.86	3.84	3.82	3.81	3.79	3.77	3.76	3.74	3.72	3.70	3.69	3.67	3.65	3.63	3.62	3.60	3.58	3.56	3.55	3.53
77.2	3.60	3.65	3.70	3.93	3.92	3.90	3.88	3.86	3.85	3.83	3.81	3.79	3.78	3.76	3.74	3.72	3.71	3.69	3.67	3.66	3.64	3.62	3.60	3.59	3.57
77.6	3.63	3.68	3.73	3.97	3.96	3.94	3.92	3.90	3.89	3.87	3.85	3.83	3.82	3.80	3.78	3.76	3.75	3.73	3.71	3.69	3.68	3.66	3.64	3.62	3.61
78.0	3.66	3.71	3.76	4.01	3.99	3.98	3.96	3.94	3.92	3.91	3.89	3.87	3.86	3.84	3.82	3.80	3.79	3.77	3.75	3.73	3.72	3.70	3.68	3.66	3.65
78.3	3.69	3.74	3.79	4.05	4.03	4.02	4.00	3.98	3.96	3.95	3.93	3.91	3.89	3.88	3.86	3.84	3.82	3.81	3.79	3.77	3.75	3.74	3.72	3.70	3.69
78.7	3.72	3.77	3.82	4.09	4.07	4.05	4.04	4.02	4.00	3.99	3.97	3.95	3.93	3.92	3.90	3.88	3.86	3.85	3.83	3.81	3.79	3.78	3.76	3.74	3.72
79.1	3.75	3.80	3.85	4.13	4.11	4.09	4.08	4.06	4.04	4.02	4.01	3.99	3.97	3.95	3.94	3.92	3.90	3.88	3.87	3.85	3.83	3.82	3.80	3.78	3.76
79.5	3.78	3.83	3.88	4.17	4.15	4.13	4.12	4.10	4.08	4.06	4.05	4.03	4.01	3.99	3.98	3.96	3.94	3.92	3.91	3.89	3.87	3.85	3.84	3.82	3.80
79.9	3.81	3.86	3.91	4.21	4.19	4.17	4.15	4.14	4.12	4.10	4.08	4.07	4.05	4.03	4.02	4.00	3.98	3.96	3.95	3.93	3.91	3.89	3.88	3.86	3.84
80.3	3.84	3.89	3.94	4.25	4.23	4.21	4.19	4.18	4.16	4.14	4.12	4.11	4.09	4.07	4.05	4.04	4.02	4.00	3.98	3.97	3.95	3.93	3.91	3.90	3.88
80.7	3.87	3.92	3.97	4.28	4.27	4.25	4.23	4.22	4.20	4.18	4.16	4.15	4.13	4.11	4.09	4.08	4.06	4.04	4.02	4.01	3.99	3.97	3.95	3.94	3.92
81.1	3.90	3.95	4.00	4.32	4.31	4.29	4.27	4.25	4.24	4.22	4.20	4.18	4.17	4.15	4.13	4.11	4.10	4.08	4.06	4.05	4.03	4.01	3.99	3.98	3.96
81.5	3.93	3.98	4.03	4.36	4.35	4.33	4.31	4.29	4.28	4.26	4.24	4.22	4.21	4.19	4.17	4.15	4.14	4.12	4.10	4.08	4.07	4.05	4.03	4.01	4.00
81.9	3.96	4.01	4.06	4.40	4.38	4.37	4.35	4.33	4.31	4.30	4.28	4.26	4.24	4.23	4.21	4.19	4.18	4.16	4.14	4.12	4.11	4.09	4.07	4.05	4.04
82.3	3.99	4.04	4.09	4.44	4.42	4.41	4.39	4.37	4.35	4.34	4.32	4.30	4.28	4.27	4.25	4.23	4.21	4.20	4.18	4.16	4.14	4.13	4.11	4.09	4.08
82.7	4.02	4.07	4.12	4.48	4.46	4.44	4.43	4.41	4.39	4.38	4.36	4.34	4.32	4.31	4.29	4.27	4.25	4.24	4.22	4.20	4.18	4.17	4.15	4.13	4.11

PREDICTION EQUATIONS FOR FVC — MALES — * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
59.1	1.76	1.74	1.72	1.70	1.69	1.67	1.65	1.63	1.62	1.60	1.58	1.57	1.55	1.53	1.51	1.50	1.48	1.46	1.44	1.43	1.41	1.39	1.37	1.36	1.34
59.4	1.80	1.78	1.76	1.74	1.73	1.71	1.69	1.67	1.66	1.64	1.62	1.60	1.59	1.57	1.55	1.53	1.52	1.50	1.48	1.47	1.45	1.43	1.41	1.40	1.38
59.8	1.83	1.82	1.80	1.78	1.77	1.75	1.73	1.71	1.70	1.68	1.66	1.64	1.63	1.61	1.59	1.57	1.56	1.54	1.52	1.50	1.49	1.47	1.45	1.43	1.42
60.2	1.87	1.86	1.84	1.82	1.80	1.79	1.77	1.75	1.73	1.72	1.70	1.68	1.66	1.65	1.63	1.61	1.60	1.58	1.56	1.54	1.53	1.51	1.49	1.47	1.46
60.6	1.91	1.90	1.88	1.86	1.84	1.83	1.81	1.79	1.77	1.76	1.74	1.72	1.70	1.69	1.67	1.65	1.63	1.62	1.60	1.58	1.56	1.55	1.53	1.51	1.50
61.0	1.95	1.93	1.92	1.90	1.88	1.86	1.85	1.83	1.81	1.80	1.78	1.76	1.74	1.73	1.71	1.69	1.67	1.66	1.64	1.62	1.60	1.59	1.57	1.55	1.53
61.4	1.99	1.97	1.96	1.94	1.92	1.90	1.89	1.87	1.85	1.83	1.82	1.80	1.78	1.76	1.75	1.73	1.71	1.69	1.68	1.66	1.64	1.63	1.61	1.59	1.57
61.8	2.03	2.01	2.00	1.98	1.96	1.94	1.93	1.91	1.89	1.87	1.86	1.84	1.82	1.80	1.79	1.77	1.75	1.73	1.72	1.70	1.68	1.66	1.65	1.63	1.61
62.2	2.07	2.05	2.03	2.02	2.00	1.98	1.96	1.95	1.93	1.91	1.89	1.88	1.86	1.84	1.83	1.81	1.79	1.77	1.76	1.74	1.72	1.70	1.69	1.67	1.65
62.6	2.11	2.09	2.07	2.06	2.04	2.02	2.00	1.99	1.97	1.95	1.93	1.92	1.90	1.88	1.86	1.85	1.83	1.81	1.79	1.78	1.76	1.74	1.73	1.71	1.69
63.0	2.15	2.13	2.11	2.09	2.08	2.06	2.04	2.02	2.01	1.99	1.97	1.96	1.94	1.92	1.90	1.89	1.87	1.85	1.83	1.82	1.80	1.78	1.76	1.75	1.73
63.4	2.19	2.17	2.15	2.13	2.12	2.10	2.08	2.06	2.05	2.03	2.01	1.99	1.98	1.96	1.94	1.92	1.91	1.89	1.87	1.86	1.84	1.82	1.80	1.79	1.77
63.8	2.22	2.21	2.19	2.17	2.16	2.14	2.12	2.10	2.09	2.07	2.05	2.03	2.02	2.00	1.98	1.96	1.95	1.93	1.91	1.89	1.88	1.86	1.84	1.82	1.81
64.2	2.26	2.25	2.23	2.21	2.19	2.18	2.16	2.14	2.12	2.11	2.09	2.07	2.05	2.04	2.02	2.00	1.99	1.97	1.95	1.93	1.92	1.90	1.88	1.86	1.85
64.6	2.30	2.29	2.27	2.25	2.23	2.22	2.20	2.18	2.16	2.15	2.13	2.11	2.09	2.08	2.06	2.04	2.02	2.01	1.99	1.97	1.95	1.94	1.92	1.90	1.89
65.0	2.34	2.32	2.31	2.29	2.27	2.25	2.24	2.22	2.20	2.19	2.17	2.15	2.13	2.12	2.10	2.08	2.06	2.05	2.03	2.01	1.99	1.98	1.96	1.94	1.92
65.4	2.38	2.36	2.35	2.33	2.31	2.29	2.28	2.26	2.24	2.22	2.21	2.19	2.17	2.15	2.14	2.12	2.10	2.09	2.07	2.05	2.03	2.02	2.00	1.98	1.96
65.7	2.42	2.40	2.38	2.37	2.35	2.33	2.32	2.30	2.28	2.26	2.25	2.23	2.21	2.19	2.18	2.16	2.14	2.12	2.11	2.09	2.07	2.05	2.04	2.02	2.00
66.1	2.46	2.44	2.42	2.41	2.39	2.37	2.35	2.34	2.32	2.30	2.28	2.27	2.25	2.23	2.22	2.20	2.18	2.16	2.15	2.13	2.11	2.09	2.08	2.06	2.04
66.5	2.50	2.48	2.46	2.45	2.43	2.41	2.39	2.38	2.36	2.34	2.32	2.31	2.29	2.27	2.25	2.24	2.22	2.20	2.18	2.17	2.15	2.13	2.11	2.10	2.08
66.9	2.54	2.52	2.50	2.48	2.47	2.45	2.43	2.41	2.40	2.38	2.36	2.35	2.33	2.31	2.29	2.28	2.26	2.24	2.22	2.21	2.19	2.17	2.15	2.14	2.12
67.3	2.58	2.56	2.54	2.52	2.51	2.49	2.47	2.45	2.44	2.42	2.40	2.38	2.37	2.35	2.33	2.31	2.30	2.28	2.26	2.25	2.23	2.21	2.19	2.18	2.16
67.7	2.61	2.60	2.58	2.56	2.55	2.53	2.51	2.49	2.48	2.46	2.44	2.42	2.41	2.39	2.37	2.35	2.34	2.32	2.30	2.28	2.27	2.25	2.23	2.21	2.20
68.1	2.65	2.64	2.62	2.60	2.58	2.57	2.55	2.53	2.51	2.50	2.48	2.46	2.44	2.43	2.41	2.39	2.38	2.36	2.34	2.32	2.31	2.29	2.27	2.25	2.24
68.5	2.69	2.68	2.66	2.64	2.62	2.61	2.59	2.57	2.55	2.54	2.52	2.50	2.48	2.47	2.45	2.43	2.41	2.40	2.38	2.36	2.34	2.33	2.31	2.29	2.28
68.9	2.73	2.71	2.70	2.68	2.66	2.64	2.63	2.61	2.59	2.58	2.56	2.54	2.52	2.51	2.49	2.47	2.45	2.44	2.42	2.40	2.38	2.37	2.35	2.33	2.31
69.3	2.77	2.75	2.74	2.72	2.70	2.68	2.67	2.65	2.63	2.61	2.60	2.58	2.56	2.54	2.53	2.51	2.49	2.47	2.46	2.44	2.42	2.41	2.39	2.37	2.35
69.7	2.81	2.79	2.77	2.76	2.74	2.72	2.71	2.69	2.67	2.65	2.64	2.62	2.60	2.58	2.57	2.55	2.53	2.51	2.50	2.48	2.46	2.44	2.43	2.41	2.39
70.1	2.85	2.83	2.81	2.80	2.78	2.76	2.74	2.73	2.71	2.69	2.67	2.66	2.64	2.62	2.61	2.59	2.57	2.55	2.54	2.52	2.50	2.48	2.47	2.45	2.43
70.5	2.89	2.87	2.85	2.84	2.82	2.80	2.78	2.77	2.75	2.73	2.71	2.70	2.68	2.66	2.64	2.63	2.61	2.59	2.57	2.56	2.54	2.52	2.50	2.49	2.47
70.9	2.93	2.91	2.89	2.87	2.86	2.84	2.82	2.80	2.79	2.77	2.75	2.74	2.72	2.70	2.68	2.67	2.65	2.63	2.61	2.60	2.58	2.56	2.54	2.53	2.51
71.3	2.97	2.95	2.93	2.91	2.90	2.88	2.86	2.84	2.83	2.81	2.79	2.77	2.76	2.74	2.72	2.70	2.69	2.67	2.65	2.64	2.62	2.60	2.58	2.57	2.55
71.7	3.00	2.99	2.97	2.95	2.94	2.92	2.90	2.88	2.87	2.85	2.83	2.81	2.80	2.78	2.76	2.74	2.73	2.71	2.69	2.67	2.66	2.64	2.62	2.60	2.59
72.0	3.04	3.03	3.01	2.99	2.97	2.96	2.94	2.92	2.90	2.89	2.87	2.85	2.83	2.82	2.80	2.78	2.77	2.75	2.73	2.71	2.70	2.68	2.66	2.64	2.63
72.4	3.08	3.07	3.05	3.03	3.01	3.00	2.98	2.96	2.94	2.93	2.91	2.89	2.87	2.86	2.84	2.82	2.80	2.79	2.77	2.75	2.73	2.72	2.70	2.68	2.67
72.8	3.12	3.10	3.09	3.07	3.05	3.03	3.02	3.00	2.98	2.97	2.95	2.93	2.91	2.90	2.88	2.86	2.84	2.83	2.81	2.79	2.77	2.76	2.74	2.72	2.70
73.2	3.16	3.14	3.13	3.11	3.09	3.07	3.06	3.04	3.02	3.00	2.99	2.97	2.95	2.93	2.92	2.90	2.88	2.86	2.85	2.83	2.81	2.80	2.78	2.76	2.74
73.6	3.20	3.18	3.16	3.15	3.13	3.11	3.10	3.08	3.06	3.04	3.03	3.01	2.99	2.97	2.96	2.94	2.92	2.90	2.89	2.87	2.85	2.83	2.82	2.80	2.78
74.0	3.24	3.22	3.20	3.19	3.17	3.15	3.13	3.12	3.10	3.08	3.06	3.05	3.03	3.01	3.00	2.98	2.96	2.94	2.93	2.91	2.89	2.87	2.86	2.84	2.82
74.4	3.28	3.26	3.24	3.23	3.21	3.19	3.17	3.16	3.14	3.12	3.10	3.09	3.07	3.05	3.03	3.02	3.00	2.98	2.96	2.95	2.93	2.91	2.89	2.88	2.86
74.8	3.32	3.30	3.28	3.26	3.25	3.23	3.21	3.19	3.18	3.16	3.14	3.13	3.11	3.09	3.07	3.06	3.04	3.02	3.00	2.99	2.97	2.95	2.93	2.92	2.90
75.2	3.36	3.34	3.32	3.30	3.29	3.27	3.25	3.23	3.22	3.20	3.18	3.16	3.15	3.13	3.11	3.09	3.08	3.06	3.04	3.03	3.01	2.99	2.97	2.96	2.94
75.6	3.39	3.38	3.36	3.34	3.33	3.31	3.29	3.27	3.26	3.24	3.22	3.20	3.19	3.17	3.15	3.13	3.12	3.10	3.08	3.06	3.05	3.03	3.01	2.99	2.98
76.0	3.43	3.42	3.40	3.38	3.36	3.35	3.33	3.31	3.29	3.28	3.26	3.24	3.22	3.21	3.19	3.17	3.16	3.14	3.12	3.10	3.09	3.07	3.05	3.03	3.02
76.4	3.47	3.46	3.44	3.42	3.40	3.39	3.37	3.35	3.33	3.32	3.30	3.28	3.26	3.25	3.23	3.21	3.19	3.18	3.16	3.14	3.12	3.11	3.09	3.07	3.06
76.8	3.51	3.49	3.48	3.46	3.44	3.42	3.41	3.39	3.37	3.36	3.34	3.32	3.30	3.29	3.27	3.25	3.23	3.22	3.20	3.18	3.16	3.15	3.13	3.11	3.09
77.2	3.55	3.53	3.52	3.50	3.48	3.46	3.45	3.43	3.41	3.39	3.38	3.36	3.34	3.32	3.31	3.29	3.27	3.25	3.24	3.22	3.20	3.19	3.17	3.15	3.13
77.6	3.59	3.57	3.55	3.54	3.52	3.50	3.49	3.47	3.45	3.43	3.42	3.40	3.38	3.36	3.35	3.33	3.31	3.29	3.28	3.26	3.24	3.22	3.21	3.19	3.17
78.0	3.63	3.61	3.59	3.58	3.56	3.54	3.52	3.51	3.49	3.47	3.45	3.44	3.42	3.40	3.39	3.37	3.35	3.33	3.32	3.30	3.28	3.26	3.25	3.23	3.21
78.3	3.67	3.65	3.63	3.62	3.60	3.58	3.56	3.55	3.53	3.51	3.49	3.48	3.46	3.44	3.42	3.41	3.39	3.37	3.35	3.34	3.32	3.30	3.28	3.27	3.25
78.7	3.71	3.69	3.67	3.65	3.64	3.62	3.60	3.59	3.57	3.55	3.53	3.52	3.50	3.48	3.46	3.45	3.43	3.41	3.39	3.38	3.36	3.34	3.32	3.31	3.29
79.1	3.75	3.73	3.71	3.69	3.68	3.66	3.64	3.62	3.61	3.59	3.57	3.55	3.54	3.52	3.50	3.48	3.47	3.45	3.43	3.42	3.40	3.38	3.36	3.35	3.33
79.5	3.78	3.77	3.75	3.73	3.72	3.70	3.68	3.66	3.65	3.63	3.61	3.59	3.58	3.56	3.54	3.52	3.51	3.49	3.47	3.45	3.44	3.42	3.40	3.38	3.37
79.9	3.82	3.81	3.79	3.77	3.75	3.74	3.72	3.70	3.68	3.67	3.65	3.63	3.62	3.60	3.58	3.56	3.55	3.53	3.51	3.49	3.48	3.46	3.44	3.42	3.41
80.3	3.86	3.85	3.83	3.81	3.79	3.78	3.76	3.74	3.72	3.71	3.69	3.67	3.65	3.64	3.62	3.60	3.58	3.57	3.55	3.53	3.51	3.50	3.48	3.46	3.45
80.7	3.90	3.88	3.87	3.85	3.83	3.81	3.80	3.78	3.76	3.75	3.73	3.71	3.69	3.68	3.66	3.64	3.62	3.61	3.59	3.57	3.55	3.54	3.52	3.50	3.48
81.1	3.94	3.92	3.91	3.89	3.87	3.85	3.84	3.82	3.80	3.78	3.77	3.75	3.73	3.71	3.70	3.68	3.66	3.64	3.63	3.61	3.59	3.58	3.56	3.54	3.52
81.5	3.98	3.96	3.94	3.93	3.91	3.89	3.88	3.86	3.84	3.82	3.81	3.79	3.77	3.75	3.74	3.72	3.70	3.68	3.67	3.65	3.63	3.61	3.60	3.58	3.56
81.9	4.02	4.00	3.98	3.97	3.95	3.93	3.91	3.90	3.88	3.86	3.84	3.83	3.81	3.79	3.78	3.76	3.74	3.72	3.71	3.69	3.67	3.65	3.64	3.62	3.60
82.3	4.06	4.04	4.02	4.01	3.99	3.97	3.95	3.94	3.92	3.90	3.88	3.87	3.85	3.83	3.81	3.80	3.78	3.76	3.74	3.73	3.71	3.69	3.67	3.66	3.64
82.7	4.10	4.08	4.06	4.04	4.03	4.01	3.99	3.97	3.96	3.94	3.92	3.91	3.89	3.87	3.85	3.84	3.82	3.80	3.78	3.77	3.75	3.73	3.71	3.70	3.68

PREDICTION EQUATIONS FOR FVC FEMALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
51.2	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.25	1.24	1.23	1.21
51.6	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.43	1.42	1.41	1.40	1.38	1.37	1.36	1.34	1.33	1.32	1.30	1.29	1.28	1.26	1.25	1.24
52.0	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.29	1.27	1.26
52.4	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28
52.8	1.62	1.61	1.59	1.58	1.57	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37	1.36	1.34	1.33	1.32	1.30
53.1	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.37	1.35	1.34	1.33
53.5	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35
53.9	1.69	1.67	1.66	1.65	1.63	1.62	1.61	1.59	1.58	1.57	1.55	1.54	1.53	1.52	1.50	1.49	1.48	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37
54.3	1.71	1.70	1.68	1.67	1.66	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.41	1.39
54.7	1.73	1.72	1.70	1.69	1.68	1.67	1.65	1.64	1.63	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44	1.43	1.41
55.1	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.63	1.62	1.61	1.59	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.46	1.45	1.44
55.5	1.78	1.76	1.75	1.74	1.72	1.71	1.70	1.68	1.67	1.66	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.49	1.47	1.46
55.9	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.63	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48
56.3	1.82	1.81	1.79	1.78	1.77	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.63	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50
56.7	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.72	1.71	1.70	1.68	1.67	1.66	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.53
57.1	1.86	1.85	1.84	1.82	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.63	1.61	1.60	1.59	1.57	1.56	1.55
57.5	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.79	1.78	1.77	1.75	1.74	1.73	1.71	1.70	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57
57.9	1.91	1.90	1.88	1.87	1.86	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.72	1.71	1.70	1.68	1.67	1.66	1.64	1.63	1.62	1.61	1.59
58.3	1.93	1.92	1.90	1.89	1.88	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.63	1.61
58.7	1.95	1.94	1.93	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.79	1.78	1.77	1.75	1.74	1.73	1.72	1.70	1.69	1.68	1.66	1.65	1.64
59.1	1.98	1.96	1.95	1.94	1.92	1.91	1.90	1.88	1.87	1.86	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.72	1.71	1.70	1.68	1.67	1.66
59.4	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.90	1.89	1.88	1.87	1.85	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.71	1.69	1.68
59.8	2.02	2.01	1.99	1.98	1.97	1.95	1.94	1.93	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.70
60.2	2.04	2.03	2.02	2.00	1.99	1.98	1.96	1.95	1.94	1.92	1.91	1.90	1.88	1.87	1.86	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.73
60.6	2.06	2.05	2.04	2.02	2.01	2.00	1.98	1.97	1.96	1.95	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75
61.0	2.09	2.07	2.06	2.05	2.03	2.02	2.01	1.99	1.98	1.97	1.95	1.94	1.93	1.91	1.90	1.89	1.88	1.86	1.85	1.84	1.82	1.81	1.80	1.78	1.77
61.4	2.11	2.10	2.08	2.07	2.06	2.04	2.03	2.02	2.00	1.99	1.98	1.96	1.95	1.94	1.92	1.91	1.90	1.88	1.87	1.86	1.84	1.83	1.82	1.80	1.79
61.8	2.13	2.12	2.10	2.09	2.08	2.06	2.05	2.04	2.03	2.01	2.00	1.99	1.97	1.96	1.95	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.81
62.2	2.15	2.14	2.13	2.11	2.10	2.09	2.07	2.06	2.05	2.03	2.02	2.01	1.99	1.98	1.97	1.95	1.94	1.93	1.92	1.90	1.89	1.88	1.86	1.85	1.84
62.6	2.17	2.16	2.15	2.14	2.12	2.11	2.10	2.08	2.07	2.06	2.04	2.03	2.02	2.00	1.99	1.98	1.96	1.95	1.94	1.92	1.91	1.90	1.88	1.87	1.86
63.0	2.20	2.18	2.17	2.16	2.14	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04	2.03	2.01	2.00	1.99	1.97	1.96	1.95	1.93	1.92	1.91	1.89	1.88
63.4	2.22	2.21	2.19	2.18	2.17	2.15	2.14	2.13	2.11	2.10	2.09	2.07	2.06	2.05	2.03	2.02	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.90
63.8	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.14	2.12	2.11	2.10	2.08	2.07	2.06	2.04	2.03	2.02	2.00	1.99	1.98	1.96	1.95	1.94	1.92
64.2	2.26	2.25	2.24	2.22	2.21	2.20	2.18	2.17	2.16	2.15	2.13	2.12	2.11	2.09	2.08	2.07	2.05	2.04	2.03	2.01	2.00	1.99	1.97	1.96	1.95
64.6	2.29	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.15	2.14	2.13	2.11	2.10	2.09	2.07	2.06	2.05	2.04	2.02	2.01	2.00	1.98	1.97
65.0	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.14	2.12	2.11	2.10	2.08	2.07	2.06	2.04	2.03	2.02	2.00	1.99
65.4	2.33	2.32	2.30	2.29	2.28	2.26	2.25	2.24	2.22	2.21	2.20	2.19	2.17	2.16	2.15	2.13	2.12	2.11	2.09	2.08	2.07	2.05	2.04	2.03	2.01
65.7	2.35	2.34	2.33	2.31	2.30	2.29	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.15	2.14	2.13	2.12	2.10	2.09	2.08	2.06	2.05	2.04
66.1	2.37	2.36	2.35	2.34	2.32	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.14	2.12	2.11	2.10	2.08	2.07	2.06
66.5	2.40	2.38	2.37	2.36	2.34	2.33	2.32	2.30	2.29	2.28	2.27	2.25	2.24	2.23	2.21	2.20	2.19	2.17	2.16	2.15	2.13	2.12	2.11	2.09	2.08
66.9	2.42	2.41	2.39	2.38	2.37	2.35	2.34	2.33	2.31	2.30	2.29	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.16	2.14	2.13	2.12	2.10
67.3	2.44	2.43	2.42	2.40	2.39	2.38	2.36	2.35	2.34	2.32	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.14	2.12
67.7	2.46	2.45	2.44	2.42	2.41	2.40	2.38	2.37	2.36	2.34	2.33	2.32	2.31	2.29	2.28	2.27	2.25	2.24	2.23	2.21	2.20	2.19	2.17	2.16	2.15
68.1	2.49	2.47	2.46	2.45	2.43	2.42	2.41	2.39	2.38	2.37	2.35	2.34	2.33	2.31	2.30	2.29	2.27	2.26	2.25	2.24	2.22	2.21	2.20	2.18	2.17
68.5	2.51	2.49	2.48	2.47	2.46	2.44	2.43	2.42	2.40	2.39	2.38	2.36	2.35	2.34	2.32	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19
68.9	2.53	2.52	2.50	2.49	2.48	2.46	2.45	2.44	2.42	2.41	2.40	2.38	2.37	2.36	2.35	2.33	2.32	2.31	2.29	2.28	2.27	2.25	2.24	2.23	2.21
69.3	2.55	2.54	2.53	2.51	2.50	2.49	2.47	2.46	2.45	2.43	2.42	2.41	2.39	2.38	2.37	2.35	2.34	2.33	2.31	2.30	2.29	2.28	2.26	2.25	2.24
69.7	2.57	2.56	2.55	2.54	2.52	2.51	2.50	2.48	2.47	2.46	2.44	2.43	2.42	2.40	2.39	2.38	2.36	2.35	2.34	2.32	2.31	2.30	2.28	2.27	2.26
70.1	2.60	2.58	2.57	2.56	2.54	2.53	2.52	2.50	2.49	2.48	2.46	2.45	2.44	2.43	2.41	2.40	2.39	2.37	2.36	2.35	2.33	2.32	2.31	2.29	2.28
70.5	2.62	2.61	2.59	2.58	2.57	2.55	2.54	2.53	2.51	2.50	2.49	2.47	2.46	2.45	2.43	2.42	2.41	2.39	2.38	2.37	2.36	2.34	2.33	2.32	2.30
70.9	2.64	2.63	2.61	2.60	2.59	2.58	2.56	2.55	2.54	2.52	2.51	2.50	2.48	2.47	2.46	2.44	2.43	2.42	2.40	2.39	2.38	2.36	2.35	2.34	2.32
71.3	2.66	2.65	2.64	2.62	2.61	2.60	2.58	2.57	2.56	2.54	2.53	2.52	2.50	2.49	2.48	2.47	2.45	2.44	2.43	2.41	2.40	2.39	2.37	2.36	2.35
71.7	2.69	2.67	2.66	2.65	2.63	2.62	2.61	2.59	2.58	2.57	2.55	2.54	2.53	2.51	2.50	2.49	2.47	2.46	2.45	2.43	2.42	2.41	2.40	2.38	2.37
72.0	2.71	2.69	2.68	2.67	2.65	2.64	2.63	2.62	2.60	2.59	2.58	2.56	2.55	2.54	2.52	2.51	2.50	2.48	2.47	2.46	2.44	2.43	2.42	2.40	2.39
72.4	2.73	2.72	2.70	2.69	2.68	2.66	2.65	2.64	2.62	2.61	2.60	2.58	2.57	2.56	2.55	2.53	2.52	2.51	2.49	2.48	2.47	2.45	2.44	2.43	2.41
72.8	2.75	2.74	2.73	2.71	2.70	2.69	2.67	2.66	2.65	2.63	2.62	2.61	2.59	2.58	2.57	2.55	2.54	2.53	2.51	2.50	2.49	2.48	2.46	2.45	2.44
73.2	2.77	2.76	2.75	2.73	2.72	2.71	2.70	2.68	2.67	2.66	2.64	2.63	2.62	2.60	2.59	2.58	2.56	2.55	2.54	2.52	2.51	2.50	2.48	2.47	2.46
73.6	2.80	2.78	2.77	2.76	2.74	2.73	2.72	2.70	2.69	2.68	2.66	2.65	2.64	2.63	2.61	2.60	2.59	2.57	2.56	2.55	2.53	2.52	2.51	2.49	2.48
74.0	2.82	2.81	2.79	2.78	2.77	2.75	2.74	2.73	2.71	2.70	2.69	2.67	2.66	2.65	2.63	2.62	2.61	2.59	2.58	2.57	2.55	2.54	2.53	2.52	2.50
74.4	2.84	2.83	2.81	2.80	2.79	2.78	2.76	2.75	2.74	2.72	2.71	2.70	2.68	2.67	2.66	2.64	2.63	2.62	2.60	2.59	2.58	2.56	2.55	2.54	2.52
74.8	2.86	2.85	2.84	2.82	2.81	2.80	2.78	2.77	2.76	2.74	2.73	2.72	2.70	2.69	2.68	2.67	2.65	2.64	2.63	2.61	2.60	2.59	2.57	2.56	2.55

PREDICTION EQUATIONS FOR FVC FEMALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
51.2	1.20	1.19	1.17	1.16	1.15	1.14	1.12	1.11	1.10	1.08	1.07	1.06	1.04	1.03	1.02	1.00	0.99	0.98	0.96	0.95	0.94	0.92	0.91	0.90	0.88
51.6	1.22	1.21	1.20	1.18	1.17	1.16	1.14	1.13	1.12	1.10	1.09	1.08	1.07	1.05	1.04	1.03	1.01	1.00	0.99	0.97	0.96	0.95	0.93	0.92	0.91
52.0	1.25	1.23	1.22	1.21	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.07	1.06	1.05	1.03	1.02	1.01	0.99	0.98	0.97	0.96	0.94	0.93
52.4	1.27	1.25	1.24	1.23	1.21	1.20	1.19	1.18	1.16	1.15	1.14	1.12	1.11	1.10	1.08	1.07	1.06	1.04	1.03	1.02	1.00	0.99	0.98	0.96	0.95
52.8	1.29	1.28	1.26	1.25	1.24	1.22	1.21	1.20	1.18	1.17	1.16	1.14	1.13	1.12	1.11	1.09	1.08	1.07	1.05	1.04	1.03	1.01	1.00	0.99	0.97
53.1	1.31	1.30	1.29	1.27	1.26	1.25	1.23	1.22	1.21	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.07	1.06	1.05	1.03	1.02	1.01	1.00
53.5	1.33	1.32	1.31	1.29	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.16	1.15	1.14	1.12	1.11	1.10	1.08	1.07	1.06	1.04	1.03	1.02
53.9	1.36	1.34	1.33	1.32	1.30	1.29	1.28	1.26	1.25	1.24	1.22	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11	1.09	1.08	1.07	1.05	1.04
54.3	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.27	1.26	1.25	1.23	1.22	1.21	1.19	1.18	1.17	1.15	1.14	1.13	1.11	1.10	1.09	1.08	1.06
54.7	1.40	1.39	1.37	1.36	1.35	1.34	1.32	1.31	1.30	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.16	1.15	1.14	1.12	1.11	1.10	1.08
55.1	1.42	1.41	1.40	1.38	1.37	1.36	1.34	1.33	1.32	1.30	1.29	1.28	1.26	1.25	1.24	1.23	1.21	1.20	1.19	1.17	1.16	1.15	1.13	1.12	1.11
55.5	1.45	1.43	1.42	1.41	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.27	1.26	1.25	1.23	1.22	1.21	1.19	1.18	1.17	1.15	1.14	1.13
55.9	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.28	1.27	1.26	1.24	1.23	1.22	1.20	1.19	1.18	1.16	1.15
56.3	1.49	1.48	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37	1.36	1.34	1.33	1.32	1.30	1.29	1.28	1.27	1.25	1.24	1.23	1.21	1.20	1.19	1.17
56.7	1.51	1.50	1.49	1.47	1.46	1.45	1.43	1.42	1.41	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.27	1.26	1.25	1.23	1.22	1.21	1.20
57.1	1.53	1.52	1.51	1.49	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.28	1.27	1.26	1.24	1.23	1.22
57.5	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.46	1.45	1.44	1.42	1.41	1.40	1.38	1.37	1.36	1.35	1.33	1.32	1.31	1.29	1.28	1.27	1.25	1.24
57.9	1.58	1.57	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.43	1.42	1.41	1.39	1.38	1.37	1.35	1.34	1.33	1.31	1.30	1.29	1.28	1.26
58.3	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35	1.34	1.32	1.31	1.30	1.28
58.7	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.46	1.45	1.44	1.43	1.41	1.40	1.39	1.37	1.36	1.35	1.33	1.32	1.31
59.1	1.65	1.63	1.62	1.61	1.59	1.58	1.57	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.43	1.42	1.41	1.39	1.38	1.37	1.35	1.34	1.33
59.4	1.67	1.65	1.64	1.63	1.61	1.60	1.59	1.57	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42	1.40	1.39	1.38	1.36	1.35
59.8	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.54	1.53	1.52	1.50	1.49	1.48	1.47	1.45	1.44	1.43	1.41	1.40	1.39	1.37
60.2	1.71	1.70	1.69	1.67	1.66	1.65	1.63	1.62	1.61	1.59	1.58	1.57	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46	1.45	1.43	1.42	1.41	1.40
60.6	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48	1.47	1.46	1.44	1.43	1.42
61.0	1.76	1.74	1.73	1.72	1.70	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.58	1.57	1.56	1.55	1.53	1.52	1.51	1.49	1.48	1.47	1.45	1.44
61.4	1.78	1.77	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.63	1.62	1.61	1.59	1.58	1.57	1.55	1.54	1.53	1.51	1.50	1.49	1.47	1.46
61.8	1.80	1.79	1.77	1.76	1.75	1.73	1.72	1.71	1.69	1.68	1.67	1.66	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55	1.54	1.52	1.51	1.50	1.48
62.2	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.70	1.69	1.68	1.66	1.65	1.64	1.62	1.61	1.60	1.59	1.57	1.56	1.55	1.53	1.52	1.51
62.6	1.84	1.83	1.82	1.81	1.79	1.78	1.77	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.63	1.62	1.61	1.59	1.58	1.57	1.55	1.54	1.53
63.0	1.87	1.85	1.84	1.83	1.81	1.80	1.79	1.77	1.76	1.75	1.74	1.72	1.71	1.70	1.68	1.67	1.66	1.64	1.63	1.62	1.60	1.59	1.58	1.56	1.55
63.4	1.89	1.88	1.86	1.85	1.84	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.70	1.69	1.68	1.67	1.65	1.64	1.63	1.61	1.60	1.59	1.57
63.8	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.79	1.78	1.77	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66	1.65	1.63	1.62	1.61	1.59
64.2	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.72	1.71	1.70	1.68	1.67	1.66	1.64	1.63	1.62
64.6	1.96	1.94	1.93	1.92	1.90	1.89	1.88	1.86	1.85	1.84	1.82	1.81	1.80	1.78	1.77	1.76	1.74	1.73	1.72	1.71	1.69	1.68	1.67	1.65	1.64
65.0	1.98	1.97	1.95	1.94	1.93	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.79	1.78	1.77	1.75	1.74	1.73	1.71	1.70	1.69	1.67	1.66
65.4	2.00	1.99	1.97	1.96	1.95	1.93	1.92	1.91	1.89	1.88	1.87	1.86	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75	1.74	1.72	1.71	1.70	1.68
65.7	2.02	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.90	1.89	1.88	1.86	1.85	1.84	1.82	1.81	1.80	1.78	1.77	1.76	1.75	1.73	1.72	1.71
66.1	2.04	2.03	2.02	2.01	1.99	1.98	1.97	1.95	1.94	1.93	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.79	1.78	1.77	1.75	1.74	1.73
66.5	2.07	2.05	2.04	2.03	2.01	2.00	1.99	1.97	1.96	1.95	1.94	1.92	1.91	1.90	1.88	1.87	1.86	1.84	1.83	1.82	1.80	1.79	1.78	1.76	1.75
66.9	2.09	2.08	2.06	2.05	2.04	2.02	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.90	1.89	1.88	1.86	1.85	1.84	1.83	1.81	1.80	1.79	1.77
67.3	2.11	2.10	2.09	2.07	2.06	2.05	2.03	2.02	2.01	1.99	1.98	1.97	1.95	1.94	1.93	1.91	1.90	1.89	1.87	1.86	1.85	1.83	1.82	1.81	1.79
67.7	2.13	2.12	2.11	2.09	2.08	2.07	2.05	2.04	2.03	2.01	2.00	1.99	1.98	1.96	1.95	1.94	1.92	1.91	1.90	1.88	1.87	1.86	1.84	1.83	1.82
68.1	2.16	2.14	2.13	2.12	2.10	2.09	2.08	2.06	2.05	2.04	2.02	2.01	2.00	1.98	1.97	1.96	1.94	1.93	1.92	1.91	1.89	1.88	1.87	1.85	1.84
68.5	2.18	2.16	2.15	2.14	2.13	2.11	2.10	2.09	2.07	2.06	2.05	2.03	2.02	2.01	1.99	1.98	1.97	1.95	1.94	1.93	1.91	1.90	1.89	1.87	1.86
68.9	2.20	2.19	2.17	2.16	2.15	2.13	2.12	2.11	2.09	2.08	2.07	2.05	2.04	2.03	2.02	2.00	1.99	1.98	1.96	1.95	1.94	1.92	1.91	1.90	1.88
69.3	2.22	2.21	2.20	2.18	2.17	2.16	2.14	2.13	2.12	2.10	2.09	2.08	2.06	2.05	2.04	2.02	2.01	2.00	1.98	1.97	1.96	1.95	1.93	1.92	1.91
69.7	2.24	2.23	2.22	2.21	2.19	2.18	2.17	2.15	2.14	2.13	2.11	2.10	2.09	2.07	2.06	2.05	2.03	2.02	2.01	1.99	1.98	1.97	1.95	1.94	1.93
70.1	2.27	2.25	2.24	2.23	2.21	2.20	2.19	2.17	2.16	2.15	2.13	2.12	2.11	2.10	2.08	2.07	2.06	2.04	2.03	2.02	2.00	1.99	1.98	1.96	1.95
70.5	2.29	2.28	2.26	2.25	2.24	2.22	2.21	2.20	2.18	2.17	2.16	2.14	2.13	2.12	2.10	2.09	2.08	2.06	2.05	2.04	2.03	2.01	2.00	1.99	1.97
70.9	2.31	2.30	2.28	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.15	2.14	2.13	2.11	2.10	2.09	2.07	2.06	2.05	2.03	2.02	2.01	1.99
71.3	2.33	2.32	2.31	2.29	2.28	2.27	2.25	2.24	2.23	2.21	2.20	2.19	2.18	2.16	2.15	2.14	2.12	2.11	2.10	2.08	2.07	2.06	2.04	2.03	2.02
71.7	2.36	2.34	2.33	2.32	2.30	2.29	2.28	2.26	2.25	2.24	2.22	2.21	2.20	2.18	2.17	2.16	2.14	2.13	2.12	2.10	2.09	2.08	2.07	2.05	2.04
72.0	2.38	2.36	2.35	2.34	2.33	2.31	2.30	2.29	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.15	2.14	2.13	2.11	2.10	2.09	2.07	2.06
72.4	2.40	2.39	2.37	2.36	2.35	2.33	2.32	2.31	2.29	2.28	2.27	2.25	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15	2.14	2.12	2.11	2.10	2.08
72.8	2.42	2.41	2.40	2.38	2.37	2.36	2.34	2.33	2.32	2.30	2.29	2.28	2.26	2.25	2.24	2.22	2.21	2.20	2.18	2.17	2.16	2.15	2.13	2.12	2.11
73.2	2.44	2.43	2.42	2.40	2.39	2.38	2.37	2.35	2.34	2.33	2.31	2.30	2.29	2.27	2.26	2.25	2.23	2.22	2.21	2.19	2.18	2.17	2.15	2.14	2.13
73.6	2.47	2.45	2.44	2.43	2.41	2.40	2.39	2.37	2.36	2.35	2.33	2.32	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22	2.20	2.19	2.18	2.16	2.15
74.0	2.49	2.48	2.46	2.45	2.44	2.42	2.41	2.40	2.38	2.37	2.36	2.34	2.33	2.32	2.30	2.29	2.28	2.26	2.25	2.24	2.22	2.21	2.20	2.19	2.17
74.4	2.51	2.50	2.48	2.47	2.46	2.44	2.43	2.42	2.41	2.39	2.38	2.37	2.35	2.34	2.33	2.31	2.30	2.29	2.27	2.26	2.25	2.23	2.22	2.21	2.19
74.8	2.53	2.52	2.51	2.49	2.48	2.47	2.45	2.44	2.43	2.41	2.40	2.39	2.37	2.36	2.35	2.34	2.32	2.31	2.30	2.28	2.27	2.26	2.24	2.23	2.22

PREDICTION EQUATIONS FOR MVV MALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
59.1	74.	75.	76.	70.	69.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	62.	62.	61.	60.	60.	59.	58.	58.	57.	57.
59.4	75.	76.	77.	71.	71.	70.	69.	69.	68.	67.	67.	66.	66.	65.	64.	64.	63.	62.	62.	61.	60.	60.	59.	58.	58.
59.8	76.	77.	78.	73.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.	64.	63.	62.	62.	61.	60.	60.	59.
60.2	77.	78.	79.	74.	73.	73.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.	64.	63.	62.	62.	61.	60.
60.6	78.	79.	81.	75.	74.	74.	73.	73.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.	63.	63.	62.	62.
61.0	79.	81.	82.	76.	76.	75.	74.	74.	73.	72.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.	63.	63.
61.4	81.	82.	83.	78.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.
61.8	82.	83.	84.	79.	78.	78.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	68.	68.	67.	67.	66.	65.
62.2	83.	84.	85.	80.	79.	79.	78.	78.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	68.	68.	67.	67.
62.6	84.	85.	86.	81.	81.	80.	79.	79.	78.	77.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	68.	68.
63.0	85.	86.	87.	83.	82.	81.	81.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.
63.4	86.	87.	88.	84.	83.	83.	82.	81.	81.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.	73.	73.	72.	72.	71.	70.
63.8	87.	88.	89.	85.	84.	84.	83.	83.	82.	81.	81.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.	73.	73.	72.	71.
64.2	88.	89.	90.	86.	86.	85.	84.	84.	83.	82.	82.	81.	81.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.	73.	73.
64.6	89.	91.	92.	88.	87.	86.	86.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.
65.0	91.	92.	93.	89.	88.	88.	87.	86.	86.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.	78.	78.	77.	77.	76.	75.
65.4	92.	93.	94.	90.	89.	89.	88.	88.	87.	86.	86.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.	78.	78.	77.	76.
65.7	93.	94.	95.	91.	91.	90.	89.	89.	88.	87.	87.	86.	86.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.	78.	78.
66.1	94.	95.	96.	93.	92.	91.	91.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.
66.5	95.	96.	97.	94.	93.	93.	92.	91.	91.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.	83.	83.	82.	82.	81.	80.
66.9	96.	97.	98.	95.	94.	94.	93.	92.	92.	91.	91.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.	83.	83.	82.	81.
67.3	97.	98.	99.	96.	96.	95.	94.	94.	93.	92.	92.	91.	91.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.	83.	83.
67.7	98.	99.	100.	98.	97.	96.	96.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.
68.1	99.	100.	102.	99.	98.	98.	97.	96.	96.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.	88.	88.	87.	87.	86.	85.
68.5	100.	102.	103.	100.	99.	99.	98.	97.	97.	96.	96.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.	88.	88.	87.	86.
68.9	102.	103.	104.	101.	101.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.	88.	88.
69.3	103.	104.	105.	103.	102.	101.	101.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.
69.7	104.	105.	106.	104.	103.	103.	102.	101.	101.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.	93.	93.	92.	92.	91.	90.
70.1	105.	106.	107.	105.	104.	104.	103.	102.	102.	101.	101.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.	93.	93.	92.	91.
70.5	106.	107.	108.	106.	106.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.	93.	93.
70.9	107.	108.	109.	108.	107.	106.	106.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	98.	98.	97.	97.	96.	95.	95.	94.
71.3	108.	109.	110.	109.	108.	108.	107.	106.	106.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	98.	98.	97.	97.	96.	95.
71.7	109.	110.	111.	110.	109.	109.	108.	107.	107.	106.	106.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	98.	98.	97.	96.
72.0	110.	111.	113.	111.	111.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	98.	98.
72.4	112.	113.	114.	113.	112.	111.	111.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.	103.	103.	102.	102.	101.	100.	100.	99.
72.8	113.	114.	115.	114.	113.	113.	112.	111.	111.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.	103.	103.	102.	101.	101.	100.
73.2	114.	115.	116.	115.	114.	114.	113.	112.	112.	111.	111.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.	103.	103.	102.	101.
73.6	115.	116.	117.	116.	116.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.	103.	103.
74.0	116.	117.	118.	118.	117.	116.	116.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	108.	108.	107.	107.	106.	105.	105.	104.
74.4	117.	118.	119.	119.	118.	118.	117.	116.	116.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	108.	108.	107.	106.	106.	105.
74.8	118.	119.	120.	120.	119.	119.	118.	117.	117.	116.	116.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	108.	108.	107.	106.
75.2	119.	120.	121.	121.	121.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	108.	108.
75.6	120.	121.	122.	123.	122.	121.	121.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	113.	113.	112.	112.	111.	110.	110.	109.
76.0	121.	123.	124.	124.	123.	122.	122.	121.	121.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	113.	113.	112.	111.	111.	110.
76.4	123.	124.	125.	125.	124.	124.	123.	122.	122.	121.	121.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	113.	113.	112.	111.
76.8	124.	125.	126.	126.	126.	125.	124.	124.	123.	122.	122.	121.	120.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	113.	113.
77.2	125.	126.	127.	128.	127.	126.	126.	125.	124.	124.	123.	122.	122.	121.	120.	120.	119.	118.	118.	117.	117.	116.	115.	115.	114.
77.6	126.	127.	128.	129.	128.	127.	127.	126.	126.	125.	124.	124.	123.	122.	122.	121.	120.	120.	119.	118.	118.	117.	116.	116.	115.
78.0	127.	128.	129.	130.	129.	129.	128.	127.	127.	126.	125.	125.	124.	124.	123.	122.	122.	121.	120.	120.	119.	118.	118.	117.	116.
78.3	128.	129.	130.	131.	131.	130.	129.	129.	128.	127.	127.	126.	125.	125.	124.	124.	123.	122.	122.	121.	120.	120.	119.	118.	118.
78.7	129.	130.	131.	133.	132.	131.	131.	130.	129.	129.	128.	127.	127.	126.	125.	125.	124.	123.	123.	122.	122.	121.	120.	120.	119.
79.1	130.	131.	132.	134.	133.	132.	132.	131.	131.	130.	129.	129.	128.	127.	127.	126.	125.	125.	124.	123.	123.	122.	121.	121.	120.
79.5	131.	132.	134.	135.	134.	134.	133.	132.	132.	131.	130.	130.	129.	129.	128.	127.	127.	126.	125.	125.	124.	123.	123.	122.	121.
79.9	132.	134.	135.	136.	136.	135.	134.	134.	133.	132.	132.	131.	130.	130.	129.	128.	128.	127.	127.	126.	125.	125.	124.	123.	123.
80.3	134.	135.	136.	138.	137.	136.	136.	135.	134.	134.	133.	132.	132.	131.	130.	130.	129.	128.	128.	127.	127.	126.	125.	125.	124.
80.7	135.	136.	137.	139.	138.	137.	137.	136.	136.	135.	134.	134.	133.	132.	132.	131.	130.	130.	129.	128.	128.	127.	126.	126.	125.
81.1	136.	137.	138.	140.	139.	139.	138.	137.	137.	136.	135.	135.	134.	134.	133.	132.	132.	131.	130.	130.	129.	128.	128.	127.	126.
81.5	137.	138.	139.	141.	141.	140.	139.	139.	138.	137.	137.	136.	135.	135.	134.	133.	133.	132.	132.	131.	130.	130.	129.	128.	128.
81.9	138.	139.	140.	143.	142.	141.	141.	140.	139.	139.	138.	137.	137.	136.	135.	135.	134.	133.	133.	132.	131.	131.	130.	130.	129.
82.3	139.	140.	141.	144.	143.	142.	142.	141.	141.	140.	139.	139.	138.	137.	137.	136.	135.	135.	134.	133.	133.	132.	131.	131.	130.
82.7	140.	141.	142.	145.	144.	144.	143.	142.	142.	141.	140.	140.	139.	139.	138.	137.	137.	136.	135.	135.	134.	133.	133.	132.	131.

PREDICTION EQUATIONS FOR MVV — MALES — * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
59.1	56.	55.	55.	54.	53.	53.	52.	51.	51.	50.	49.	49.	48.	47.	47.	46.	46.	45.	44.	44.	43.	42.	42.	41.	40.
59.4	57.	56.	56.	55.	55.	54.	53.	53.	52.	51.	51.	50.	49.	49.	48.	47.	47.	46.	45.	45.	44.	44.	43.	42.	42.
59.8	58.	58.	57.	56.	56.	55.	54.	54.	53.	53.	52.	51.	51.	50.	49.	49.	48.	47.	47.	46.	45.	45.	44.	43.	43.
60.2	60.	59.	58.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	51.	50.	49.	49.	48.	47.	47.	46.	45.	45.	44.
60.6	61.	60.	60.	59.	58.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	50.	49.	49.	48.	47.	47.	46.	45.
61.0	62.	61.	61.	60.	60.	59.	58.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	50.	49.	49.	48.	47.	47.
61.4	63.	63.	62.	61.	61.	60.	59.	59.	58.	58.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	50.	49.	48.	48.
61.8	65.	64.	63.	63.	62.	61.	61.	60.	59.	59.	58.	57.	57.	56.	56.	55.	54.	54.	53.	52.	52.	51.	50.	50.	49.
62.2	66.	65.	65.	64.	63.	63.	62.	61.	61.	60.	59.	59.	58.	57.	57.	56.	55.	55.	54.	54.	53.	52.	52.	51.	50.
62.6	67.	66.	66.	65.	65.	64.	63.	63.	62.	61.	61.	60.	59.	59.	58.	57.	57.	56.	55.	55.	54.	53.	53.	52.	52.
63.0	68.	68.	67.	66.	66.	65.	64.	64.	63.	63.	62.	61.	61.	60.	59.	59.	58.	57.	57.	56.	55.	55.	54.	53.	53.
63.4	70.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	62.	62.	61.	61.	60.	59.	59.	58.	57.	57.	56.	55.	55.	54.
63.8	71.	70.	70.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	62.	62.	61.	60.	60.	59.	59.	58.	57.	57.	56.	55.
64.2	72.	71.	71.	70.	70.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	62.	62.	61.	60.	60.	59.	58.	58.	57.	57.
64.6	73.	73.	72.	71.	71.	70.	69.	69.	68.	68.	67.	66.	66.	65.	64.	64.	63.	62.	62.	61.	60.	60.	59.	58.	58.
65.0	75.	74.	73.	73.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	66.	65.	64.	64.	63.	62.	62.	61.	60.	60.	59.
65.4	76.	75.	75.	74.	73.	73.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.	64.	63.	62.	62.	61.	60.
65.7	77.	76.	76.	75.	74.	74.	73.	73.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.	63.	63.	62.	62.
66.1	78.	78.	77.	76.	76.	75.	74.	74.	73.	73.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.	63.	63.
66.5	80.	79.	78.	78.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	71.	70.	69.	69.	68.	67.	67.	66.	65.	65.	64.
66.9	81.	80.	80.	79.	78.	78.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	69.	68.	67.	67.	66.	65.
67.3	82.	81.	81.	80.	79.	79.	78.	78.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	68.	68.	67.	67.
67.7	83.	83.	82.	81.	81.	80.	79.	79.	78.	77.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.	68.	68.
68.1	85.	84.	83.	83.	82.	81.	81.	80.	79.	79.	78.	77.	77.	76.	76.	75.	74.	74.	73.	72.	72.	71.	70.	70.	69.
68.5	86.	85.	85.	84.	83.	83.	82.	81.	81.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.	74.	73.	72.	72.	71.	70.
68.9	87.	86.	86.	85.	84.	84.	83.	83.	82.	81.	81.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.	73.	73.	72.	72.
69.3	88.	88.	87.	86.	86.	85.	84.	84.	83.	82.	82.	81.	81.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.	73.	73.
69.7	90.	89.	88.	88.	87.	86.	86.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.	79.	78.	77.	77.	76.	75.	75.	74.
70.1	91.	90.	90.	89.	88.	88.	87.	86.	86.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.	79.	78.	77.	77.	76.	75.
70.5	92.	91.	91.	90.	89.	89.	88.	88.	87.	86.	86.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.	78.	78.	77.	77.
70.9	93.	93.	92.	91.	91.	90.	89.	89.	88.	87.	87.	86.	86.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.	78.	78.
71.3	95.	94.	93.	93.	92.	91.	91.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.	84.	83.	82.	82.	81.	80.	80.	79.
71.7	96.	95.	95.	94.	93.	93.	92.	91.	91.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.	83.	83.	82.	82.	81.	80.
72.0	97.	96.	96.	95.	94.	94.	93.	93.	92.	91.	91.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.	83.	83.	82.	82.
72.4	98.	98.	97.	96.	96.	95.	94.	94.	93.	92.	92.	91.	91.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.	83.	83.
72.8	100.	99.	98.	98.	97.	96.	96.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.	89.	88.	87.	87.	86.	85.	85.	84.
73.2	101.	100.	100.	99.	98.	98.	97.	96.	96.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.	88.	88.	87.	87.	86.	85.
73.6	102.	101.	101.	100.	99.	99.	98.	98.	97.	96.	96.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.	88.	88.	87.	86.
74.0	103.	103.	102.	101.	101.	100.	99.	99.	98.	97.	97.	96.	96.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.	88.	88.
74.4	105.	104.	103.	103.	102.	101.	101.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.	94.	93.	92.	92.	91.	90.	90.	89.
74.8	106.	105.	104.	104.	103.	103.	102.	101.	101.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.	93.	93.	92.	92.	91.	90.
75.2	107.	106.	106.	105.	104.	104.	103.	103.	102.	101.	101.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.	93.	93.	92.	91.
75.6	108.	108.	107.	106.	106.	105.	104.	104.	103.	102.	102.	101.	101.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.	93.	93.
76.0	110.	109.	108.	108.	107.	106.	106.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	99.	98.	97.	97.	96.	95.	95.	94.
76.4	111.	110.	109.	109.	108.	108.	107.	106.	106.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	98.	98.	97.	97.	96.	95.
76.8	112.	111.	111.	110.	109.	109.	108.	107.	107.	106.	106.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	98.	98.	97.	96.
77.2	113.	113.	112.	111.	111.	110.	109.	109.	108.	107.	107.	106.	106.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.	98.	98.
77.6	115.	114.	113.	113.	112.	111.	111.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.	104.	103.	102.	102.	101.	100.	100.	99.
78.0	116.	115.	114.	114.	113.	113.	112.	111.	111.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.	103.	103.	102.	102.	101.	100.
78.3	117.	116.	116.	115.	114.	114.	113.	112.	112.	111.	111.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.	103.	103.	102.	101.
78.7	118.	118.	117.	116.	116.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.	103.	103.
79.1	120.	119.	118.	118.	117.	116.	116.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	109.	108.	107.	107.	106.	105.	105.	104.
79.5	121.	120.	119.	119.	118.	118.	117.	116.	116.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	108.	108.	107.	107.	106.	105.
79.9	122.	121.	121.	120.	119.	119.	118.	117.	117.	116.	116.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	108.	108.	107.	106.
80.3	123.	123.	122.	121.	121.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	114.	113.	112.	112.	111.	110.	110.	109.	108.	108.
80.7	125.	124.	123.	123.	122.	121.	121.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	113.	113.	112.	112.	111.	110.	110.	109.
81.1	126.	125.	124.	124.	123.	123.	122.	121.	121.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	113.	113.	112.	112.	111.	110.
81.5	127.	126.	126.	125.	124.	124.	123.	122.	122.	121.	121.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	113.	113.	112.	111.
81.9	128.	128.	127.	126.	126.	125.	124.	124.	123.	122.	122.	121.	120.	120.	119.	119.	118.	117.	117.	116.	115.	115.	114.	113.	113.
82.3	130.	129.	128.	128.	127.	126.	126.	125.	124.	124.	123.	122.	122.	121.	120.	120.	119.	118.	118.	117.	117.	116.	115.	115.	114.
82.7	131.	130.	129.	129.	128.	128.	127.	126.	126.	125.	124.	124.	123.	122.	122.	121.	120.	120.	119.	118.	118.	117.	116.	116.	115.

PREDICTION EQUATIONS FOR MVP FEMALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
51.2	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.
51.6	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.
52.0	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.
52.4	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.
52.8	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.
53.1	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.
53.5	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.
53.9	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.
54.3	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.
54.7	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.
55.1	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	50.	50.	49.	49.	48.
55.5	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.
55.9	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.
56.3	63.	62.	62.	61.	61.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.
56.7	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.
57.1	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.
57.5	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.
57.9	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.
58.3	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.
58.7	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.
59.1	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.
59.4	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.
59.8	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.
60.2	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.
60.6	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.
61.0	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.
61.4	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.
61.8	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	59.
62.2	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.
62.6	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.
63.0	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.
63.4	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.
63.8	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.
64.2	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.
64.6	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.
65.0	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.
65.4	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.
65.7	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	68.	68.	67.	67.	66.	66.
66.1	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.
66.5	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.
66.9	80.	80.	79.	79.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.
67.3	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.
67.7	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.
68.1	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.
68.5	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.
68.9	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.
69.3	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.
69.7	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.
70.1	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.
70.5	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.
70.9	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.
71.3	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.
71.7	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.
72.0	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.	77.	77.	76.
72.4	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	77.	77.
72.8	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.	78.
73.2	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.	78.
73.6	91.	91.	90.	90.	89.	89.	88.	88.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.	79.	79.
74.0	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.	80.
74.4	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.	80.
74.8	93.	92.	92.	91.	91.	90.	90.	89.	89.	88.	88.	87.	87.	86.	86.	85.	85.	84.	84.	83.	83.	82.	82.	81.	81.

PREDICTION EQUATIONS FOR MVV FEMALES * 60% OF PREDICTED **

HEIGHT (IN)	AGE (YEARS) 47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71
51.2	41.	41.	40.	39.	40.	40.	39.	38.	37.	37.	36.	36.	35.	35.	34.	34.	33.	33.	32.	32.	31.	31.	30.	30.	29.
51.5	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.	36.	35.	35.	34.	34.	33.	33.	32.	32.	31.	31.	30.
52.0	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.	36.	35.	35.	34.	34.	33.	33.	32.	32.	31.	31.
52.4	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.	36.	35.	35.	34.	34.	33.	33.	32.	32.	31.
52.8	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.	36.	35.	35.	34.	34.	33.	32.	32.
53.3	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.	36.	35.	35.	34.	34.	33.	33.
53.9	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.	36.	35.	35.	34.	34.	33.
54.3	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.	36.	35.	35.	34.	34.
54.7	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.	36.	35.	35.
55.1	48.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.	36.	35.
55.5	49.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.	37.	36.
55.9	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.	37.
56.3	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.	38.	38.
56.7	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.	39.
57.1	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.	39.
57.6	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.	40.	40.
58.3	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.	41.	41.
58.7	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.	42.
59.1	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.	42.
59.4	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.	43.
59.8	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.	43.
60.2	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.	44.	44.
60.6	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.	45.	45.
61.0	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.	46.
61.4	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.	46.
61.8	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.	47.	47.
62.2	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.	48.
62.6	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.	48.
63.0	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.	49.
63.4	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.	49.
63.8	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.	50.
64.2	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.	50.
64.6	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.	51.
65.0	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.	51.
65.4	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.	52.
65.7	65.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.	52.
66.1	65.	65.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.	53.
66.5	66.	65.	65.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.	53.
66.9	67.	66.	65.	65.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.	55.	54.	54.
67.3	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.	55.
67.7	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.	56.
68.1	69.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.	57.	56.
68.5	70.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.	58.	57.
68.9	71.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.	58.
69.3	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.	59.	59.
69.7	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.	60.	60.
70.1	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.	61.
70.5	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.	61.
70.9	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.	62.	62.
71.3	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.	63.
71.7	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.	63.
72.0	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.	64.
72.4	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.	64.
72.8	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.	65.	65.
73.2	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.	66.
73.6	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.	66.
74.0	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.	67.	67.
74.4	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.	68.
74.8	80.	80.	79.	79.	78.	78.	77.	77.	76.	76.	75.	75.	74.	74.	73.	73.	72.	72.	71.	71.	70.	70.	69.	69.	68.

APPENDIX C TO PART 718—BLOOD-GAS TABLES

The following tables set forth the values to be applied in determining whether total disability may be established in accordance with §718.204(b)(2)(ii). The values contained in the tables are indicative of impairment only. They do not establish a degree of disability except as provided in §718.204(b)(2)(ii) of this subchapter, nor do they establish standards for determining normal alveolar gas exchange values for any particular individual. Tests must not be performed during or soon after an acute respiratory or cardiac illness. A miner who meets the following medical specifications must be found to be totally disabled, in the absence of rebutting evidence, if the values specified in one of the following tables are met:

(1) For arterial blood-gas studies performed at test sites up to 2,999 feet above sea level:

Arterial PCO2 (mm Hg)	Arterial PO2 equal to or less than (mm Hg)
25 or below	75
26	74
27	73
28	72
29	71
30	70
31	69
32	68
33	67
34	66
35	65
36	64
37	63
38	62
39	61
40–49	60
Above 50	(1)

[1] Any value.

(2) For arterial blood-gas studies performed at test sites 3,000 to 5,999 feet above sea level:

Arterial PCO2 (mm Hg)	Arterial PO2 equal to or less than (mm Hg)
25 or below	70
26	69
27	68
28	67
29	66
30	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40–49	55
Above 50	(2)

[2] Any value.

(3) For arterial blood-gas studies performed at test sites 6,000 feet or more above sea level:

Arterial PCO2 (mm Hg)	Arterial PO2 equal to or less than (mm Hg)
25 or below	65
26	64
27	63
28	62
29	61
30	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40–49	50
Above 50	(3)

[3] Any value.

[65 FR 80045, Dec. 20, 2000, as amended at 78 FR 59115, Sept. 25, 2013]

PART 722—CRITERIA FOR DETERMINING WHETHER STATE WORKERS' COMPENSATION LAWS PROVIDE ADEQUATE COVERAGE FOR PNEUMOCONIOSIS AND LISTING OF APPROVED STATE LAWS

Sec.
722.1 Purpose.
722.2 Definitions.
722.3 General criteria; inclusion in and removal from the Secretary's list.
722.4 The Secretary's list.

AUTHORITY: 5 U.S.C. 301, Reorganization Plan No. 6 of 1950, 15 FR 3174, 30 U.S.C. 901 *et seq.*, 921, 932, 936; 33 U.S.C. 901 *et seq.*, Secretary's Order 7–87, 52 FR 48466, Employment Standards Order No. 90–02.

SOURCE: 65 FR 80053, Dec. 20, 2000, unless otherwise noted.

§ 722.1 Purpose.

Section 421 of the Black Lung Benefits Act provides that a claim for benefits based on the total disability or death of a coal miner due to pneumoconiosis must be filed under a State workers' compensation law where such law provides adequate coverage for pneumoconiosis. A State workers' compensation law may be deemed to provide adequate coverage only when it is included on a list of such laws maintained by the Secretary. The purpose of this part is to set forth the procedures and criteria for inclusion on that list, and to provide that list.

§ 722.2 Definitions.

(a) The definitions and use of terms contained in subpart A of part 725 of this title shall be applicable to this part.

(b) For purposes of this part, the following definitions apply:

(1) *State agency* means, with respect to any State, the agency, department or officer designated by the workers' compensation law of the State to administer such law. In any case in which more than one agency participates in the administration of a State workers' compensation law, the Governor of the State may designate which of the agencies shall be the State agency for purposes of this part.

(2) *The Secretary's list* means the list published by the Secretary of Labor in the FEDERAL REGISTER (see § 722.4) containing the names of those States which have in effect a workers' compensation law which provides adequate coverage for death or total disability due to pneumoconiosis.

§ 722.3 General criteria; inclusion in and removal from the Secretary's list.

(a) The Governor of any State or any duly authorized State agency may, at any time, request that the Secretary include such State's workers' compensation law on his list of those State workers' compensation laws providing adequate coverage for total disability or death due to pneumoconiosis. Each such request shall include a copy of the State workers' compensation law and any other pertinent State laws; a copy of any regulations, either proposed or promulgated, implementing such laws; and a copy of any relevant administrative or court decision interpreting such laws or regulations, or, if such decisions are published in a readily available report, a citation to such decision.

(b) Upon receipt of a request that a State be included on the Secretary's list, the Secretary shall include the State on the list if he finds that the State's workers' compensation law guarantees the payment of monthly and medical benefits to all persons who would be entitled to such benefits under the Black Lung Benefits Act at the time of the request, at a rate no less than that provided by the Black Lung Benefits Act. The criteria used by the Secretary in making such determination shall include, but shall not be limited to, the criteria set forth in section 421(b)(2) of the Act.

(c) The Secretary may require each State included on the list to submit reports detailing the extent to which the State's workers' compensation laws, as reflected by statute, regulation, or administrative or court decision, continues to meet the requirements of paragraph (b) of this section. If the Secretary concludes that the State's workers' compensation law does not provide adequate coverage at any time, either because of changes to the State workers' compensation law or the Black Lung Benefits Act, he shall remove the State from the Secretary's list after providing the State with notice of such removal and an opportunity to be heard.

§ 722.4 The Secretary's list.

(a) The Secretary has determined that publication of the Secretary's list in the Code of Federal Regulations is appropriate. Accordingly, in addition to its publication in the FEDERAL REGISTER as required by section 421 of the Black Lung Benefits Act, the list shall also appear in paragraph (b) of this section.

(b) Upon review of all requests filed with the Secretary under section 421 of the Black Lung Benefits Act and this part, and examination of the workers' compensation laws of the States making such requests, the Secretary has determined that the workers' compensation law of each of the following listed States, for the period from the date shown in the list until such date as the Secretary may make a contrary determination, provides adequate coverage for pneumoconiosis.

State	Period commencing
None	

PART 725—CLAIMS FOR BENEFITS UNDER PART C OF TITLE IV OF THE FEDERAL MINE SAFETY AND HEALTH ACT, AS AMENDED

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AUTHORITY: 5 U.S.C. 301; Reorganization Plan No. 6 of 1950, 15 FR 3174; 30 U.S.C. 901 *et seq.*, 902(f), 921, 932, 936; 33 U.S.C. 901 *et seq.;* 42 U.S.C. 405; Secretary's Order 10–2009, 74 FR 58834.

SOURCE: 65 FR 80054, Dec. 20, 2000, unless otherwise noted.

Subpart A—General

§ 725.1 Statutory provisions.

(a) *General*. Subchapter IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972, the Federal Mine Safety and Health Amendments Act of 1977, the Black Lung Benefits Reform Act of 1977, the Black Lung Benefits Revenue Act of 1977, the Black Lung Benefits Amendments of 1981, the Black Lung Benefits Revenue Act of 1981, the Black Lung Consolidation of Responsibility Act of 2002, and the Patient Protection and Affordable Care Act of 2010 (together comprising the Black Lung Benefits Act (*see* § 725.101(a)(1)) provides for the payment of benefits to certain disabled coal miners and their survivors. *See* § 725.201.

(b) *Part B*. Part B of subchapter IV of the Act provided that claims filed before July 1, 1973 were to be filed with, and adjudicated and administered by, the Social Security Administration (SSA). If awarded, these claims were paid by SSA out of appropriated funds. The Black Lung Consolidation of Administrative Responsibility Act (*see* paragraph (h) of this section) transferred all responsibility for continued administration of these claims to the Department of Labor.

(c) *Part C*. Claims filed by a miner or survivor on or after January 1, 1974, are filed, adjudicated, and paid under the provisions of part C of subchapter IV of the Act. Part C requires that a claim filed on or after January 1, 1974, shall be filed under an applicable approved State workers' compensation law, or if no such law has been approved by the Secretary of Labor, the claim may be filed with the Secretary of Labor under Section 422 of the Act. Claims filed with the Secretary of Labor under part C are processed and adjudicated by the Secretary. Individual coal mine operators are primarily liable for benefits; however, if the miner's last coal mine employment terminated before January 1, 1970, or if no responsible operator can be identified, benefits are paid by the Black Lung Disability Trust Fund. Claims adjudicated under part C are subject to certain incorporated provisions of the Longshore and Harbor Workers' Compensation Act.

(d) *Changes made by the Black Lung Benefits Reform Act of 1977*. The Black Lung Benefits Reform Act of 1977 contains a number of significant amendments to the Act's standards for determining eligibility for benefits. Among these are:

(1) A provision which clarifies the definition of ''pneumoconiosis'' to include any ''chronic dust disease of the

lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment'';

(2) A provision which defines ''miner'' to include any person who works or has worked in or around a coal mine or coal preparation facility, and in coal mine construction or coal transportation under certain circumstances;

(3) A provision that continued employment in a coal mine is not conclusive proof that a miner is not or was not totally disabled;

(4) A provision which authorizes the Secretary of Labor to establish standards and develop criteria for determining total disability or death due to pneumoconiosis with respect to a part C claim;

(5) Provisions relating to the treatment to be accorded a survivor's affidavit, certain X-ray interpretations, and certain autopsy reports in the development of a claim; and

(6) Other clarifying, procedural, and technical amendments.

(e) *Changes made by the Black Lung Benefits Revenue Act of 1977*. The Black Lung Benefits Revenue Act of 1977 established the Black Lung Disability Trust Fund which is financed by a specified tax imposed upon each ton of coal (except lignite) produced and sold or used in the United States after March 31, 1978. The Secretary of the Treasury is the managing trustee of the fund and benefits are paid from the fund upon the direction of the Secretary of Labor. The fund was made liable for the payment of all claims approved under part C of the Act for all periods of eligibility occurring on or after January 1, 1974, with respect to claims where the miner's last coal mine employment terminated before January 1, 1970, or where individual liability can not be assessed against a coal mine operator due to bankruptcy, insolvency, or the like. The fund was also authorized to pay certain claims which a responsible operator has refused to pay within a reasonable time, and to seek reimbursement from such operator. The purpose of the fund and the Black Lung Benefits Revenue Act of 1977 was to insure that coal mine operators, or the coal industry, will fully bear the cost of black lung disease for the present time and in the future. The Black Lung Benefits Revenue Act of 1977 also contained other provisions relating to the fund and authorized a coal mine operator to establish its own trust fund for the payment of certain claims.

(f) *Changes made by the Black Lung Benefits Amendments of 1981*. The Black Lung Benefits Amendments of 1981 made a number of significant changes in the Act's standards for determining eligibility for benefits and concerning the payment of such benefits, and applied the changes to claims filed on or after January 1, 1982. Among these are:

(1) The Secretary of Labor may reread any X-ray submitted in support of a claim and may rely upon a second opinion concerning such an X-ray as a means of auditing the validity of the claim;

(2) The rebuttable presumption that the total disability of a miner with fifteen or more years employment in the coal mines, who has demonstrated a totally disabling respiratory or pulmonary impairment, is due to pneumoconiosis is no longer applicable (but the presumption was reinstated for claims filed after January 1, 2005, and pending on or after March 23, 2010, by the Patient Protection and Affordable Care Act of 2010 (*see* paragraph (i) of this section));

(3) In the case of deceased miners, where no medical or other relevant evidence is available, only affidavits from persons not eligible to receive benefits as a result of the adjudication of the claim will be considered sufficient to establish entitlement to benefits;

(4) Unless the miner was found entitled to benefits as a result of a claim filed prior to January 1, 1982, benefits are payable on survivors' claims filed on and after January 1, 1982, only when the miner's death was due to pneumoconiosis (but for survivors' claims filed after January 1, 2005, and pending on or after March 23, 2010, an award of a miner's claim may form the basis for a survivor's entitlement under the Patient Protection and Affordable Care Act of 2010 (*see* paragraph (i) of this section));

(5) Benefits payable under this part are subject to an offset on account of excess earnings by the miner; and

(6) Other technical amendments.

(g) *Changes made by the Black Lung Benefits Revenue Act of 1981.* The Black Lung Benefits Revenue Act of 1981 temporarily doubles the amount of the tax upon coal until the fund has repaid all advances received from the United States Treasury and the interest on all such advances. With respect to claims filed on or after January 1, 1982, the fund's authorization for the payment of interim benefits is limited to the payment of prospective benefits only. These changes also define the rates of interest to be paid to and by the fund.

(h) *Changes made by the Black Lung Consolidation of Administrative Responsibility Act.* The Black Lung Consolidation of Administrative Responsibility Act of 2002 transferred administrative responsibility for all claims previously filed with or administered by the Social Security Administration to the Department of Labor, effective January 31, 2003. As a result, certain obsolete provisions in the BLBA (30 U.S.C. 904, 924a, and 945) were repealed. Various technical changes were made to other statutory provisions.

(i) *Changes made by the Patient Protection and Affordable Care Act of 2010.* The Patient Protection and Affordable Care Act of 2010 (the ACA) changed the entitlement criteria for miners' and survivors' claims filed after January 1, 2005, and pending on or after March 23, 2010, by reinstating two provisions made inapplicable by the Black Lung Benefits Amendments of 1981.

(1) For miners' claims meeting these date requirements, the ACA reinstated the rebuttable presumption that the miner is (or was) totally disabled due to pneumoconiosis if the miner has (or had) 15 or more years of qualifying coal mine employment and a totally disabling respiratory or pulmonary impairment.

(2) For survivors' claims meeting these date requirements, the ACA made two changes. First, it reinstated the rebuttable presumption that the miner's death was due to pneumoconiosis if the miner had 15 years or more of qualifying coal mine employment and was totally disabled by a respiratory or pulmonary impairment at the time of death. Second, it reinstituted derivative survivors' entitlement. As a result, an eligible survivor will be entitled to benefits if the miner is or was found entitled to benefits on his or her lifetime claim based on total disability due to pneumoconiosis arising out of coal-mine employment.

(j) *Longshore Act provisions.* The adjudication of claims filed under part C of the Act (*i.e.*, claims filed on or after January 1, 1974) is governed by various procedural and other provisions contained in the Longshore and Harbor Workers' Compensation Act (LHWCA), as amended from time to time, which are incorporated within the Act by section 422. The incorporated LHWCA provisions are applicable under the Act except as is otherwise provided by the Act or as provided by regulations of the Secretary. Although occupational disease benefits are also payable under the LHWCA, the primary focus of the procedures set forth in that Act is upon a time-definite-traumatic injury or death. Because of this and other significant differences between a black lung and longshore claim, it is determined, in accordance with the authority set forth in Section 422 of the Act, that certain of the incorporated procedures prescribed by the LHWCA must be altered to fit the circumstances ordinarily confronted in the adjudication of a black lung claim. The changes made are based upon the Department's experience in processing black lung claims since July 1, 1973, and all such changes are specified in this part. No other departure from the incorporated provisions of the LHWCA is intended.

(k) *Social Security Act provisions.* Section 402 of Part A of the Act incorporates certain definitional provisions from the Social Security Act, 42 U.S.C. 301 *et seq.* Section 430 provides that the 1972, 1977 and 1981 amendments to part B of the Act shall also apply to part C ''to the extent appropriate.'' Sections 412 and 413 incorporate various provisions of the Social Security Act into part B of the Act. To the extent appropriate, therefore, these provisions also apply to part C. In certain cases, the Department has varied the terms of the Social Security Act provisions to accommodate the unique needs of the black lung benefits program. Parts of the Longshore and Harbor Workers'

Compensation Act are also incorporated into part C. Where the incorporated provisions of the two acts are inconsistent, the Department has exercised its broad regulatory powers to choose the extent to which each incorporation is appropriate. Finally, Section 422(g), contained in part C of the Act, incorporates 42 U.S.C. 403(b)–(l).

[78 FR 59115, Sept. 25, 2013]

§ 725.2 Purpose and applicability of this part.

(a) This part sets forth the procedures to be followed and standards to be applied in filing, processing, adjudicating, and paying claims filed under part C of subchapter IV of the Act.

(b) This part applies to all claims filed under part C of subchapter IV of the Act on or after June 30, 1982. Publication of certain provisions or parts of certain provisions that apply only to claims filed prior to June 30, 1982, or to claims subject to Section 435 of the Act, has been discontinued because those provisions affect an increasingly smaller number of claims. The version of Part 725 set forth in 20 CFR, parts 500 to end, edition revised as of April 1, 2010, applies to the adjudication of all claims filed prior to June 30, 1982, as appropriate.

(c) The provisions of this part reflect revisions that became effective on January 19, 2001. This part applies to all claims filed after January 19, 2001 and all benefits payments made on such claims. With the exception of the following sections, this part also applies to the adjudication of claims that were pending on January 19, 2001 and all benefits payments made on such claims: §§ 725.101(a)(31), 725.204, 725.212(b), 725.213(c), 725.214(d), 725.219(d), 725.309, 725.310, 725.351, 725.360, 725.367, 725.406, 725.407, 725.408, 725.409, 725.410, 725.411, 725.412, 725.414, 725.415, 725.416, 725.417, 725.418, 725.421(b), 725.423, 725.454, 725.456, 725.457, 725.458, 725.459, 725.465, 725.491, 725.492, 725.493, 725.494, 725.495, 725.547, 725.701(e). The version of those sections set forth in 20 CFR, parts 500 to end, edition revised as of April 1, 1999, apply to the adjudications of claims that were pending on January 19, 2001. For purposes of construing the provisions of this section, a claim will be considered pending on January 19, 2001 if it was not finally denied more than one year prior to that date.

[78 FR 59117, Sept. 25, 2013]

§ 725.3 Contents of this part.

(a) This subpart describes the statutory provisions which relate to claims considered under this part, the purpose and scope of this part, definitions and usages of terms applicable to this part, and matters relating to the availability of information collected by the Department of Labor in connection with the processing of claims.

(b) Subpart B contains criteria for determining who may be found entitled to benefits under this part and other provisions relating to the conditions and duration of eligibility of a particular individual.

(c) Subpart C describes the procedures to be followed and action to be taken in connection with the filing of a claim under this part.

(d) Subpart D sets forth the duties and powers of the persons designated by the Secretary of Labor to adjudicate claims and provisions relating to the rights of parties and representatives of parties.

(e) Subpart E contains the procedures for developing evidence and adjudicating entitlement and liability issues by the district director.

(f) Subpart F describes the procedures to be followed if a hearing before the Office of Administrative Law Judges is required.

(g) Subpart G contains provisions governing the identification of a coal mine operator which may be liable for the payment of a claim.

(h) Subpart H contains provisions governing the payment of benefits with respect to an approved claim.

(i) Subpart I describes the statutory mechanisms provided for the enforcement of a coal mine operator's liability, sets forth the penalties which may be applied in the case of a defaulting coal mine operator, and describes the obligation of coal operators and their insurance carriers to file certain reports.

(j) Subpart J describes the right of certain beneficiaries to receive medical treatment benefits and vocational rehabilitation under the Act.

§ 725.4 Applicability of other parts in this title.

(a) Part 718. Part 718 of this subchapter, which contains the criteria and standards to be applied in determining whether a miner is or was totally disabled due to pneumoconiosis, or whether a miner died due to pneumoconiosis, shall be applicable to the determination of claims under this part. Claims filed after March 31, 1980, are subject to part 718 as promulgated by the Secretary in accordance with section 402(f)(1) of the Act on February 29, 1980 (see § 725.2(c)). The criteria contained in subpart C of part 727 of this subchapter are applicable in determining claims filed prior to April 1, 1980, under this part, and such criteria shall be applicable at all times with respect to claims filed under this part and under section 11 of the Black Lung Benefits Reform Act of 1977.

(b) *Parts 715, 717, and 720.* Pertinent and significant provisions of Parts 715, 717, and 720 of this subchapter (formerly contained in 20 CFR, parts 500 to end, edition revised as of April 1, 1978), which established the procedures for the filing, processing, and payment of claims filed under section 415 of the Act, are included within this part as appropriate.

(c) *Part 726.* Part 726 of this subchapter, which sets forth the obligations imposed upon a coal operator to insure or self-insure its liability for the payment of benefits to certain eligible claimants, is applicable to this part as appropriate.

(d) *Part 727.* Part 727 of this subchapter, which governs the review, adjudication and payment of pending and denied claims under section 435 of the Act, is applicable with respect to such claims. The criteria contained in subpart C of part 727 for determining a claimant's eligibility for benefits are applicable under this part with respect to all claims filed before April 1, 1980, and to all claims filed under this part and under section 11 of the Black Lung Benefits Reform Act of 1977. Because the part 727 regulations affect an increasingly smaller number of claims, however, the Department has discontinued publication of the criteria in the Code of Federal Regulations. The part 727 criteria may be found at 43 FR 36818, Aug. 18, 1978 or 20 CFR, parts 500 to end, edition revised as of April 1, 1999.

(e) *Part 410.* Part 410 of this title, which sets forth provisions relating to a claim for black lung benefits under part B of title IV of the Act, is inapplicable to this part except as is provided in this part, or in part 718 of this subchapter.

§ 725.101 Definition and use of terms.

(a) *Definitions.* For purposes of this subchapter, except where the content clearly indicates otherwise, the following definitions apply:

(1) The *Act* means the Black Lung Benefits Act, 30 U.S.C. 901–44, as amended.

(2) The *Longshore Act* or *LHWCA* means the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901–950, as amended from time to time.

(3) The *Social Security Act* means the Social Security Act, Act of August 14, 1935, c. 531, 49 Stat. 620, 42 U.S.C. 301–431, as amended from time to time.

(4) *Administrative law judge* means a person qualified under *5 U.S.C. 3105* to conduct hearings and adjudicate claims for benefits filed pursuant to section 415 and part C of the Act. Until March 1, 1979, it also means an individual appointed to conduct such hearings and adjudicate such claims under Public Law 94–504.

(5) *Beneficiary* means a miner or any surviving spouse, divorced spouse, child, parent, brother or sister, who is entitled to benefits under either section 415 or part C of title IV of the Act.

(6) *Benefits* means all money or other benefits paid or payable under section 415 or part C of title IV of the Act on account of disability or death due to pneumoconiosis, including augmented benefits (see § 725.520(c)). The term also includes any expenses related to the medical examination and testing authorized by the district director pursuant to § 725.406.

(7) *Benefits Review Board* or *Board* means the Benefits Review Board, U.S. Department of Labor, an appellate tribunal appointed by the Secretary of Labor pursuant to the provisions of section 21(b)(1) of the LHWCA. See parts 801 and 802 of this title.

(8) *Black Lung Disability Trust Fund* or the *fund* means the Black Lung Disability Trust Fund established by the Black Lung Benefits Revenue Act of 1977, as amended by the Black Lung Benefits Revenue Act of 1981, for the payment of certain claims adjudicated under this part (see subpart G of this part).

(9) *Chief Administrative Law Judge* means the Chief Administrative Law Judge of the Office of Administrative Law Judges, U.S. Department of Labor, 800 K Street, NW., suite 400, Washington, DC 20001–8002.

(10) *Claim* means a written assertion of entitlement to benefits under section 415 or part C of title IV of the Act, submitted in a form and manner authorized by the provisions of this subchapter.

(11) *Claimant* means an individual who files a claim for benefits under this part.

(12) *Coal mine* means an area of land and all structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations and other property, real or personal, placed upon, under or above the surface of such land by any person, used in, or to be used in, or resulting from, the work of extracting in such area bituminous coal, lignite or anthracite from its natural deposits in the earth by any means or method, and in the work of preparing the coal so extracted, and includes custom coal preparation facilities.

(13) *Coal preparation* means the breaking, crushing, sizing, cleaning, washing, drying, mixing, storing and loading of bituminous coal, lignite or anthracite, and such other work of preparing coal as is usually done by the operator of a coal mine.

(14) *Department* means the United States Department of Labor.

(15) *Director* means the Director, OWCP, or his or her designee.

(16) *District Director* means a person appointed as provided in sections 39 and 40 of the LHWCA, or his or her designee, who is authorized to develop and adjudicate claims as provided in this subchapter (see § 725.350). The term District Director is substituted for the term Deputy Commissioner wherever that term appears in the regulations. This substitution is for administrative purposes only and in no way affects the power or authority of the position as established in the statute. Any action taken by a person under the authority of a district director will be considered the action of a deputy commissioner.

(17) *Division* or *DCMWC* means the Division of Coal Mine Workers' Compensation in the OWCP, United States Department of Labor.

(18) *Insurer* or *carrier* means any private company, corporation, mutual association, reciprocal or interinsurance exchange, or any other person or fund, including any State fund, authorized under the laws of a State to insure employers' liability under workers' compensation laws. The term also includes the Secretary of Labor in the exercise of his or her authority under section 433 of the Act.

(19) *Miner* or *coal miner* means any individual who works or has worked in or around a coal mine or coal preparation facility in the extraction or preparation of coal. The term also includes an individual who works or has worked in coal mine construction or transportation in or around a coal mine, to the extent such individual was exposed to coal mine dust as a result of such employment (see § 725.202). For purposes of this definition, the term does not include coke oven workers.

(20) *The Nation's coal mines* means all coal mines located in any State.

(21) *Office* or *OWCP* means the Office of Workers' Compensation Programs, United States Department of Labor.

(22) *Office of Administrative Law Judges* means the Office of Administrative Law Judges, U.S. Department of Labor.

(23) *Operator* means any owner, lessee, or other person who operates, controls or supervises a coal mine, including a prior or successor operator as defined in section 422 of the Act and certain transportation and construction employers (see subpart G of this part).

(24) *Person* means an individual, partnership, association, corporation, firm, subsidiary or parent of a corporation, or other organization or business entity.

(25) *Pneumoconiosis* means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of

coal mine employment (see part 718 of this subchapter).

(26) *Responsible operator* means an operator which has been determined to be liable for the payment of benefits to a claimant for periods of eligibility after December 31, 1973, with respect to a claim filed under section 415 or part C of title IV of the Act or reviewed under section 435 of the Act.

(27) *Secretary* means the Secretary of Labor, United States Department of Labor, or a person, authorized by him or her to perform his or her functions under title IV of the Act.

(28) *State* includes any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, the Trust Territory of the Pacific Islands, and prior to January 3, 1959, and August 21, 1959, respectively, the territories of Alaska and Hawaii.

(29) *Total disability* and *partial disability*, for purposes of this part, have the meaning given them as provided in part 718 of this subchapter.

(30) *Underground coal mine* means a coal mine in which the earth and other materials which lie above and around the natural deposit of coal (*i.e.*, overburden) are not removed in mining; including all land, structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations and other property, real or personal, appurtenant thereto.

(31) A *workers' compensation law* means a law providing for payment of benefits to employees, and their dependents and survivors, for disability on account of injury, including occupational disease, or death, suffered in connection with their employment. A payment funded wholly out of general revenues shall not be considered a payment under a workers' compensation law.

(32) *Year* means a period of one calendar year (365 days, or 366 days if one of the days is February 29), or partial periods totaling one year, during which the miner worked in or around a coal mine or mines for at least 125 ''working days.'' A ''working day'' means any day or part of a day for which a miner received pay for work as a miner, but shall not include any day for which the miner received pay while on an approved absence, such as vacation or sick leave. In determining whether a miner worked for one year, any day for which the miner received pay while on an approved absence, such as vacation or sick leave, may be counted as part of the calendar year and as partial periods totaling one year.

(i) If the evidence establishes that the miner worked in or around coal mines at least 125 working days during a calendar year or partial periods totaling one year, then the miner has worked one year in coal mine employment for all purposes under the Act. If a miner worked fewer than 125 working days in a year, he or she has worked a fractional year based on the ratio of the actual number of days worked to 125. Proof that the miner worked more than 125 working days in a calendar year or partial periods totaling a year, does not establish more than one year.

(ii) To the extent the evidence permits, the beginning and ending dates of all periods of coal mine employment must be ascertained. The dates and length of employment may be established by any credible evidence including (but not limited to) company records, pension records, earnings statements, coworker affidavits, and sworn testimony. If the evidence establishes that the miner's employment lasted for a calendar year or partial periods totaling a 365-day period amounting to one year, it must be presumed, in the absence of evidence to the contrary, that the miner spent at least 125 working days in such employment.

(iii) If the evidence is insufficient to establish the beginning and ending dates of the miner's coal mine employment, or the miner's employment lasted less than a calendar year, then the adjudication officer may use the following formula: divide the miner's yearly income from work as a miner by the coal mine industry's average daily earnings for that year, as reported by the Bureau of Labor Statistics (BLS). A copy of the BLS table must be made a part of the record if the adjudication officer uses this method to establish the length of the miner's work history.

(iv) Periods of coal mine employment occurring outside the United States must not be considered in computing the miner's work history.

(b) *Statutory terms.* The definitions contained in this section must not be construed in derogation of terms of the Act.

(c) *Dependents and survivors.* Dependents and survivors are those persons described in subpart B of this part.

[65 FR 80054, Dec. 20, 2000, as amended at 77 FR 37286, June 21, 2012; 78 FR 59117, Sept. 25, 2013]

§ 725.102 Disclosure of program information.

(a) All reports, records, or other documents filed with the OWCP with respect to claims are the records of the OWCP. The Director or his or her designee shall be the official custodian of those records maintained by the OWCP at its national office. The District Director shall be the official custodian of those records maintained at a district office.

(b) The official custodian of any record sought to be inspected shall permit or deny inspection in accordance with the Department of Labor's regulations pertaining thereto (see 29 CFR Part 70). The original record in any such case shall not be removed from the Office of the custodian for such inspection. The custodian may, in his or her discretion, deny inspection of any record or part thereof which is of a character specified in 5 U.S.C. 552(b) if in his or her opinion such inspection may result in damage, harm, or harassment to the beneficiary or to any other person. For special provisions concerning release of information regarding injured employees undergoing vocational rehabilitation, see § 702.508 of this chapter.

(c) Any person may request copies of records he or she has been permitted to inspect. Such requests shall be addressed to the official custodian of the records sought to be copied. The official custodian shall provide the requested copies under the terms and conditions specified in the Department of Labor's regulations relating thereto (see 29 CFR Part 70).

(d) Any party to a claim (§ 725.360) or his or her duly authorized representative shall be permitted upon request to inspect the file which has been compiled in connection with such claim. Any party to a claim or representative of such party shall upon request be provided with a copy of any or all material contained in such claim file. A request for information by a party or representative made under this paragraph shall be answered within a reasonable time after receipt by the Office. Internal documents prepared by the district director which do not constitute evidence of a fact which must be established in connection with a claim shall not be routinely provided or presented for inspection in accordance with a request made under this paragraph.

§ 725.103 Burden of proof.

Except as otherwise provided in this part and part 718, the burden of proving a fact alleged in connection with any provision shall rest with the party making such allegation.

Subpart B—Persons Entitled to Benefits, Conditions, and Duration of Entitlement

§ 725.201 Who is entitled to benefits; contents of this subpart.

(a) Part C of the Act provides for the payment of periodic benefits in accordance with this part to:

(1) A miner who meets the conditions of entitlement set forth in § 725.202(d); or

(2) The surviving spouse or surviving divorced spouse of a deceased miner who meets the conditions of entitlement set forth in § 725.212; or,

(3) Where neither exists, the child of a deceased miner who meets the conditions of entitlement set forth in § 725.218; or

(4) The surviving dependent parents, where there is no surviving spouse or child, or the surviving dependent brothers or sisters, where there is no surviving spouse, child, or parent, of a miner, who meet the conditions of entitlement set forth in § 725.222; or

(5) The child of a miner's surviving spouse who was receiving benefits under Part C of the Act at the time of such spouse's death.

(b) The provisions contained in this subpart describe the conditions of entitlement to benefits applicable to a miner, or a surviving spouse, child, parent, brother, or sister, and the

events which establish or terminate entitlement to benefits.

(c) In order for an entitled miner or surviving spouse to qualify for augmented benefits because of one or more dependents, such dependents must meet relationship and dependency requirements with respect to such beneficiary prescribed by or pursuant to the Act. Such requirements are also set forth in this subpart.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 59117, Sept. 25, 2013]

CONDITIONS AND DURATION OF ENTITLEMENT: MINER

§ 725.202 Miner defined; condition of entitlement, miner.

(a) *Miner defined.* A ''miner'' for the purposes of this part is any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal, and any person who works or has worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. There shall be a rebuttable presumption that any person working in or around a coal mine or coal preparation facility is a miner. This presumption may be rebutted by proof that:

(1) The person was not engaged in the extraction, preparation or transportation of coal while working at the mine site, or in maintenance or construction of the mine site; or

(2) The individual was not regularly employed in or around a coal mine or coal preparation facility.

(b) *Coal mine construction and transportation workers; special provisions.* A coal mine construction or transportation worker shall be considered a miner to the extent such individual is or was exposed to coal mine dust as a result of employment in or around a coal mine or coal preparation facility. A transportation worker shall be considered a miner to the extent that his or her work is integral to the extraction or preparation of coal. A construction worker shall be considered a miner to the extent that his or her work is integral to the building of a coal or underground mine (see § 725.101(a)(12), (30)).

(1) There shall be a rebuttable presumption that such individual was exposed to coal mine dust during all periods of such employment occurring in or around a coal mine or coal preparation facility for purposes of:

(i) Determining whether such individual is or was a miner;

(ii) Establishing the applicability of any of the presumptions described in section 411(c) of the Act and part 718 of this subchapter; and

(iii) Determining the identity of a coal mine operator liable for the payment of benefits in accordance with § 725.495.

(2) The presumption may be rebutted by evidence which demonstrates that:

(i) The individual was not regularly exposed to coal mine dust during his or her work in or around a coal mine or coal preparation facility; or

(ii) The individual did not work regularly in or around a coal mine or coal preparation facility.

(c) A person who is or was a self-employed miner or independent contractor, and who otherwise meets the requirements of this paragraph, shall be considered a miner for the purposes of this part.

(d) *Conditions of entitlement; miner.* An individual is eligible for benefits under this subchapter if the individual:

(1) Is a miner as defined in this section; and

(2) Has met the requirements for entitlement to benefits by establishing that he or she:

(i) Has pneumoconiosis (see § 718.202), and

(ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

(iii) Is totally disabled (see § 718.204(c)), and

(iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

(3) Has filed a claim for benefits in accordance with the provisions of this part.

§ 725.203 Duration and cessation of entitlement; miner.

(a) An individual is entitled to benefits as a miner for each month beginning with the first month on or after January 1, 1974, in which the miner is

totally disabled due to pneumoconiosis arising out of coal mine employment.

(b) The last month for which such individual is entitled to benefits is the month before the month during which either of the following events first occurs:

(1) The miner dies; or

(2) The miner's total disability ceases (see § 725.504).

(c) An individual who has been finally adjudged to be totally disabled due to pneumoconiosis and is receiving benefits under the Act shall promptly notify the Office and the responsible coal mine operator, if any, if he or she engages in his or her usual coal mine work or comparable and gainful work.

(d) Upon reasonable notice, an individual who has been finally adjudged entitled to benefits shall submit to any additional tests or examinations the Office deems appropriate, and shall submit medical reports and other relevant evidence the Office deems necessary, if an issue arises pertaining to the validity of the original award.

CONDITIONS AND DURATION OF ENTITLEMENT: MINER'S DEPENDENTS (AUGMENTED BENEFITS)

§ 725.204 Determination of relationship; spouse.

(a) For the purpose of augmenting benefits, an individual will be considered to be the spouse of a miner if:

(1) The courts of the State in which the miner is domiciled would find that such individual and the miner validly married; or

(2) The courts of the State in which the miner is domiciled would find, under the law they would apply in determining the devolution of the miner's intestate personal property, that the individual is the miner's spouse; or

(3) Under State law, such individual would have the right of a spouse to share in the miner's intestate personal property; or

(4) Such individual went through a marriage ceremony with the miner resulting in a purported marriage between them and which, but for a legal impediment, would have been a valid marriage, unless the individual entered into the purported marriage with knowledge that it was not a valid marriage, or if such individual and the miner were not living in the same household in the month in which a request is filed that the miner's benefits be augmented because such individual qualifies as the miner's spouse.

(b) The qualification of an individual for augmentation purposes under this section shall end with the month before the month in which:

(1) The individual dies, or

(2) The individual who previously qualified as a spouse for purposes of § 725.520(c), entered into a valid marriage without regard to this section, with a person other than the miner.

§ 725.205 Determination of dependency; spouse.

For the purposes of augmenting benefits, an individual who is the miner's spouse (see § 725.204) will be determined to be dependent upon the miner if:

(a) The individual is a member of the same household as the miner (see § 725.232); or

(b) The individual is receiving regular contributions from the miner for support (see § 725.233(c)); or

(c) The miner has been ordered by a court to contribute to such individual's support (see § 725.233(e)); or

(d) The individual is the natural parent of the son or daughter of the miner; or

(e) The individual was married to the miner (see § 725.204) for a period of not less than 1 year.

§ 725.206 Determination of relationship; divorced spouse.

For the purposes of augmenting benefits with respect to any claim considered or reviewed under this part or part 727 of this subchapter (see § 725.4(d)), an individual will be considered to be the divorced spouse of a miner if the individual's marriage to the miner has been terminated by a final divorce on or after the 10th anniversary of the marriage unless, if such individual was married to and divorced from the miner more than once, such individual was married to the miner in each calendar year of the period beginning 10 years immediately before the date on which any divorce became final.

§ 725.207 Determination of dependency; divorced spouse.

For the purpose of augmenting benefits, an individual who is the miner's divorced spouse (§ 725.206) will be determined to be dependent upon the miner if:

(a) The individual is receiving at least one-half of his or her support from the miner (see § 725.233(g)); or

(b) The individual is receiving substantial contributions from the miner pursuant to a written agreement (see § 725.233(c) and (f)); or

(c) A court order requires the miner to furnish substantial contributions to the individual's support (see § 725.233(c) and (e)).

§ 725.208 Determination of relationship; child.

As used in this section, the term ''beneficiary'' means only a surviving spouse entitled to benefits at the time of death (see § 725.212), or a miner. An individual will be considered to be the child of a beneficiary if:

(a) The courts of the State in which the beneficiary is domiciled (see § 725.231) would find, under the law they would apply, that the individual is the beneficiary's child; or

(b) The individual is the legally adopted child of such beneficiary; or

(c) The individual is the stepchild of such beneficiary by reason of a valid marriage of the individual's parent or adopting parent to such beneficiary; or

(d) The individual does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, but would, under State law, have the same right as a child to share in the beneficiary's intestate personal property; or

(e) The individual is the natural son or daughter of a beneficiary but is not a child under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) of this section if the beneficiary and the mother or the father, as the case may be, of the individual went through a marriage ceremony resulting in a purported marriage between them which but for a legal impediment (see § 725.230) would have been a valid marriage; or

(f) The individual is the natural son or daughter of a beneficiary but is not a child under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) or (e) of this section, such individual shall nevertheless be considered to be the child of the beneficiary if:

(1) The beneficiary, prior to his or her entitlement to benefits, has acknowledged in writing that the individual is his or her son or daughter, or has been decreed by a court to be the parent of the individual, or has been ordered by a court to contribute to the support of the individual (see § 725.233(e)) because the individual is his or her son or daughter; or

(2) Such beneficiary is shown by satisfactory evidence to be the father or mother of the individual and was living with or contributing to the support of the individual at the time the beneficiary became entitled to benefits.

§ 725.209 Determination of dependency; child.

(a) For purposes of augmenting the benefits of a miner or surviving spouse, the term ''beneficiary'' as used in this section means only a miner or surviving spouse entitled to benefits (see § 725.202 and § 725.212). An individual who is the beneficiary's child (§ 725.208) will be determined to be, or to have been, dependent on the beneficiary, if the child:

(1) Is unmarried; and

(2)(i) Is under 18 years of age; or

(ii) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d); or

(iii) Is 18 years of age or older and is a student.

(b)(1) The term ''student'' means a ''full-time student'' as defined in section 202(d)(7) of the Social Security Act, 42 U.S.C. 402(d)(7) (see §§ 404.367–404.369 of this title), or an individual under 23 years of age who has not completed 4 years of education beyond the high school level and who is regularly pursuing a full-time course of study or training at an institution which is:

(i) A school, college, or university operated or directly supported by the United States, or by a State or local

government or political subdivision thereof; or

(ii) A school, college, or university which has been accredited by a State or by a State-recognized or nationally-recognized accrediting agency or body; or

(iii) A school, college, or university not so accredited but whose credits are accepted, on transfer, by at least three institutions which are so accredited; or

(iv) A technical, trade, vocational, business, or professional school accredited or licensed by the Federal or a State government or any political subdivision thereof, providing courses of not less than 3 months' duration that prepare the student for a livelihood in a trade, industry, vocation, or profession.

(2) A student will be considered to be ''pursuing a full-time course of study or training at an institution'' if the student is enrolled in a noncorrespondence course of at least 13 weeks duration and is carrying a subject load which is considered full-time for day students under the institution's standards and practices. A student beginning or ending a full-time course of study or training in part of any month will be considered to be pursuing such course for the entire month.

(3) A child is considered not to have ceased to be a student:

(i) During any interim between school years, if the interim does not exceed 4 months and the child shows to the satisfaction of the Office that he or she has a bona fide intention of continuing to pursue a full-time course of study or training; or

(ii) During periods of reasonable duration in which, in the judgment of the Office, the child is prevented by factors beyond the child's control from pursuing his or her education.

(4) A student whose 23rd birthday occurs during a semester or the enrollment period in which such student is pursuing a full-time course of study or training shall continue to be considered a student until the end of such period, unless eligibility is otherwise terminated.

§ 725.210 Duration of augmented benefits.

Augmented benefits payable on behalf of a spouse or divorced spouse, or a child, shall begin with the first month in which the dependent satisfies the conditions of relationship and dependency set forth in this subpart. Augmentation of benefits on account of a dependent continues through the month before the month in which the dependent ceases to satisfy these conditions, except in the case of a child who qualifies as a dependent because such child is a student. In the latter case, benefits continue to be augmented through the month before the first month during no part of which such child qualifies as a student.

§ 725.211 Time of determination of relationship and dependency of spouse or child for purposes of augmentation of benefits.

With respect to the spouse or child of a miner entitled to benefits, and with respect to the child of a surviving spouse entitled to benefits, the determination as to whether an individual purporting to be a spouse or child is related to or dependent upon such miner or surviving spouse shall be based on the facts and circumstances present in each case, at the appropriate time.

CONDITIONS AND DURATION OF ENTITLEMENT: MINER'S SURVIVORS

§ 725.212 Conditions of entitlement; surviving spouse or surviving divorced spouse.

(a) An individual who is the surviving spouse or surviving divorced spouse of a miner is eligible for benefits if such individual:

(1) Is not married;

(2) Was dependent on the miner at the pertinent time; and

(3) The deceased miner either:

(i) Is determined to have died due to pneumoconiosis; or

(ii) Filed a claim for benefits on or after January 1, 1982, which results or resulted in a final award of benefits, and the surviving spouse or surviving divorced spouse filed a claim for benefits after January 1, 2005 which was pending on or after March 23, 2010.

(b) If more than one spouse meets the conditions of entitlement prescribed in paragraph (a), then each spouse will be considered a beneficiary for purposes of section 412(a)(2) of the Act without regard to the existence of any other entitled spouse or spouses.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 59117, Sept. 25, 2013]

§ 725.213 Duration of entitlement; surviving spouse or surviving divorced spouse.

(a) An individual is entitled to benefits as a surviving spouse, or as a surviving divorced spouse, for each month beginning with the first month in which all of the conditions of entitlement prescribed in § 725.212 are satisfied.

(b) The last month for which such individual is entitled to such benefits is the month before the month in which either of the following events first occurs:

(1) The surviving spouse or surviving divorced spouse marries; or

(2) The surviving spouse or surviving divorced spouse dies.

(c) A surviving spouse or surviving divorced spouse whose entitlement to benefits has been terminated pursuant to § 725.213(b)(1) may thereafter again become entitled to such benefits upon filing application for such reentitlement, beginning with the first month after the marriage ends and such individual meets the requirements of § 725.212. The individual shall not be required to reestablish the miner's entitlement to benefits (§ 725.212(a)(3)(i)) or the miner's death due to pneumoconiosis (§ 725.212(a)(3)(ii)).

§ 725.214 Determination of relationship; surviving spouse.

An individual shall be considered to be the surviving spouse of a miner if:

(a) The courts of the State in which the miner was domiciled (see § 725.231) at the time of his or her death would find that the individual and the miner were validly married; or

(b) The courts of the State in which the miner was domiciled (see § 725.231) at the time of the miner's death would find that the individual was the miner's surviving spouse; or

(c) Under State law, such individual would have the right of the spouse to share in the miner's intestate personal property; or

(d) Such individual went through a marriage ceremony with the miner, resulting in a purported marriage between them which, but for a legal impediment (see § 725.230), would have been a valid marriage, unless such individual entered into the purported marriage with knowledge that it was not a valid marriage, or if such individual and the miner were not living in the same household at the time of the miner's death.

§ 725.215 Determination of dependency; surviving spouse.

An individual who is the miner's surviving spouse (see § 725.214) shall be determined to have been dependent on the miner if, at the time of the miner's death:

(a) The individual was living with the miner (see § 725.232); or

(b) The individual was dependent upon the miner for support or the miner has been ordered by a court to contribute to such individual's support (see § 725.233); or

(c) The individual was living apart from the miner because of the miner's desertion or other reasonable cause; or

(d) The individual is the natural parent of the miner's son or daughter; or

(e) The individual had legally adopted the miner's son or daughter while the individual was married to the miner and while such son or daughter was under the age of 18; or

(f) The individual was married to the miner at the time both of them legally adopted a child under the age of 18; or

(g)(1) The individual was married to the miner for a period of not less than 9 months immediately before the day on which the miner died, unless the miner's death:

(i) Is accidental (as defined in paragraph (g)(2) of this section), or

(ii) Occurs in line of duty while the miner is a member of a uniformed service serving on active duty (as defined in § 404.1019 of this title), and the surviving spouse was married to the miner for a period of not less than 3 months immediately prior to the day on which such miner died.

(2) For purposes of paragraph (g)(1)(i) of this section, the death of a miner is accidental if such individual received bodily injuries solely through violent, external, and accidental means, and as a direct result of the bodily injuries and independently of all other causes, dies not later than 3 months after the day on which such miner receives such bodily injuries. The term ''accident'' means an event that was unpremeditated and unforeseen from the standpoint of the deceased individual. To determine whether the death of an individual did, in fact, result from an accident the adjudication officer will consider all the circumstances surrounding the casualty. An intentional and voluntary suicide will not be considered to be death by accident; however, suicide by an individual who is so incompetent as to be incapable of acting intentionally and voluntarily will be considered to be a death by accident. In no event will the death of an individual resulting from violent and external causes be considered a suicide unless there is direct proof that the fatal injury was self-inflicted.

(3) The provisions of paragraph (g) shall not apply if the adjudication officer determines that at the time of the marriage involved, the miner would not reasonably have been expected to live for 9 months.

§ 725.216 Determination of relationship; surviving divorced spouse.

An individual will be considered to be the surviving divorced spouse of a deceased miner in a claim considered under this part or reviewed under part 727 of this subchapter (see § 725.4(d)), if such individual's marriage to the miner had been terminated by a final divorce on or after the 10th anniversary of the marriage unless, if such individual was married to and divorced from the miner more than once, such individual was married to such miner in each calendar year of the period beginning 10 years immediately before the date on which any divorce became final and ending with the year in which the divorce became final.

§ 725.217 Determination of dependency; surviving divorced spouse.

An individual who is the miner's surviving divorced spouse (see § 725.216) shall be determined to have been dependent on the miner if, for the month before the month in which the miner died:

(a) The individual was receiving at least one-half of his or her support from the miner (see § 725.233(g)); or

(b) The individual was receiving substantial contributions from the miner pursuant to a written agreement (see § 725.233(c) and (f)); or

(c) A court order required the miner to furnish substantial contributions to the individual's support (see § 725.233(c) and (e)).

§ 725.218 Conditions of entitlement; child.

(a) An individual is entitled to benefits where he or she meets the required standards of relationship and dependency under this subpart (see § 725.220 and § 725.221) and is the child of a deceased miner who:

(1) Is determined to have died due to pneumoconiosis; or

(2) Filed a claim for benefits on or after January 1, 1982, which results or resulted in a final award of benefits, and the surviving child filed a claim for benefits after January 1, 2005 which was pending on or after March 23, 2010.

(b) A child is not entitled to benefits for any month for which a miner, or the surviving spouse or surviving divorced spouse of a miner, establishes entitlement to benefits.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 59117, Sept. 25, 2013]

§ 725.219 Duration of entitlement; child.

(a) An individual is entitled to benefits as a child for each month beginning with the first month in which all of the conditions of entitlement prescribed in § 725.218 are satisfied.

(b) The last month for which such individual is entitled to such benefits is the month before the month in which any one of the following events first occurs:

(1) The child dies;

(2) The child marries;

(3) The child attains age 18; and

(i) Is not a student (as defined in § 725.209(b)) during any part of the month in which the child attains age 18; and

(ii) Is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(4) If the child's entitlement beyond age 18 is based on his or her status as a student, the earlier of:

(i) The first month during no part of which the child is a student; or

(ii) The month in which the child attains age 23 and is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(5) If the child's entitlement beyond age 18 is based on disability, the first month in no part of which such individual is under a disability.

(c) A child whose entitlement to benefits terminated with the month before the month in which the child attained age 18, or later, may thereafter (provided such individual is not married) again become entitled to such benefits upon filing application for such reentitlement, beginning with the first month after termination of benefits in which such individual is a student and has not attained the age of 23.

(d) A child whose entitlement to benefits has been terminated pursuant to § 725.219(b)(2) may thereafter again become entitled to such benefits upon filing application for such reentitlement, beginning with the first month after the marriage ends and such individual meets the requirements of § 725.218. The individual shall not be required to reestablish the miner's entitlement to benefits (§ 725.218(a)(1)) or the miner's death due to pneumoconiosis (§ 725.212(a)(2)).

§ 725.220 Determination of relationship; child.

For purposes of determining whether an individual may qualify for benefits as the child of a deceased miner, the provisions of § 725.208 shall be applicable. As used in this section, the term ''beneficiary'' means only a surviving spouse entitled to benefits at the time of such surviving spouse's death (see § 725.212), or a miner. For purposes of a survivor's claim, an individual will be considered to be a child of a beneficiary if:

(a) The courts of the State in which such beneficiary is domiciled (see § 725.231) would find, under the law they would apply in determining the devolution of the beneficiary's intestate personal property, that the individual is the beneficiary's child; or

(b) Such individual is the legally adopted child of such beneficiary; or

(c) Such individual is the stepchild of such beneficiary by reason of a valid marriage of such individual's parent or adopting parent to such beneficiary; or

(d) Such individual does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, but would, under State law, have the same right as a child to share in the beneficiary's intestate personal property; or

(e) Such individual is the natural son or daughter of a beneficiary but does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) of this section, such individual shall nevertheless be considered to be the child of such beneficiary if the beneficiary and the mother or father, as the case may be, of such individual went through a marriage ceremony resulting in a purported marriage between them which but for a legal impediment (see § 725.230) would have been a valid marriage; or

(f) Such individual is the natural son or daughter of a beneficiary but does not have the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) or (e) of this section, such individual shall nevertheless be considered to be the child of such beneficiary if:

(1) Such beneficiary, prior to his or her entitlement to benefits, has acknowledged in writing that the individual is his or her son or daughter, or has been decreed by a court to be the father or mother of the individual, or has been ordered by a court to contribute to the support of the individual (see § 725.233(a)) because the individual is a son or daughter; or

(2) Such beneficiary is shown by satisfactory evidence to be the father or

mother of the individual and was living with or contributing to the support of the individual at the time such beneficiary became entitled to benefits.

§ 725.221 Determination of dependency; child.

For the purposes of determining whether a child was dependent upon a deceased miner, the provisions of § 725.209 shall be applicable, except that for purposes of determining the eligibility of a child who is under a disability as defined in section 223(d) of the Social Security Act, such disability must have begun before the child attained age 22, or in the case of a student, before the child ceased to be a student.

§ 725.222 Conditions of entitlement; parent, brother, or sister.

(a) An individual is eligible for benefits as a surviving parent, brother or sister if all of the following requirements are met:

(1) The individual is the parent, brother, or sister of a deceased miner;

(2) The individual was dependent on the miner at the pertinent time;

(3) Proof of support is filed within 2 years after the miner's death, unless the time is extended for good cause (§ 725.226);

(4) In the case of a brother or sister, such individual also:

(i) Is under 18 years of age; or

(ii) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d), which began before such individual attained age 22, or in the case of a student, before the student ceased to be a student; or

(iii) Is a student (see § 725.209(b)); or

(iv) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d), at the time of the miner's death;

(5) The deceased miner:

(i) Is determined to have died due to pneumoconiosis; or

(ii) Filed a claim for benefits on or after January 1, 1982, which results or resulted in a final award of benefits, and the surviving parent, brother or sister filed a claim for benefits after January 1, 2005 which was pending on or after March 23, 2010.

(b)(1) A parent is not entitled to benefits if the deceased miner was survived by a spouse or child at the time of such miner's death.

(2) A brother or sister is not entitled to benefits if the deceased miner was survived by a spouse, child, or parent at the time of such miner's death.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 59117, Sept. 25, 2013]

§ 725.223 Duration of entitlement; parent, brother, or sister.

(a) A parent, sister, or brother is entitled to benefits beginning with the month all the conditions of entitlement described in § 725.222 are met.

(b) The last month for which such parent is entitled to benefits is the month in which the parent dies.

(c) The last month for which such brother or sister is entitled to benefits is the month before the month in which any of the following events first occurs:

(1) The individual dies;

(2)(i) The individual marries or remarries; or

(ii) If already married, the individual received support in any amount from his or her spouse;

(3) The individual attains age 18; and

(i) Is not a student (as defined in § 725.209(b)) during any part of the month in which the individual attains age 18; and

(ii) Is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(4) If the individual's entitlement beyond age 18 is based on his or her status as a student, the earlier of:

(i) The first month during no part of which the individual is a student; or

(ii) The month in which the individual attains age 23 and is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(5) If the individual's entitlement beyond age 18 is based on disability, the first month in no part of which such individual is under a disability.

§ 725.224 Determination of relationship; parent, brother, or sister.

(a) An individual will be considered to be the parent, brother, or sister of a miner if the courts of the State in which the miner was domiciled (see § 225.231) at the time of death would

find, under the law they would apply, that the individual is the miner's parent, brother, or sister.

(b) Where, under State law, the individual is not the miner's parent, brother, or sister, but would, under State law, have the same status (*i.e.*, right to share in the miner's intestate personal property) as a parent, brother, or sister, the individual will be considered to be the parent, brother, or sister as appropriate.

§ 725.225 Determination of dependency; parent, brother, or sister.

An individual who is the miner's parent, brother, or sister will be determined to have been dependent on the miner if, during the 1–year period immediately prior to the miner's death:

(a) The individual and the miner were living in the same household (see § 725.232); and

(b) The individual was totally dependent on the miner for support (see § 725.233(h)).

§ 725.226 "Good cause" for delayed filing of proof of support.

(a) *What constitutes ''good cause.''* ''Good cause'' may be found for failure to file timely proof of support where the parent, brother, or sister establishes to the satisfaction of the Office that such failure to file was due to:

(1) Circumstances beyond the individual's control, such as extended illness, mental, or physical incapacity, or communication difficulties; or

(2) Incorrect or incomplete information furnished the individual by the Office; or

(3) Efforts by the individual to secure supporting evidence without a realization that such evidence could be submitted after filing proof of support.

(b) *What does not constitute ''good cause.''* ''Good cause'' for failure to file timely proof of support (see § 725.222(a)(3)) does not exist when there is evidence of record in the Office that the individual was informed that he or she should file within the prescribed period and he or she failed to do so deliberately or through negligence.

§ 725.227 Time of determination of relationship and dependency of survivors.

The determination as to whether an individual purporting to be an entitled survivor of a miner or beneficiary was related to, or dependent upon, the miner is made after such individual files a claim for benefits as a survivor. Such determination is based on the facts and circumstances with respect to a reasonable period of time ending with the miner's death. A prior determination that such individual was, or was not, a dependent for the purposes of augmenting the miner's benefits for a certain period, is not determinative of the issue of whether the individual is a dependent survivor of such miner.

§ 725.228 Effect of conviction of felonious and intentional homicide on entitlement to benefits.

An individual who has been convicted of the felonious and intentional homicide of a miner or other beneficiary shall not be entitled to receive any benefits payable because of the death of such miner or other beneficiary, and such person shall be considered nonexistent in determining the entitlement to benefits of other individuals.

TERMS USED IN THIS SUBPART

§ 725.229 Intestate personal property.

References in this subpart to the ''same right to share in the intestate personal property'' of a deceased miner (or surviving spouse) refer to the right of an individual to share in such distribution in the individual's own right and not the right of representation.

§ 725.230 Legal impediment.

For purposes of this subpart, ''legal impediment'' means an impediment resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution or resulting from a defect in the procedure followed in connection with the purported marriage ceremony—for example, the solemnization of a marriage only through a religious ceremony in a country which requires a civil ceremony for a valid marriage.

§ 725.231 Domicile.

(a) For purposes of this subpart, the term ''domicile'' means the place of an individual's true, fixed, and permanent home.

(b) The domicile of a deceased miner or surviving spouse is determined as of the time of death.

(c) If an individual was not domiciled in any State at the pertinent time, the law of the District of Columbia is applied.

§ 725.232 Member of the same household—"living with," "living in the same household," and "living in the miner's household," defined.

(a) *Defined.* (1) The term ''member of the same household'' as used in section 402(a)(2) of the Act (with respect to a spouse); the term ''living with'' as used in section 402(e) of the Act (with respect to a surviving spouse); and the term ''living in the same household'' as used in this subpart, means that a husband and wife were customarily living together as husband and wife in the same place.

(2) The term ''living in the miner's household'' as used in section 412(a)(5) of the Act (with respect to a parent, brother, or sister) means that the miner and such parent, brother, or sister were sharing the same residence.

(b) *Temporary absence.* The temporary absence from the same residence of either the miner, or the miner's spouse, parent, brother, or sister (as the case may be), does not preclude a finding that one was ''living with'' the other, or that they were ''members of the same household.'' The absence of one such individual from the residence in which both had customarily lived shall, in the absence of evidence to the contrary, be considered temporary:

(1) If such absence was due to service in the Armed Forces of the United States; or

(2) If the period of absence from his or her residence did not exceed 6 months and the absence was due to business or employment reasons, or because of confinement in a penal institution or in a hospital, nursing home, or other curative institution; or

(3) In any other case, if the evidence establishes that despite such absence they nevertheless reasonably expected to resume physically living together.

(c) *Relevant period of time.* (1) The determination as to whether a surviving spouse had been ''living with'' the miner shall be based upon the facts and circumstances as of the time of the death of the miner.

(2) The determination as to whether a spouse is a ''member of the same household'' as the miner shall be based upon the facts and circumstances with respect to the period or periods of time as to which the issue of membership in the same household is material.

(3) The determination as to whether a parent, brother, or sister was ''living in the miner's household'' shall take account of the 1-year period immediately prior to the miner's death.

§ 725.233 Support and contributions.

(a) *Support* defined. The term ''support'' includes food, shelter, clothing, ordinary medical expenses, and other ordinary and customary items for the maintenance of the person supported.

(b) *Contributions* defined. The term ''contributions'' refers to contributions actually provided by the contributor from such individual's property, or the use thereof, or by the use of such individual's own credit.

(c) *Regular contributions* and *substantial contributions* defined. The terms ''regular contributions'' and ''substantial contributions'' mean contributions that are customary and sufficient to constitute a material factor in the cost of the individual's support.

(d) *Contributions and community property.* When a spouse receives and uses for his or her support income from services or property, and such income, under applicable State law, is the community property of the wife and her husband, no part of such income is a ''contribution'' by one spouse to the other's support regardless of the legal interest of the donor. However, when a spouse receives and uses for support, income from the services and the property of the other spouse and, under applicable State law, such income is community property, all of such income is considered to be a contribution by the donor to the spouse's support.

(e) *Court order for support* defined. References to a support order in this

subpart means any court order, judgment, or decree of a court of competent jurisdiction which requires regular contributions that are a material factor in the cost of the individual's support and which is in effect at the applicable time. If such contributions are required by a court order, this condition is met whether or not the contributions were actually made.

(f) *Written agreement* defined. The term ''written agreement'' in the phrase ''substantial contributions pursuant to a written agreement'', as used in this subpart means an agreement signed by the miner providing for substantial contributions by the miner for the individual's support. It must be in effect at the applicable time but it need not be legally enforceable.

(g) *One-half support* defined. The term ''one-half support'' means that the miner made regular contributions, in cash or in kind, to the support of a divorced spouse at the specified time or for the specified period, and that the amount of such contributions equalled or exceeded one-half the total cost of such individual's support at such time or during such period.

(h) *Totally dependent for support* defined. The term ''totally dependent for support'' as used in § 725.225(b) means that the miner made regular contributions to the support of the miner's parents, brother, or sister, as the case may be, and that the amount of such contributions at least equalled the total cost of such individual's support.

Subpart C—Filing of Claims

§ 725.301 Who may file a claim.

(a) Any person who believes he or she may be entitled to benefits under the Act may file a claim in accordance with this subpart.

(b) A claimant who has attained the age of 18, is mentally competent and physically able, may file a claim on his or her own behalf.

(c) If a claimant is unable to file a claim on his or her behalf because of a legal or physical impairment, the following rules shall apply:

(1) A claimant between the ages of 16 and 18 years who is mentally competent and not under the legal custody or care of another person, or a committee or institution, may upon filing a statement to the effect, file a claim on his or her own behalf. In any other case where the claimant is under 18 years of age, only a person, or the manager or principal officer of an institution having legal custody or care of the claimant may file a claim on his or her behalf.

(2) If a claimant over 18 years of age has a legally appointed guardian or committee, only the guardian or committee may file a claim on his or her behalf.

(3) If a claimant over 18 years of age is mentally incompetent or physically unable to file a claim and is under the care of another person, or an institution, only the person, or the manager or principal officer of the institution responsible for the care of the claimant, may file a claim on his or her behalf.

(4) For good cause shown, the Office may accept a claim executed by a person other than one described in paragraphs (c)(2) or (3) of this section.

(d) Except as provided in § 725.305, in order for a claim to be considered, the claimant must be alive at the time the claim is filed.

§ 725.302 Evidence of authority to file a claim on behalf of another.

A person filing a claim on behalf of a claimant shall submit evidence of his or her authority to so act at the time of filing or at a reasonable time thereafter in accordance with the following:

(a) A legally appointed guardian or committee shall provide the Office with certification of appointment by a proper official of the court.

(b) Any other person shall provide a statement describing his or her relationship to the claimant, the extent to which he or she has care of the claimant, or his or her position as an officer of the institution of which the claimant is an inmate. The Office may, at any time, require additional evidence to establish the authority of any such person.

§ 725.303 Date and place of filing of claims.

(a)(1) Claims for benefits shall be delivered, mailed to, or presented at, any

of the various district offices of the Social Security Administration, or any of the various offices of the Department of Labor authorized to accept claims, or, in the case of a claim filed by or on behalf of a claimant residing outside the United States, mailed or presented to any office maintained by the Foreign Service of the United States. A claim shall be considered filed on the day it is received by the office in which it is first filed.

(2) A claim submitted to a Foreign Service Office or any other agency or subdivision of the U.S. Government shall be forwarded to the Office and considered filed as of the date it was received at the Foreign Service Office or other governmental agency or unit.

(b) A claim submitted by mail shall be considered filed as of the date of delivery unless a loss or impairment of benefit rights would result, in which case a claim shall be considered filed as of the date of its postmark. In the absence of a legible postmark, other evidence may be used to establish the mailing date.

§ 725.304 Forms and initial processing.

(a) Claims shall be filed on forms prescribed and approved by the Office. The district office at which the claim is filed will assist claimants in completing their forms.

(b) If the place at which a claim is filed is an office of the Social Security Administration, such office shall forward the completed claim form to an office of the DCMWC, which is authorized to process the claim.

§ 725.305 When a written statement is considered a claim.

(a) The filing of a statement signed by an individual indicating an intention to claim benefits shall be considered to be the filing of a claim for the purposes of this part under the following circumstances:

(1) The claimant or a proper person on his or her behalf (see § 725.301) executes and files a prescribed claim form with the Office during the claimant's lifetime within the period specified in paragraph (b) of this section.

(2) Where the claimant dies within the period specified in paragraph (b) of this section without filing a prescribed claim form, and a person acting on behalf of the deceased claimant's estate executes and files a prescribed claim form within the period specified in paragraph (c) of this section.

(b) Upon receipt of a written statement indicating an intention to claim benefits, the Office shall notify the signer in writing that to be considered the claim must be executed by the claimant or a proper party on his or her behalf on the prescribed form and filed with the Office within six months from the date of mailing of the notice.

(c) If before the notice specified in paragraph (b) of this section is sent, or within six months after such notice is sent, the claimant dies without having executed and filed a prescribed form, or without having had one executed and filed in his or her behalf, the Office shall upon receipt of notice of the claimant's death advise his or her estate, or those living at his or her last known address, in writing that for the claim to be considered, a prescribed claim form must be executed and filed by a person authorized to do so on behalf of the claimant's estate within six months of the date of the later notice.

(d) Claims based upon written statements indicating an intention to claim benefits not perfected in accordance with this section shall not be processed.

§ 725.306 Withdrawal of a claim.

(a) A claimant or an individual authorized to execute a claim on a claimant's behalf or on behalf of claimant's estate under § 725.305, may withdraw a previously filed claim provided that:

(1) He or she files a written request with the appropriate adjudication officer indicating the reasons for seeking withdrawal of the claim;

(2) The appropriate adjudication officer approves the request for withdrawal on the grounds that it is in the best interests of the claimant or his or her estate, and;

(3) Any payments made to the claimant in accordance with § 725.522 are reimbursed.

(b) When a claim has been withdrawn under paragraph (a) of this section, the claim will be considered not to have been filed.

§ 725.307 Cancellation of a request for withdrawal.

At any time prior to approval, a request for withdrawal may be canceled by a written request of the claimant or a person authorized to act on the claimant's behalf or on behalf of the claimant's estate.

§ 725.308 Time limits for filing claims.

(a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Reform Act of 1977, whichever is later. There is no time limit on the filing of a claim by the survivor of a miner.

(b) A miner who is receiving benefits under part B of title IV of the Act and who is notified by HEW of the right to seek medical benefits may file a claim for medical benefits under part C of title IV of the Act and this part. The Secretary of Health, Education, and Welfare is required to notify each miner receiving benefits under part B of this right. Notwithstanding the provisions of paragraph (a) of this section, a miner notified of his or her rights under this paragraph may file a claim under this part on or before December 31, 1980. Any claim filed after that date shall be untimely unless the time for filing has been enlarged for good cause shown.

(c) There shall be a rebuttable presumption that every claim for benefits is timely filed. However, except as provided in paragraph (b) of this section, the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

§ 725.309 Additional claims; effect of prior denial of benefits.

(a) If a claimant files a claim under this part while another claim filed by the claimant under this part is still pending, the later claim must be merged with the earlier claim for all purposes. For purposes of this section, a claim must be considered pending if it has not yet been finally denied.

(b) If a claimant files a claim under this part within one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim must be considered a request for modification of the prior denial and will be processed and adjudicated under § 725.310.

(c) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim must be considered a subsequent claim for benefits. A subsequent claim will be processed and adjudicated in accordance with the provisions of subparts E and F of this part. Except as provided in paragraph (1) below, a subsequent claim must be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see §§ 725.202(d) (miner), 725.212 (spouse), 725.218 (child), and 725.222 (parent, brother, or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules apply to the adjudication of a subsequent claim:

(1) The requirement to establish a change in an applicable condition of entitlement does not apply to a survivor's claim if the requirements of §§ 725.212(a)(3)(ii), 725.218(a)(2), or 725.222(a)(5)(ii) are met, and the survivor's prior claim was filed—

(i) On or before January 1, 2005, or

(ii) After January 1, 2005 and was finally denied prior to March 23, 2010.

(2) Any evidence submitted in connection with any prior claim must be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(3) For purposes of this section, the applicable conditions of entitlement are limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual

worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(4) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister must be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(5) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), will be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim will be binding on that party in the adjudication of the subsequent claim.

(6) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

(d) In any case involving more than one claim filed by the same claimant, under no circumstances are duplicate benefits payable for concurrent periods of eligibility. Any duplicate benefits paid will be subject to collection or offset under subpart H of this part.

[78 FR 59118, Sept. 25, 2013]

§ 725.310 Modification of awards and denials.

(a) Upon his or her own initiative, or upon the request of any party on grounds of a change in conditions or because of a mistake in a determination of fact, the district director may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

(b) Modification proceedings shall be conducted in accordance with the provisions of this part as appropriate, except that the claimant and the operator, or group of operators or the fund, as appropriate, shall each be entitled to submit no more than one additional chest X-ray interpretation, one additional pulmonary function test, one additional arterial blood gas study, and one additional medical report in support of its affirmative case along with such rebuttal evidence and additional statements as are authorized by paragraphs (a)(2)(ii) and (a)(3)(ii) of § 725.414. Modification proceedings shall not be initiated before an administrative law judge or the Benefits Review Board.

(c) At the conclusion of modification proceedings before the district director, the district director may issue a proposed decision and order (§ 725.418) or, if appropriate, deny the claim by reason of abandonment (§ 725.409). In any case in which the district director has initiated modification proceedings on his own initiative to alter the terms of an award or denial of benefits issued by an administrative law judge, the district director shall, at the conclusion of modification proceedings, forward the claim for a hearing (§ 725.421). In any case forwarded for a hearing, the administrative law judge assigned to hear such case shall consider whether any additional evidence submitted by the parties demonstrates a change in condition and, regardless of whether the parties have submitted new evidence, whether the evidence of record demonstrates a mistake in a determination of fact.

(d) An order issued following the conclusion of modification proceedings may terminate, continue, reinstate, increase or decrease benefit payments or award benefits. Such order shall not affect any benefits previously paid, except that an order increasing the amount of benefits payable based on a finding of a mistake in a determination of fact may be made effective on the date from which benefits were determined payable by the terms of an earlier award. In the case of an award which is decreased, no payment made in excess of the decreased rate prior to

the date upon which the party requested reconsideration under paragraph (a) of this section shall be subject to collection or offset under subpart H of this part, provided the claimant is without fault as defined by § 725.543. In the case of an award which is decreased following the initiation of modification by the district director, no payment made in excess of the decreased rate prior to the date upon which the district director initiated modification proceedings under paragraph (a) shall be subject to collection or offset under subpart H of this part, provided the claimant is without fault as defined by § 725.543. In the case of an award which has become final and is thereafter terminated, no payment made prior to the date upon which the party requested reconsideration under paragraph (a) shall be subject to collection or offset under subpart H of this part. In the case of an award which has become final and is thereafter terminated following the initiation of modification by the district director, no payment made prior to the date upon which the district director initiated modification proceedings under paragraph (a) shall be subject to collection or offset under subpart H of this part.

§ 725.311 Communications with respect to claims; time computations.

(a) Unless otherwise specified by this part, all requests, responses, notices, decisions, orders, or other communications required or permitted by this part shall be in writing.

(b) If required by this part, any document, brief, or other statement submitted in connection with the adjudication of a claim under this part shall be sent to each party to the claim by the submitting party. If proof of service is required with respect to any communication, such proof of service shall be submitted to the appropriate adjudication officer and filed as part of the claim record.

(c) In computing any period of time described in this part, by any applicable statute, or by the order of any adjudication officer, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or legal holiday, in which event the period extends until the next day which is not a Saturday, Sunday, or legal holiday. ''Legal holiday'' includes New Year's Day, Birthday of Martin Luther King, Jr., Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

(d) In computing any period of time described in this part in which the period within which to file a response commences upon receipt of a document, it shall be presumed, in the absence of evidence to the contrary, that the document was received on the seventh day after it was mailed. In any case in which a provision of this part requires a document to be sent to a person or party by certified mail, and the document is not sent by certified mail, but the person or party actually received the document, the document shall be deemed to have been sent in compliance with the provisions of this part. In such a case, any time period which commences upon the service of the document shall commence on the date the document was received.

Subpart D—Adjudication Officers; Parties and Representatives

§ 725.350 Who are the adjudication officers?

(a) *General*. The persons authorized by the Secretary of Labor to accept evidence and decide claims on the basis of such evidence are called ''adjudication officers.'' This section describes the status of black lung claims adjudication officers.

(b) *District Director*. The district director is that official of the DCMWC or his designee who is authorized to perform functions with respect to the development, processing, and adjudication of claims in accordance with this part.

(c) *Administrative law judge*. An administrative law judge is that official appointed pursuant to 5 U.S.C. 3105 (or Public Law 94–504) who is qualified to preside at hearings under 5 U.S.C. 557 and is empowered by the Secretary to conduct formal hearings with respect

to, and adjudicate, claims in accordance with this part. A person appointed under Public Law 94–504 shall not be considered an administrative law judge for purposes of this part for any period after March 1, 1979.

§ 725.351 Powers of adjudication officers.

(a) *District Director*. The district director is authorized to:

(1) Make determinations with respect to claims as is provided in this part;

(2) Conduct conferences and informal discovery proceedings as provided in this part;

(3) Compel the production of documents by the issuance of a subpoena;

(4) Prepare documents for the signature of parties;

(5) Issue appropriate orders as provided in this part; and

(6) Do all other things necessary to enable him or her to discharge the duties of the office.

(b) Administrative Law Judge. An administrative law judge is authorized to:

(1) Conduct formal hearings in accordance with the provisions of this part;

(2) Administer oaths and examine witnesses;

(3) Compel the production of documents and appearance of witnesses by the issuance of subpoenas;

(4) Issue decisions and orders with respect to claims as provided in this part; and

(5) Do all other things necessary to enable him or her to discharge the duties of the office.

(c) If any person in proceedings before an adjudication officer disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the same, or neglects to produce, after having been ordered to do so, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take the oath as a witness, or after having taken the oath refuses to be examined according to law, the district director, or the administrative law judge responsible for the adjudication of the claim, shall certify the facts to the Federal district court having jurisdiction in the place in which he or she is sitting (or to the U.S. District Court for the District of Columbia if he or she is sitting in the District) which shall thereupon in a summary manner hear the evidence as to the acts complained of, and, if the evidence so warrants, punish such person in the same manner and to the same extent as for a contempt committed before the court, or commit such person upon the same condition as if the doing of the forbidden act had occurred with reference to the process or in the presence of the court.

§ 725.352 Disqualification of adjudication officer.

(a) No adjudication officer shall conduct any proceedings in a claim in which he or she is prejudiced or partial, or where he or she has any interest in the matter pending for decision. A decision to withdraw from the consideration of a claim shall be within the discretion of the adjudication officer. If that adjudication officer withdraws, another officer shall be designated by the Director or the Chief Administrative Law Judge, as the case may be, to complete the adjudication of the claim.

(b) No adjudication officer shall be permitted to appear or act as a representative of a party under this part while such individual is employed as an adjudication officer. No adjudication officer shall be permitted at any time to appear or act as a representative in connection with any case or claim in which he or she was personally involved. No fee or reimbursement shall be awarded under this part to an individual who acts in violation of this paragraph.

(c) No adjudication officer shall act in any claim involving a party which employed such adjudication officer within one year before the adjudication of such claim.

(d) Notwithstanding paragraph (a) of this section, no adjudication officer shall be permitted to act in any claim involving a party who is related to the adjudication officer by consanguinity or affinity within the third degree as determined by the law of the place where such party is domiciled. Any action taken by an adjudication officer in knowing violation of this paragraph shall be void.

§ 725.360 Parties to proceedings.

(a) Except as provided in § 725.361, no person other than the Secretary of Labor and authorized personnel of the Department of Labor shall participate at any stage in the adjudication of a claim for benefits under this part, unless such person is determined by the appropriate adjudication officer to qualify under the provisions of this section as a party to the claim. The following persons shall be parties:

(1) The claimant;

(2) A person other than a claimant, authorized to execute a claim on such claimant's behalf under § 725.301;

(3) Any coal mine operator notified under § 725.407 of its possible liability for the claim;

(4) Any insurance carrier of such operator; and

(5) The Director in all proceedings relating to a claim for benefits under this part.

(b) A widow, child, parent, brother, or sister, or the representative of a decedent's estate, who makes a showing in writing that his or her rights with respect to benefits may be prejudiced by a decision of an adjudication officer, may be made a party.

(c) Any coal mine operator or prior operator or insurance carrier which has not been notified under § 725.407 and which makes a showing in writing that its rights may be prejudiced by a decision of an adjudication officer may be made a party.

(d) Any other individual may be made a party if that individual's rights with respect to benefits may be prejudiced by a decision to be made.

§ 725.361 Party amicus curiae.

At the discretion of the Chief Administrative Law Judge or the administrative law judge assigned to the case, a person or entity which is not a party may be allowed to participate amicus curiae in a formal hearing only as to an issue of law. A person may participate amicus curiae in a formal hearing upon written request submitted with supporting arguments prior to the hearing. If the request is granted, the administrative law judge hearing the case will inform the party of the extent to which participation will be permitted. The request may, however, be denied summarily and without explanation.

§ 725.362 Representation of parties.

(a) Except for the Secretary of Labor, whose interests shall be represented by the Solicitor of Labor or his or her designee, each of the parties may appoint an individual to represent his or her interest in any proceeding for determination of a claim under this part. Such appointment shall be made in writing or on the record at the hearing. An attorney qualified in accordance with § 725.363(a) shall file a written declaration that he or she is authorized to represent a party, or declare his or her representation on the record at a formal hearing. Any other person (see § 725.363(b)) shall file a written notice of appointment signed by the party or his or her legal guardian, or enter his or her appearance on the record at a formal hearing if the party he or she seeks to represent is present and consents to the representation. Any written declaration or notice required by this section shall include the OWCP number assigned by the Office and shall be sent to the Office or, for representation at a formal hearing, to the Chief Administrative Law Judge. In any case, such representative must be qualified under § 725.363. No authorization for representation or agreement between a claimant and representative as to the amount of a fee, filed with the Social Security Administration in connection with a claim under part B of title IV of the Act, shall be valid under this part. A claimant who has previously authorized a person to represent him or her in connection with a claim originally filed under part B of title IV may renew such authorization by filing a statement to such effect with the Office or appropriate adjudication officer.

(b) Any party may waive his or her right to be represented in the adjudication of a claim. If an adjudication officer determines, after an appropriate inquiry has been made, that a claimant who has been informed of his or her right to representation does not wish to obtain the services of a representative, such adjudication officer shall

proceed to consider the claim in accordance with this part, unless it is apparent that the claimant is, for any reason, unable to continue without the help of a representative. However, it shall not be necessary for an adjudication officer to inquire as to the ability of a claimant to proceed without representation in any adjudication taking place without a hearing. The failure of a claimant to obtain representation in an adjudication taking place without a hearing shall be considered a waiver of the claimant's right to representation. However, at any time during the processing or adjudication of a claim, any claimant may revoke such waiver and obtain a representative.

§ 725.363 Qualification of representative.

(a) *Attorney*. Any attorney in good standing who is admitted to practice before a court of a State, territory, district, or insular possession, or before the Supreme Court of the United States or other Federal court and is not, pursuant to any provision of law, prohibited from acting as a representative, may be appointed as a representative.

(b) *Other person*. With the approval of the adjudication officer, any other person may be appointed as a representative so long as that person is not, pursuant to any provision of law, prohibited from acting as a representative.

§ 725.364 Authority of representative.

A representative, appointed and qualified as provided in §§ 725.362 and 725.363, may make or give on behalf of the party he or she represents, any request or notice relative to any proceeding before an adjudication officer, including formal hearing and review, except that such representative may not execute a claim for benefits, unless he or she is a person designated in § 725.301 as authorized to execute a claim. A representative shall be entitled to present or elicit evidence and make allegations as to facts and law in any proceeding affecting the party represented and to obtain information with respect to the claim of such party to the same extent as such party. Notice given to any party of any administrative action, determination, or decision, or request to any party for the production of evidence shall be sent to the representative of such party and such notice or request shall have the same force and effect as if it had been sent to the party represented.

§ 725.365 Approval of representative's fees; lien against benefits.

No fee charged for representation services rendered to a claimant with respect to any claim under this part shall be valid unless approved under this subpart. No contract or prior agreement for a fee shall be valid. In cases where the obligation to pay the attorney's fee is upon the claimant, the amount of the fee awarded may be made a lien upon the benefits due under an award and the adjudication officer shall fix, in the award approving the fee, such lien and the manner of payment of the fee. Any representative who is not an attorney may be awarded a fee for services under this subpart, except that no lien may be imposed with respect to such representative's fee.

§ 725.366 Fees for representatives.

(a) A representative seeking a fee for services performed on behalf of a claimant shall make application therefor to the district director, administrative law judge, or appropriate appellate tribunal, as the case may be, before whom the services were performed. The application shall be filed and served upon the claimant and all other parties within the time limits allowed by the district director, administrative law judge, or appropriate appellate tribunal. The application shall be supported by a complete statement of the extent and character of the necessary work done, and shall indicate the professional status (e.g., attorney, paralegal, law clerk, lay representative or clerical) of the person performing such work, and the customary billing rate for each such person. The application shall also include a listing of reasonable unreimbursed expenses, including those for travel, incurred by the representative or an employee of a representative in establishing the claimant's case. Any fee requested under this paragraph shall also contain a description of any fee requested, charged,

or received for services rendered to the claimant before any State or Federal court or agency in connection with a related matter.

(b) Any fee approved under paragraph (a) of this section shall be reasonably commensurate with the necessary work done and shall take into account the quality of the representation, the qualifications of the representative, the complexity of the legal issues involved, the level of proceedings to which the claim was raised, the level at which the representative entered the proceedings, and any other information which may be relevant to the amount of fee requested. No fee approved shall include payment for time spent in preparation of a fee application. No fee shall be approved for work done on claims filed between December 30, 1969, and June 30, 1973, under part B of title IV of the Act, except for services rendered on behalf of the claimant in regard to the review of the claim under section 435 of the Act and part 727 of this subchapter (see § 725.4(d)).

(c) In awarding a fee, the appropriate adjudication officer shall consider, and shall add to the fee, the amount of reasonable and unreimbursed expenses incurred in establishing the claimant's case. Reimbursement for travel expenses incurred by an attorney shall be determined in accordance with the provisions of § 725.459(a). No reimbursement shall be permitted for expenses incurred in obtaining medical or other evidence which has previously been submitted to the Office in connection with the claim.

(d) Upon receipt of a request for approval of a fee, such request shall be reviewed and evaluated by the appropriate adjudication officer and a fee award issued. Any party may request reconsideration of a fee awarded by the adjudication officer. A revised or modified fee award may then be issued, if appropriate.

(e) Each request for reconsideration or review of a fee award shall be in writing and shall contain supporting statements or information pertinent to any increase or decrease requested. If a fee awarded by a district director is disputed, such award shall be appealable directly to the Benefits Review Board. In such a fee dispute case, the record before the Board shall consist of the order of the district director awarding or denying the fee, the application for a fee, any written statement in opposition to the fee and the documentary evidence contained in the file which verifies or refutes any item claimed in the fee application.

§ 725.367 Payment of a claimant's attorney's fee by responsible operator or fund.

(a) An attorney who represents a claimant in the successful prosecution of a claim for benefits may be entitled to collect a reasonable attorney's fee from the responsible operator that is ultimately found liable for the payment of benefits, or, in a case in which there is no operator who is liable for the payment of benefits, from the fund. Generally, the operator or fund liable for the payment of benefits shall be liable for the payment of the claimant's attorney's fees where the operator or fund, as appropriate, took action, or acquiesced in action, that created an adversarial relationship between itself and the claimant. The fees payable under this section shall include reasonable fees for necessary services performed prior to the creation of the adversarial relationship. Circumstances in which a successful attorney's fees shall be payable by the responsible operator or the fund include, but are not limited to, the following:

(1) The responsible operator designated by the district director (see § 725.410(a)(3)) fails to accept the claimant's entitlement to benefits within the 30-day period provided by § 725.412(b) and is ultimately determined to be liable for benefits. The operator shall be liable for an attorney's fee with respect to all necessary services performed by the claimant's attorney;

(2) There is no operator that may be held liable for the payment of benefits, and the district director issues a schedule for the submission of additional evidence under § 725.410. The fund shall be liable for an attorney's fee with respect to all necessary services performed by the claimant's attorney;

(3) The claimant submits a bill for medical treatment, and the party liable for the payment of benefits declines

to pay the bill on the grounds that the treatment is unreasonable, or is for a condition that is not compensable. The responsible operator or fund, as appropriate, shall be liable for an attorney's fee with respect to all necessary services performed by the claimant's attorney;

(4) A beneficiary seeks an increase in the amount of benefits payable, and the responsible operator or fund contests the claimant's right to that increase. If the beneficiary is successful in securing an increase in the amount of benefits payable, the operator or fund shall be liable for an attorney's fee with respect to all necessary services performed by the beneficiary's attorney;

(5) The responsible operator or fund seeks a decrease in the amount of benefits payable. If the beneficiary is successful in resisting the request for a decrease in the amount of benefits payable, the operator or fund shall be liable for an attorney's fee with respect to all necessary services performed by the beneficiary's attorney. A request for information clarifying the amount of benefits payable shall not be considered a request to decrease that amount.

(b) Any fee awarded under this section shall be in addition to the award of benefits, and shall be awarded, in an order, by the district director, administrative law judge, Board or court, before whom the work was performed. The operator or fund shall pay such fee promptly and directly to the claimant's attorney in a lump sum after the award of benefits becomes final.

(c) Section 205(a) of the Black Lung Benefits Amendments of 1981, Public Law 97–119, amended section 422 of the Act and relieved operators and carriers from liability for the payment of benefits on certain claims. Payment of benefits on those claims was made the responsibility of the fund. The claims subject to this transfer of liability are described in § 725.496. On claims subject to the transfer of liability described in this paragraph the fund will pay all fees and costs which have been or will be awarded to claimant's attorneys which were or would have become the liability of an operator or carrier but for the enactment of the 1981 Amendments and which have not already been paid by such operator or carrier. Section 9501(d)(7) of the Internal Revenue Code (26 U.S.C.), which was also enacted as a part of the 1981 Amendments to the Act, expressly prohibits the fund from reimbursing an operator or carrier for any attorney fees or costs which it has paid on cases subject to the transfer of liability provisions.

Subpart E—Adjudication of Claims by the District Director

§ 725.401 Claims development—general.

After a claim has been received by the district director, the district director shall take such action as is necessary to develop, process, and make determinations with respect to the claim as provided in this subpart.

§ 725.402 Approved State workers' compensation law.

If a district director determines that any claim filed under this part is one subject to adjudication under a workers' compensation law approved under part 722 of this subchapter, he or she shall advise the claimant of this determination and of the Act's requirement that the claim must be filed under the applicable State workers' compensation law. The district director shall then prepare a proposed decision and order dismissing the claim for lack of jurisdiction pursuant to § 725.418 and proceed as appropriate.

§ 725.403 [Reserved]

§ 725.404 Development of evidence—general.

(a) *Employment history*. Each claimant shall furnish the district director with a complete and detailed history of the coal miner's employment and, upon request, supporting documentation.

(b) *Matters of record*. Where it is necessary to obtain proof of age, marriage or termination of marriage, death, family relationship, dependency (see subpart B of this part), or any other fact which may be proven as a matter of public record, the claimant shall furnish such proof to the district director upon request.

(c) *Documentary evidence.* If a claimant is required to submit documents to the district director, the claimant shall submit either the original, a certified copy or a clear readable copy thereof. The district director or administrative law judge may require the submission of an original document or certified copy thereof, if necessary.

(d) *Submission of insufficient evidence.* In the event a claimant submits insufficient evidence regarding any matter, the district director shall inform the claimant of what further evidence is necessary and request that such evidence be submitted within a specified reasonable time which may, upon request, be extended for good cause.

§ 725.405 Development of medical evidence; scheduling of medical examinations and tests.

(a) Upon receipt of a claim, the district director shall ascertain whether the claim was filed by or on account of a miner as defined in § 725.202, and in the case of a claim filed on account of a deceased miner, whether the claim was filed by an eligible survivor of such miner as defined in subpart B of this part.

(b) In the case of a claim filed by or on behalf of a miner, the district director shall, where necessary, schedule the miner for a medical examination and testing under § 725.406.

(c) In the case of a claim filed by or on behalf of a survivor of a miner, the district director shall obtain whatever medical evidence is necessary and available for the development and evaluation of the claim.

(d) The district director shall, where appropriate, collect other evidence necessary to establish:

(1) The nature and duration of the miner's employment; and

(2) All other matters relevant to the determination of the claim.

(e) If at any time during the processing of the claim by the district director, the evidence establishes that the claimant is not entitled to benefits under the Act, the district director may terminate evidentiary development of the claim and proceed as appropriate.

§ 725.406 Medical examinations and tests.

(a) The Act requires the Department to provide each miner who applies for benefits with the opportunity to undergo a complete pulmonary evaluation at no expense to the miner. A complete pulmonary evaluation includes a report of physical examination, a pulmonary function study, a chest radiograph, and, unless medically contraindicated, a blood gas study.

(b) As soon as possible after a miner files an application for benefits, the district director will provide the miner with a list of medical facilities and physicians in the state of the miner's residence and states contiguous to the state of the miner's residence that the Office has authorized to perform complete pulmonary evaluations. The miner must select one of the facilities or physicians on the list, provided that the miner may not select any physician to whom the miner or the miner's spouse is related to the fourth degree of consanguinity, and the miner may not select any physician who has examined or provided medical treatment to the miner within the twelve months preceding the date of the miner's application. The district director will make arrangements for the miner to be given a complete pulmonary evaluation by that facility or physician. The results of the complete pulmonary evaluation must not be counted as evidence submitted by the miner under § 725.414.

(c) If any medical examination or test conducted under paragraph (a) of this section is not administered or reported in substantial compliance with the provisions of part 718 of this subchapter, or does not provide sufficient information to allow the district director to decide whether the miner is eligible for benefits, the district director must schedule the miner for further examination and testing. Where the deficiencies in the report are the result of a lack of effort on the part of the miner, the miner will be afforded one additional opportunity to produce a satisfactory result. In order to determine whether any medical examination or test was administered and reported in substantial compliance with the provisions of part 718 of this subchapter, the district director may have

any component of such examination or test reviewed by a physician selected by the district director.

(d) After the physician completes the report authorized by paragraph (a), the district director will inform the miner that he may elect to have the results of the objective testing sent to his treating physician for use in preparing a medical opinion. The district director will also inform the claimant that any medical opinion submitted by his treating physician will count as one of the two medical opinions that the miner may submit under § 725.414 of this part.

(e) The cost of any medical examination or test authorized under this section, including the cost of travel to and from the examination, must be paid by the fund. Reimbursement for overnight accommodations must not be authorized unless the district director determines that an adequate testing facility is unavailable within one day's round trip travel by automobile from the miner's residence. The fund must be reimbursed for such payments by an operator, if any, found liable for the payment of benefits to the claimant. If an operator fails to repay such expenses, with interest, upon request of the Office, the entire amount may be collected in an action brought under section 424 of the Act and § 725.603.

[65 FR 80054, Dec. 20, 2000, as amended at 78 FR 35558, June 13, 2013; 79 FR 21615, Apr. 17, 2014]

§ 725.407 Identification and notification of responsible operator.

(a) Upon receipt of the miner's employment history, the district director shall investigate whether any operator may be held liable for the payment of benefits as a responsible operator in accordance with the criteria contained in Subpart G of this part.

(b) The district director may identify one or more operators potentially liable for the payment of benefits in accordance with the criteria set forth in § 725.495 of this part. The district director shall notify each such operator of the existence of the claim. Where the records maintained by the Office pursuant to part 726 of this subchapter indicate that the operator had obtained a policy of insurance, and the claim falls within such policy, the notice provided pursuant to this section shall also be sent to the operator's carrier. Any operator or carrier notified of the claim shall thereafter be considered a party to the claim in accordance with § 725.360 of this part unless it is dismissed by an adjudication officer and is not thereafter notified again of its potential liability.

(c) The notification issued pursuant to this section shall include a copy of the claimant's application and a copy of all evidence obtained by the district director relating to the miner's employment. The district director may request the operator to answer specific questions, including, but not limited to, questions related to the nature of its operations, its relationship with the miner, its financial status, including any insurance obtained to secure its obligations under the Act, and its relationship with other potentially liable operators. A copy of any notification issued pursuant to this section shall be sent to the claimant by regular mail.

(d) If at any time before a case is referred to the Office of Administrative Law Judges, the district director determines that an operator which may be liable for the payment of benefits has not been notified under this section or has been incorrectly dismissed pursuant to § 725.410(a)(3), the district director shall give such operator notice of its potential liability in accordance with this section. The adjudication officer shall then take such further action on the claim as may be appropriate. There shall be no time limit applicable to a later identification of an operator under this paragraph if the operator fraudulently concealed its identity as an employer of the miner. The district director may not notify additional operators of their potential liability after a case has been referred to the Office of Administrative Law Judges, unless the case was referred for a hearing to determine whether the claim was properly denied as abandoned pursuant to § 725.409.

§ 725.408 Operator's response to notification.

(a)(1) An operator which receives notification under § 725.407 shall, within

30 days of receipt, file a response indicating its intent to accept or contest its identification as a potentially liable operator. The operator's response shall also be sent to the claimant by regular mail.

(2) If the operator contests its identification, it shall, on a form supplied by the district director, state the precise nature of its disagreement by admitting or denying each of the following assertions. In answering these assertions, the term ''operator'' shall include any operator for which the identified operator may be considered a successor operator pursuant to § 725.492.

(i) That the named operator was an operator for any period after June 30, 1973;

(ii) That the operator employed the miner as a miner for a cumulative period of not less than one year;

(iii) That the miner was exposed to coal mine dust while working for the operator;

(iv) That the miner's employment with the operator included at least one working day after December 31, 1969; and

(v) That the operator is capable of assuming liability for the payment of benefits.

(3) An operator which receives notification under § 725.407, and which fails to file a response within the time limit provided by this section, shall not be allowed to contest its liability for the payment of benefits on any of the grounds set forth in paragraph (a)(2).

(b)(1) Within 90 days of the date on which it receives notification under § 725.407, an operator may submit documentary evidence in support of its position.

(2) No documentary evidence relevant to the grounds set forth in paragraph (a)(2) may be admitted in any further proceedings unless it is submitted within the time limits set forth in this section.

§ 725.409 Denial of a claim by reason of abandonment.

(a) A claim may be denied at any time by the district director by reason of abandonment where the claimant fails:

(1) To undergo a required medical examination without good cause; or,

(2) To submit evidence sufficient to make a determination of the claim; or,

(3) To pursue the claim with reasonable diligence; or,

(4) To attend an informal conference without good cause.

(b)(1) If the district director determines that a denial by reason of abandonment under paragraphs (a)(1) through (3) of this section is appropriate, he or she shall notify the claimant of the reasons for such denial and of the action which must be taken to avoid a denial by reason of abandonment. If the claimant completes the action requested within the time allowed, the claim shall be developed, processed and adjudicated as specified in this part. If the claimant does not fully comply with the action requested by the district director, the district director shall notify the claimant that the claim has been denied by reason of abandonment. Such notification shall be served on the claimant and all other parties to the claim by certified mail.

(2) In any case in which a claimant has failed to attend an informal conference and has not provided the district director with his reasons for failing to attend, the district director shall ask the claimant to explain his absence. In considering whether the claimant had good cause for his failure to attend the conference, the district director shall consider all relevant circumstances, including the age, education, and health of the claimant, as well as the distance between the claimant's residence and the location of the conference. If the district director concludes that the claimant had good cause for failing to attend the conference, he may continue processing the claim, including, where appropriate under § 725.416, the scheduling of an informal conference. If the claimant does not supply the district director with his reasons for failing to attend the conference within 30 days of the date of the district director's request, or the district director concludes that the reasons supplied by the claimant do not establish good cause, the district director shall notify the claimant that the claim has been denied by reason of abandonment. Such notification shall be served on the claimant and all other parties to the claim by certified mail.

(c) The denial of a claim by reason of abandonment shall become effective and final unless, within 30 days after the denial is issued, the claimant requests a hearing. Following the expiration of the 30-day period, a new claim may be filed at any time pursuant to § 725.309. For purposes of § 725.309, a denial by reason of abandonment shall be deemed a finding that the claimant has not established any applicable condition of entitlement. If the claimant timely requests a hearing, the district director shall refer the case to the Office of Administrative Law Judges in accordance with § 725.421. Except upon the motion or written agreement of the Director, the hearing will be limited to the issue of whether the claim was properly denied by reason of abandonment. If the hearing is limited to the issue of abandonment and the administrative law judge determines that the claim was not properly denied by reason of abandonment, he shall remand the claim to the district director for the completion of administrative processing.

§ 725.410 Submission of additional evidence.

(a) After the district director completes the development of medical evidence under § 725.405 of this part, including the complete pulmonary evaluation authorized by § 725.406, and receives the responses and evidence submitted pursuant to § 725.408, he shall issue a schedule for the submission of additional evidence. The schedule shall contain the following information:

(1) If the claim was filed by, or on behalf of, a miner, the schedule shall contain a summary of the complete pulmonary evaluation administered pursuant to § 725.406. If the claim was filed by, or on behalf of, a survivor, the schedule shall contain a summary of any medical evidence developed by the district director pursuant to § 725.405(c).

(2) The schedule shall contain the district director's preliminary analysis of the medical evidence. If the district director believes that the evidence fails to establish any necessary element of entitlement, he shall inform the claimant of the element of entitlement not established and the reasons for his conclusions and advise the claimant that, unless he submits additional evidence, the district director will issue a proposed decision and order denying the claim.

(3) The schedule shall contain the district director's designation of a responsible operator liable for the payment of benefits. In the event that the district director has designated as the responsible operator an employer other than the employer who last employed the claimant as a miner, the district director shall include, with the schedule, a copy of the statements required by § 725.495(d) of this part. The district director may, in his discretion, dismiss as parties any of the operators notified of their potential liability pursuant to § 725.407. If the district director thereafter determines that the participation of a party dismissed pursuant to this section is required, he may once again notify the operator in accordance with § 725.407(d).

(4) The schedule shall notify the claimant and the designated responsible operator that they have the right to obtain further adjudication of the claim in accordance with this subpart, and that they have the right to submit additional evidence in accordance with this subpart. The schedule shall also notify the claimant that he has the right to obtain representation, under the terms set forth in subpart D, in order to assist him. In a case in which the district director has designated a responsible operator pursuant to paragraph (a)(3), the schedule shall further notify the claimant that if the operator fails to accept the claimant's entitlement to benefits within the time limit provided by § 725.412, the cost of obtaining additional medical and other necessary evidence, along with a reasonable attorney's fee, shall be reimbursed by the responsible operator in the event that the claimant establishes his entitlement to benefits payable by that operator. In a case in which there is no operator liable for the payment of benefits, the schedule shall notify the claimant that the cost of obtaining additional medical and other necessary evidence, along with a reasonable attorney's fee, shall be reimbursed by the fund.

(b) The schedule shall allow all parties not less than 60 days within which to submit additional evidence, including evidence relevant to the claimant's eligibility for benefits and evidence relevant to the liability of the designated responsible operator, and shall provide not less than an additional 30 days within which the parties may respond to evidence submitted by other parties. Any such evidence must meet the requirements set forth in § 725.414 in order to be admitted into the record.

(c) The district director shall serve a copy of the schedule, together with a copy of all of the evidence developed, on the claimant, the designated responsible operator, and all other operators which received notification pursuant to § 725.407. The schedule shall be served on each party by certified mail.

§ 725.411 Initial adjudication in Trust Fund cases.

Notwithstanding the requirements of § 725.410 of this part, if the district director concludes that the results of the complete pulmonary evaluation support a finding of eligibility, and that there is no operator responsible for the payment of benefits, the district director shall issue a proposed decision and order in accordance with § 725.418 of this part.

§ 725.412 Operator's response.

(a)(1) Within 30 days after the district director issues a schedule pursuant to § 725.410 of this part containing a designation of the responsible operator liable for the payment of benefits, that operator shall file a response with regard to its liability. The response shall specifically indicate whether the operator agrees or disagrees with the district director's designation.

(2) If the responsible operator designated by the district director does not file a timely response, it shall be deemed to have accepted the district director's designation with respect to its liability, and to have waived its right to contest its liability in any further proceeding conducted with respect to the claim.

(b) The responsible operator designated by the district director may also file a statement accepting claimant's entitlement to benefits. If that operator fails to file a timely response to the district director's designation, the district director shall, upon receipt of such a statement, issue a proposed decision and order in accordance with § 725.418 of this part. If the operator fails to file a statement accepting the claimant's entitlement to benefits within 30 days after the district director issues a schedule pursuant to § 725.410 of this part, the operator shall be deemed to have contested the claimant's entitlement.

§ 725.413 [Reserved]

§ 725.414 Development of evidence.

(a) *Medical evidence.* (1) For purposes of this section, a medical report shall consist of a physician's written assessment of the miner's respiratory or pulmonary condition. A medical report may be prepared by a physician who examined the miner and/or reviewed the available admissible evidence. A physician's written assessment of a single objective test, such as a chest X-ray or a pulmonary function test, shall not be considered a medical report for purposes of this section.

(2)(i) The claimant shall be entitled to submit, in support of his affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports. Any chest X-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a)(4) of this section.

(ii) The claimant shall be entitled to submit, in rebuttal of the case presented by the party opposing entitlement, no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by the designated responsible operator or the fund, as appropriate, under paragraph (a)(3)(i) or (a)(3)(iii) of this section and by the Director pursuant to § 725.406. In any case in which the party

opposing entitlement has submitted the results of other testing pursuant to § 718.107, the claimant shall be entitled to submit one physician's assessment of each piece of such evidence in rebuttal. In addition, where the responsible operator or fund has submitted rebuttal evidence under paragraph (a)(3)(ii) or (a)(3)(iii) of this section with respect to medical testing submitted by the claimant, the claimant shall be entitled to submit an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing. Where the rebuttal evidence tends to undermine the conclusion of a physician who prepared a medical report submitted by the claimant, the claimant shall be entitled to submit an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence.

(3)(i) The responsible operator designated pursuant to § 725.410 shall be entitled to obtain and submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports. Any chest X-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a)(4) of this section. In obtaining such evidence, the responsible operator may not require the miner to travel more than 100 miles from his or her place of residence, or the distance traveled by the miner in obtaining the complete pulmonary evaluation provided by § 725.406 of this part, whichever is greater, unless a trip of greater distance is authorized in writing by the district director. If a miner unreasonably refuses—

(A) To provide the Office or the designated responsible operator with a complete statement of his or her medical history and/or to authorize access to his or her medical records, or

(B) To submit to an evaluation or test requested by the district director or the designated responsible operator, the miner's claim may be denied by reason of abandonment. (See § 725.409 of this part).

(ii) The responsible operator shall be entitled to submit, in rebuttal of the case presented by the claimant, no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by the claimant under paragraph (a)(2)(i) of this section and by the Director pursuant to § 725.406. In any case in which the claimant has submitted the results of other testing pursuant to § 718.107, the responsible operator shall be entitled to submit one physician's assessment of each piece of such evidence in rebuttal. In addition, where the claimant has submitted rebuttal evidence under paragraph (a)(2)(ii) of this section, the responsible operator shall be entitled to submit an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing. Where the rebuttal evidence tends to undermine the conclusion of a physician who prepared a medical report submitted by the responsible operator, the responsible operator shall be entitled to submit an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence.

(iii) In a case in which the district director has not identified any potentially liable operators, or has dismissed all potentially liable operators under § 725.410(a)(3), the district director shall be entitled to exercise the rights of a responsible operator under this section, except that the evidence obtained in connection with the complete pulmonary evaluation performed pursuant to § 725.406 shall be considered evidence obtained and submitted by the Director, OWCP, for purposes of paragraph (a)(3)(i) of this section. In a case involving a dispute concerning medical benefits under § 725.708 of this part, the district director shall be entitled to develop medical evidence to determine whether the medical bill is compensable under the standard set forth in § 725.701 of this part.

(4) Notwithstanding the limitations in paragraphs (a)(2) and (a)(3) of this section, any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence.

(5) A copy of any documentary evidence submitted by a party must be served on all other parties to the claim. If the claimant is not represented by an attorney, the district director shall mail a copy of all documentary evidence submitted by the claimant to all other parties to the claim. Following the development and submission of affirmative medical evidence, the parties may submit rebuttal evidence in accordance with the schedule issued by the district director.

(b) *Evidence pertaining to liability*. (1) Except as provided by § 725.408(b)(2), the designated responsible operator may submit evidence to demonstrate that it is not the potentially liable operator that most recently employed the claimant.

(2) Any other party may submit evidence regarding the liability of the designated responsible operator or any other operator.

(3) A copy of any documentary evidence submitted under this paragraph must be mailed to all other parties to the claim. Following the submission of affirmative evidence, the parties may submit rebuttal evidence in accordance with the schedule issued by the district director.

(c) *Testimony*. A physician who prepared a medical report admitted under this section may testify with respect to the claim at any formal hearing conducted in accordance with subpart F of this part, or by deposition. If a party has submitted fewer than two medical reports as part of that party's affirmative case under this section, a physician who did not prepare a medical report may testify in lieu of such a medical report. The testimony of such a physician shall be considered a medical report for purposes of the limitations provided by this section. A party may offer the testimony of no more than two physicians under the provisions of this section unless the adjudication officer finds good cause under paragraph (b)(1) of § 725.456 of this part. In accordance with the schedule issued by the district director, all parties shall notify the district director of the name and current address of any potential witness whose testimony pertains to the liability of a potentially liable operator or the designated responsible operator. Absent such notice, the testimony of a witness relevant to the liability of a potentially liable operator or the designated responsible operator shall not be admitted in any hearing conducted with respect to the claim unless the administrative law judge finds that the lack of notice should be excused due to extraordinary circumstances.

(d) Except to the extent permitted by § 725.456 and § 725.310(b), the limitations set forth in this section shall apply to all proceedings conducted with respect to a claim, and no documentary evidence pertaining to liability shall be admitted in any further proceeding conducted with respect to a claim unless it is submitted to the district director in accordance with this section.

§ 725.415 Action by the district director after development of evidence.

(a) At the end of the period permitted under § 725.410(b) for the submission of evidence, the district director shall review the claim on the basis of all evidence submitted in accordance with § 725.414.

(b) After review of all evidence submitted, the district director may issue another schedule for the submission of additional evidence pursuant to § 725.410, identifying another potentially liable operator as the responsible operator liable for the payment of benefits. In such a case, the district director shall not permit the development or submission of any additional medical evidence until after he has made a final determination of the identity of the responsible operator liable for the payment of benefits. If the operator who is finally determined to be the responsible operator has not had the opportunity to submit medical evidence pursuant to § 725.410, the district director shall allow the designated responsible operator and the claimant not less than 60 days within which to submit evidence relevant to the claimant's

eligibility for benefits. The designated responsible operator may elect to adopt any medical evidence previously submitted by another operator as its own evidence, subject to the limitations of § 725.414. The district director may also schedule a conference in accordance with § 725.416, issue a proposed decision and order in accordance with § 725.418, or take such other action as the district director considers appropriate.

§ 725.416 Conferences.

(a) At the conclusion of the period permitted by § 725.410(b) of this part for the submission of evidence, the district director may conduct an informal conference in any claim where it appears that such conference will assist in the voluntary resolution of any issue raised with respect to the claim. The conference proceedings shall not be stenographically reported and sworn testimony shall not be taken. Any conference conducted pursuant to this paragraph shall be held no later than 90 days after the conclusion of the period permitted by § 725.410(b) of this part for the submission of evidence, unless one of the parties requests that the time period be extended for good cause shown. If the district director is unable to hold the conference within the time period permitted by this paragraph, he shall proceed to issue a proposed decision and order under § 725.418 of this part.

(b) The district director shall notify the parties of a definite time and place for the conference. The district director shall advise the parties that they have a right to representation at the conference, by an attorney or a lay representative, and that no conference shall take place unless the parties are represented. A coal mine operator which is self-insured, or which is covered by a policy of insurance for the claim for which a conference is scheduled, shall be deemed to be represented. The notification shall set forth the specific reasons why the district director believes that a conference will assist in the voluntary resolution of any issue raised with respect to the claim. No sanction may be imposed under paragraph (c) of this section unless the record contains a notification that meets the requirements of this section. The district director may in his or her discretion, or on the motion of any party, cancel a conference or allow any or all of the parties to participate by telephone.

(c) The unexcused failure of any party to appear at an informal conference shall be grounds for the imposition of sanctions. If the claimant fails to appear, the district director may take such steps as are authorized by § 725.409(b)(2) to deny the claim by reason of abandonment. If the responsible operator fails to appear, it shall be deemed to have waived its right to contest its potential liability for an award of benefits and, in the discretion of the district director, its right to contest any issue related to the claimant's eligibility.

(d) Any representative of an operator, of an operator's insurance carrier, or of a claimant, authorized to represent such party in accordance with paragraph (b), shall be deemed to have sufficient authority to stipulate facts or issues or agree to a final disposition of the claim.

(e) Procedures to be followed at a conference shall be within the discretion of the district director.

§ 725.417 Action at the conclusion of conference.

(a) At the conclusion of a conference, the district director shall prepare a stipulation of contested and uncontested issues which shall be signed by the parties and the district director. If a hearing is conducted with respect to the claim, this stipulation shall be submitted to the Office of Administrative Law Judges and placed in the claim record.

(b) In appropriate cases, the district director may permit a reasonable time for the submission of additional evidence following a conference, provided that such evidence does not exceed the limits set forth in § 725.414. The district director may also notify additional operators of their potential liability pursuant to § 725.407, or issue another schedule for the submission of additional evidence pursuant to § 725.410, designating another potentially liable operator as the responsible operator liable for the payment of benefits, in

order to allow that operator an opportunity to submit evidence relevant to its liability for benefits as well as the claimant's eligibility for benefits.

(c) Within 20 days after the termination of all conference proceedings, the district director shall prepare and send to the parties a proposed decision and order pursuant to § 725.418 of this part.

§ 725.418 Proposed decision and order.

(a) Within 20 days after the termination of all informal conference proceedings, or, if no informal conference is held, at the conclusion of the period permitted by § 725.410(b) for the submission of evidence, the district director will issue a proposed decision and order. A proposed decision and order is a document, issued by the district director after the evidentiary development of the claim is completed and all contested issues, if any, are joined, which purports to resolve a claim on the basis of the evidence submitted to or obtained by the district director. A proposed decision and order will be considered a final adjudication of a claim only as provided in § 725.419. A proposed decision and order may be issued by the district director at any time during the adjudication of any claim if:

(1) Issuance is authorized or required by this part;

(2) The district director determines that its issuance will expedite the adjudication of the claim; or

(3) The district director determines that the claimant is a survivor who is entitled to benefits under 30 U.S.C. 932(l). In such cases, the district director may designate the responsible operator in the proposed decision and order regardless of whether the requirements of paragraph (d) of this section have been met. Any operator identified as liable for benefits under this paragraph may challenge the finding of liability by timely requesting revision of the proposed decision and order and specifically indicating disagreement with that finding. *See* 20 CFR 725.419(a) and (b). In such cases, the district director must allow all parties 30 days within which to submit liability evidence. At the end of this period, the district director must issue a new proposed decision and order.

(b) A proposed decision and order must contain findings of fact and conclusions of law. It must be served on all parties to the claim by certified mail.

(c) The proposed decision and order must contain a notice of the right of any interested party to request a formal hearing before the Office of Administrative Law Judges. If the proposed decision and order is a denial of benefits, and the claimant has previously filed a request for a hearing, the proposed decision and order must notify the claimant that the case will be referred for a hearing pursuant to the previous request unless the claimant notifies the district director that he no longer desires a hearing. If the proposed decision and order is an award of benefits, and the designated responsible operator has previously filed a request for a hearing, the proposed decision and order must notify the operator that the case will be referred for a hearing pursuant to the previous request unless the operator notifies the district director that it no longer desires a hearing.

(d) The proposed decision and order must reflect the district director's final designation of the responsible operator liable for the payment of benefits. Except as provided in paragraph (a)(3) of this section, no operator may be finally designated as the responsible operator unless it has received notification of its potential liability pursuant to § 725.407, and the opportunity to submit additional evidence pursuant to § 725.410. The district director must dismiss, as parties to the claim, all other potentially liable operators that received notification pursuant to § 725.407 and that were not previously dismissed pursuant to § 725.410(a)(3).

[78 FR 59118, Sept. 25, 2013]

§ 725.419 Response to proposed decision and order.

(a) Within 30 days after the date of issuance of a proposed decision and order, any party may, in writing, request a revision of the proposed decision and order or a hearing. If a hearing is requested, the district director shall refer the claim to the Office of

Administrative Law Judges (see § 725.421).

(b) Any response made by a party to a proposed decision and order shall specify the findings and conclusions with which the responding party disagrees, and shall be served on the district director and all other parties to the claim.

(c) If a timely request for revision of a proposed decision and order is made, the district director may amend the proposed decision and order, as circumstances require, and serve the revised proposed decision and order on all parties or take such other action as is appropriate. If a revised proposed decision and order is issued, each party to the claim shall have 30 days from the date of issuance of that revised proposed decision and order within which to request a hearing.

(d) If no response to a proposed decision and order is sent to the district director within the period described in paragraph (a) of this section, or if no response to a revised proposed decision and order is sent to the district director within the period described in paragraph (c) of this section, the proposed decision and order shall become a final decision and order, which is effective upon the expiration of the applicable 30-day period. Once a proposed decision and order or revised proposed decision and order becomes final and effective, all rights to further proceedings with respect to the claim shall be considered waived, except as provided in § 725.310.

§ 725.420 Initial determinations.

(a) Section 9501(d)(1)(A)(1) of the Internal Revenue Code (26 U.S.C.) provides that the Black Lung Disability Trust Fund shall begin the payment of benefits on behalf of an operator in any case in which the operator liable for such payments has not commenced payment of such benefits within 30 days after the date of an initial determination of eligibility by the Secretary. For claims filed on or after January 1, 1982, the payment of such interim benefits from the fund is limited to benefits accruing after the date of such initial determination.

(b) Except as provided in § 725.415, after the district director has determined that a claimant is eligible for benefits, on the basis of all evidence submitted by a claimant and operator, and has determined that a hearing will be necessary to resolve the claim, the district director shall in writing so inform the parties and direct the operator to begin the payment of benefits to the claimant in accordance with § 725.522. The date on which this writing is sent to the parties shall be considered the date of initial determination of the claim.

(c) If a notified operator refuses to commence payment of a claim within 30 days from the date on which an initial determination is made under this section, benefits shall be paid by the fund to the claimant in accordance with § 725.522, and the operator shall be liable to the fund, if such operator is determined liable for the claim, for all benefits paid by the fund on behalf of such operator, and, in addition, such penalties and interest as are appropriate.

§ 725.421 Referral of a claim to the Office of Administrative Law Judges.

(a) In any claim for which a formal hearing is requested or ordered, and with respect to which the district director has completed evidentiary development and adjudication without having resolved all contested issues, the district director shall refer the claim to the Office of Administrative Law Judges for a hearing.

(b) In any case referred to the Office of Administrative Law Judges under this section, the district director shall transmit to that office the following documents, which shall be placed in the record at the hearing subject to the objection of any party:

(1) Copies of the claim form or forms;

(2) Any statement, document, or pleading submitted by a party to the claim;

(3) A copy of the notification to an operator of its possible liability for the claim, and any schedule for the submission of additional evidence issued pursuant to § 725.410 designating a potentially liable operator as the responsible operator;

(4) All medical evidence submitted to the district director under this part by the claimant and the potentially liable operator designated as the responsible

operator in the proposed decision and order issued pursuant to § 725.418, or the fund, as appropriate, subject to the limitations of § 725.414 of this part; this evidence shall include the results of any medical examination or test conducted pursuant to § 725.406, and all evidence relevant to the liability of the responsible operator submitted to the district director under this part;

(5) Any written stipulation of law or fact or stipulation of contested and uncontested issues entered into by the parties;

(6) Any pertinent forms submitted to the district director;

(7) The statement by the district director of contested and uncontested issues in the claim; and

(8) The district director's initial determination of eligibility or other documents necessary to establish the right of the fund to reimbursement, if appropriate. Copies of the transmittal notice shall also be sent to all parties to the claim by regular mail.

(c) A party may at any time request and obtain from the district director copies of documents transmitted to the Office of Administrative Law Judges under paragraph (b) of this section. If the party has previously been provided with such documents, additional copies may be sent to the party upon the payment of a copying fee to be determined by the district director.

§ 725.422 Legal assistance.

The Secretary or his or her designee may, upon request, provide a claimant with legal assistance in processing a claim under the Act. Such assistance may be made available to a claimant in the discretion of the Solicitor of Labor or his or her designee at any time prior to or during the time in which the claim is being adjudicated and shall be furnished without charge to the claimant. Representation of a claimant in adjudicatory proceedings shall not be provided by the Department of Labor unless it is determined by the Solicitor of Labor that such representation is in the best interests of the black lung benefits program. In no event shall representation be provided to a claimant in a claim with respect to which the claimant's interests are adverse to those of the Secretary of Labor or the fund.

§ 725.423 Extensions of time.

Except for the 30-day time limit set forth in § 725.419, any of the time periods set forth in this subpart may be extended, for good cause shown, by filing a request for an extension with the district director prior to the expiration of the time period.

Subpart F—Hearings

§ 725.450 Right to a hearing.

Any party to a claim (see § 725.360) shall have a right to a hearing concerning any contested issue of fact or law unresolved by the district director. There shall be no right to a hearing until the processing and adjudication of the claim by the district director has been completed. There shall be no right to a hearing in a claim with respect to which a determination of the claim made by the district director has become final and effective in accordance with this part.

§ 725.451 Request for hearing.

After the completion of proceedings before the district director, or as is otherwise indicated in this part, any party may in writing request a hearing on any contested issue of fact or law (see § 725.419). A district director may on his or her own initiative refer a case for hearing. If a hearing is requested, or if a district director determines that a hearing is necessary to the resolution of any issue, the claim shall be referred to the Chief Administrative Law Judge for a hearing under § 725.421.

§ 725.452 Type of hearing; parties.

(a) A hearing held under this part shall be conducted by an administrative law judge designated by the Chief Administrative Law Judge. Except as otherwise provided by this part, all hearings shall be conducted in accordance with the provisions of 5 U.S.C. 554 *et seq*.

(b) All parties to a claim shall be permitted to participate fully at a hearing held in connection with such claim.

(c) A full evidentiary hearing need not be conducted if a party moves for

summary judgment and the administrative law judge determines that there is no genuine issue as to any material fact and that the moving party is entitled to the relief requested as a matter of law. All parties shall be entitled to respond to the motion for summary judgment prior to decision thereon.

(d) If the administrative law judge believes that an oral hearing is not necessary (for any reason other than on motion for summary judgment), the judge shall notify the parties by written order and allow at least 30 days for the parties to respond. The administrative law judge shall hold the oral hearing if any party makes a timely request in response to the order.

§ 725.453 Notice of hearing.

All parties shall be given at least 30 days written notice of the date and place of a hearing and the issues to be resolved at the hearing. Such notice shall be sent to each party or representative by certified mail.

§ 725.454 Time and place of hearing; transfer of cases.

(a) The Chief Administrative Law Judge shall assign a definite time and place for a formal hearing, and shall, where possible, schedule the hearing to be held at a place within 75 miles of the claimant's residence unless an alternate location is requested by the claimant.

(b) If the claimant's residence is not in any State, the Chief Administrative Law Judge may, in his or her discretion, schedule the hearing in the country of the claimant's residence.

(c) The Chief Administrative Law Judge or the administrative law judge assigned the case may in his or her discretion direct that a hearing with respect to a claim shall begin at one location and then later be reconvened at another date and place.

(d) The Chief Administrative Law Judge or administrative law judge assigned the case may change the time and place for a hearing, either on his or her own motion or for good cause shown by a party. The administrative law judge may adjourn or postpone the hearing for good cause shown, at any time prior to the mailing to the parties of the decision in the case. Unless otherwise agreed, at least 10 days notice shall be given to the parties of any change in the time or place of hearing.

(e) The Chief Administrative Law Judge may for good cause shown transfer a case from one administrative law judge to another.

§ 725.455 Hearing procedures; generally.

(a) *General*. The purpose of any hearing conducted under this subpart shall be to resolve contested issues of fact or law. Except as provided in § 725.421(b)(8), any findings or determinations made with respect to a claim by a district director shall not be considered by the administrative law judge.

(b) *Evidence*. The administrative law judge shall at the hearing inquire fully into all matters at issue, and shall not be bound by common law or statutory rules of evidence, or by technical or formal rules of procedure, except as provided by 5 U.S.C. 554 and this subpart. The administrative law judge shall receive into evidence the testimony of the witnesses and parties, the evidence submitted to the Office of Administrative Law Judges by the district director under § 725.421, and such additional evidence as may be submitted in accordance with the provisions of this subpart. The administrative law judge may entertain the objections of any party to the evidence submitted under this section.

(c) *Procedure*. The conduct of the hearing and the order in which allegations and evidence shall be presented shall be within the discretion of the administrative law judge and shall afford the parties an opportunity for a fair hearing.

(d) *Oral argument and written allegations*. The parties, upon request, may be allowed a reasonable time for the presentation of oral argument at the hearing. Briefs or other written statements or allegations as to facts or law may be filed by any party with the permission of the administrative law judge. Copies of any brief or other written statement shall be filed with the administrative law judge and served on all parties by the submitting party.

§ 725.456 Introduction of documentary evidence.

(a) All documents transmitted to the Office of Administrative Law Judges under § 725.421 shall be placed into evidence by the administrative law judge, subject to objection by any party.

(b)(1) Documentary evidence pertaining to the liability of a potentially liable operator and/or the identification of a responsible operator which was not submitted to the district director shall not be admitted into the hearing record in the absence of extraordinary circumstances. Medical evidence in excess of the limitations contained in § 725.414 shall not be admitted into the hearing record in the absence of good cause.

(2) Subject to the limitations in paragraph (b)(1) of this section, any other documentary material, including medical reports, which was not submitted to the district director, may be received in evidence subject to the objection of any party, if such evidence is sent to all other parties at least 20 days before a hearing is held in connection with the claim.

(3) Documentary evidence, which is not exchanged with the parties in accordance with this paragraph, may be admitted at the hearing with the written consent of the parties or on the record at the hearing, or upon a showing of good cause why such evidence was not exchanged in accordance with this paragraph. If documentary evidence is not exchanged in accordance with paragraph (b)(2) of this section and the parties do not waive the 20-day requirement or good cause is not shown, the administrative law judge shall either exclude the late evidence from the record or remand the claim to the district director for consideration of such evidence.

(4) A medical report which is not made available to the parties in accordance with paragraph (b)(2) of this section shall not be admitted into evidence in any case unless the hearing record is kept open for at least 30 days after the hearing to permit the parties to take such action as each considers appropriate in response to such evidence. If, in the opinion of the administrative law judge, evidence is withheld from the parties for the purpose of delaying the adjudication of the claim, the administrative law judge may exclude such evidence from the hearing record and close the record at the conclusion of the hearing.

(c) Subject to paragraph (b) of this section, documentary evidence which the district director excludes from the record, and the objections to such evidence, may be submitted by the parties to the administrative law judge, who shall independently determine whether the evidence shall be admitted.

(1) If the evidence is admitted, the administrative law judge may, in his or her discretion, remand the claim to the district director for further consideration.

(2) If the evidence is admitted, the administrative law judge shall afford the opposing party or parties the opportunity to develop such additional documentary evidence as is necessary to protect the right of cross-examination.

(d) All medical records and reports submitted by any party shall be considered by the administrative law judge in accordance with the quality standards contained in part 718 of this subchapter.

(e) If the administrative law judge concludes that the complete pulmonary evaluation provided pursuant to § 725.406, or any part thereof, fails to comply with the applicable quality standards, or fails to address the relevant conditions of entitlement (see § 725.202(d)(2)(i) through (iv)) in a manner which permits resolution of the claim, the administrative law judge shall, in his or her discretion, remand the claim to the district director with instructions to develop only such additional evidence as is required, or allow the parties a reasonable time to obtain and submit such evidence, before the termination of the hearing.

§ 725.457 Witnesses.

(a) Witnesses at the hearing shall testify under oath or affirmation. The administrative law judge and the parties may question witnesses with respect to any matters relevant and material to any contested issue. Any party who intends to present the testimony of an expert witness at a hearing, including any physician, regardless of whether

the physician has previously prepared a medical report, shall so notify all other parties to the claim at least 10 days before the hearing. The failure to give notice of the appearance of an expert witness in accordance with this paragraph, unless notice is waived by all parties, shall preclude the presentation of testimony by such expert witness.

(b) No person shall be required to appear as a witness in any proceeding before an administrative law judge at a place more than 100 miles from his or her place of residence, unless the lawful mileage and witness fee for 1 day's attendance is paid in advance of the hearing date.

(c) No person shall be permitted to testify as a witness at the hearing, or pursuant to deposition or interrogatory under § 725.458, unless that person meets the requirements of § 725.414(c).

(1) In the case of a witness offering testimony relevant to the liability of the responsible operator, in the absence of extraordinary circumstances, the witness must have been identified as a potential hearing witness while the claim was pending before the district director.

(2) In the case of a physician offering testimony relevant to the physical condition of the miner, such physician must have prepared a medical report. Alternatively, in the absence of a showing of good cause under § 725.456(b)(1) of this part, a physician may offer testimony relevant to the physical condition of the miner only to the extent that the party offering the physician's testimony has submitted fewer medical reports than permitted by § 725.414. Such physician's opinion shall be considered a medical report subject to the limitations of § 725.414.

(d) A physician whose testimony is permitted under this section may testify as to any other medical evidence of record, but shall not be permitted to testify as to any medical evidence relevant to the miner's condition that is not admissible.

§ 725.458 Depositions; interrogatories.

The testimony of any witness or party may be taken by deposition or interrogatory according to the rules of practice of the Federal district court for the judicial district in which the case is pending (or of the U.S. District Court for the District of Columbia if the case is pending in the District or outside the United States), except that at least 30 days prior notice of any deposition shall be given to all parties unless such notice is waived. No post-hearing deposition or interrogatory shall be permitted unless authorized by the administrative law judge upon the motion of a party to the claim. The testimony of any physician which is taken by deposition shall be subject to the limitations on the scope of the testimony contained in § 725.457(d).

§ 725.459 Witness fees.

(a) A witness testifying at a hearing before an administrative law judge, or whose deposition is taken, shall receive the same fees and mileage as witnesses in courts of the United States. If the witness is an expert, he or she shall be entitled to an expert witness fee. Except as provided in paragraphs (b) and (c) of this section, such fees shall be paid by the proponent of the witness.

(b) If the witness' proponent does not intend to call the witness to appear at a hearing or deposition, any other party may subpoena the witness for cross-examination. The administrative law judge (ALJ) shall authorize the least intrusive and expensive means of cross-examination as the ALJ deems appropriate and necessary to the full and true disclosure of the facts. If such witness is required to attend the hearing, give a deposition or respond to interrogatories for cross-examination purposes, the proponent of the witness shall pay the witness' fee. The fund shall remain liable for any costs associated with the cross-examination of the physician who performed the complete pulmonary evaluation pursuant to § 725.406.

(c) If a claimant is determined entitled to benefits, there may be assessed as costs against a responsible operator, if any, or the fund, fees and mileage for necessary witnesses attending the hearing at the request of the claimant. Both the necessity for the witness and the reasonableness of the fees of any expert witness shall be approved by the administrative law judge. The amounts awarded against a responsible operator or the fund as attorney's fees, or costs,

fees and mileage for witnesses, shall not in any respect affect or diminish benefits payable under the Act.

[65 FR 80054, Dec. 20, 2000, as amended at 68 FR 69935, Dec. 15, 2003]

§ 725.460 Consolidated hearings.

When two or more hearings are to be held, and the same or substantially similar evidence is relevant and material to the matters at issue at each such hearing, the Chief Administrative Law Judge may, upon motion by any party or on his or her own motion, order that a consolidated hearing be conducted. Where consolidated hearings are held, a single record of the proceedings shall be made and the evidence introduced in one claim may be considered as introduced in the others, and a separate or joint decision shall be made, as appropriate.

§ 725.461 Waiver of right to appear and present evidence.

(a) If all parties waive their right to appear before the administrative law judge, it shall not be necessary for the administrative law judge to give notice of, or conduct, an oral hearing. A waiver of the right to appear shall be made in writing and filed with the Chief Administrative Law Judge or the administrative law judge assigned to hear the case. Such waiver may be withdrawn by a party for good cause shown at any time prior to the mailing of the decision in the claim. Even though all of the parties have filed a waiver of the right to appear, the administrative law judge may, nevertheless, after giving notice of the time and place, conduct a hearing if he or she believes that the personal appearance and testimony of the party or parties would assist in ascertaining the facts in issue in the claim. Where a waiver has been filed by all parties, and they do not appear before the administrative law judge personally or by representative, the administrative law judge shall make a record of the relevant documentary evidence submitted in accordance with this part and any further written stipulations of the parties. Such documents and stipulations shall be considered the evidence of record in the case and the decision shall be based upon such evidence.

(b) Except as provided in § 725.456(a), the unexcused failure of any party to attend a hearing shall constitute a waiver of such party's right to present evidence at the hearing, and may result in a dismissal of the claim (see § 725.465).

§ 725.462 Withdrawal of controversion of issues set for formal hearing; effect.

A party may, on the record, withdraw his or her controversion of any or all issues set for hearing. If a party withdraws his or her controversion of all issues, the administrative law judge shall remand the case to the district director for the issuance of an appropriate order.

§ 725.463 Issues to be resolved at hearing; new issues.

(a) Except as otherwise provided in this section, the hearing shall be confined to those contested issues which have been identified by the district director (see § 725.421) or any other issue raised in writing before the district director.

(b) An administrative law judge may consider a new issue only if such issue was not reasonably ascertainable by the parties at the time the claim was before the district director. Such new issue may be raised upon application of any party, or upon an administrative law judge's own motion, with notice to all parties, at any time after a claim has been transmitted by the district director to the Office of Administrative Law Judges and prior to decision by an administrative law judge. If a new issue is raised, the administrative law judge may, in his or her discretion, either remand the case to the district director with instructions for further proceedings, hear and resolve the new issue, or refuse to consider such new issue.

(c) If a new issue is to be considered by the administrative law judge, a party may, upon request, be granted an appropriate continuance.

§ 725.464 Record of hearing.

All hearings shall be open to the public and shall be mechanically or stenographically reported. All evidence upon

which the administrative law judge relies for decision shall be contained in the transcript of testimony, either directly or by appropriate reference. All medical reports, exhibits, and any other pertinent document or record, either in whole or in material part, introduced as evidence, shall be marked for identification and incorporated into the record.

§ 725.465 Dismissals for cause.

(a) The administrative law judge may, at the request of any party, or on his or her own motion, dismiss a claim:

(1) Upon the failure of the claimant or his or her representative to attend a hearing without good cause;

(2) Upon the failure of the claimant to comply with a lawful order of the administrative law judge; or

(3) Where there has been a prior final adjudication of the claim or defense to the claim under the provisions of this subchapter and no new evidence is submitted (except as provided in part 727 of this subchapter; see § 725.4(d)).

(b) A party who is not a proper party to the claim (see § 725.360) shall be dismissed by the administrative law judge. The administrative law judge shall not dismiss the operator designated as the responsible operator by the district director, except upon the motion or written agreement of the Director.

(c) In any case where a dismissal of a claim, defense, or party is sought, the administrative law judge shall issue an order to show cause why the dismissal should not be granted and afford all parties a reasonable time to respond to such order. After the time for response has expired, the administrative law judge shall take such action as is appropriate to rule on the dismissal, which may include an order dismissing the claim, defense or party.

(d) No claim shall be dismissed in a case with respect to which payments prior to final adjudication have been made to the claimant in accordance with § 725.522, except upon the motion or written agreement of the Director.

§ 725.466 Order of dismissal.

(a) An order dismissing a claim shall be served on the parties in accordance with § 725.478. The dismissal of a claim shall have the same effect as a decision and order disposing of the claim on its merits, except as provided in paragraph (b) of this section. Such order shall advise the parties of their right to request review by the Benefits Review Board.

(b) Where the Chief Administrative Law Judge or the presiding administrative law judge issues a decision and order dismissing the claim after a show cause proceeding, the district director shall terminate any payments being made to the claimant under § 725.522, and the order of dismissal shall, if appropriate, order the claimant to reimburse the fund for all benefits paid to the claimant.

§ 725.475 Termination of hearings.

Hearings are officially terminated when all the evidence has been received, witnesses heard, pleadings and briefs submitted to the administrative law judge, and the transcript of the proceedings has been printed and delivered to the administrative law judge.

§ 725.476 Issuance of decision and order.

Within 20 days after the official termination of the hearing (see § 725.475), the administrative law judge shall issue a decision and order with respect to the claim making an award to the claimant, rejecting the claim, or taking such other action as is appropriate.

§ 725.477 Form and contents of decision and order.

(a) Orders adjudicating claims for benefits shall be designated by the term ''decision and order'' or ''supplemental decision and order'' as appropriate, followed by a descriptive phrase designating the particular type of order, such as ''award of benefits,'' ''rejection of claim,'' ''suspension of benefits,'' ''modification of award.''

(b) A decision and order shall contain a statement of the basis of the order, findings of fact, conclusions of law, and an award, rejection or other appropriate paragraph containing the action of the administrative law judge, his or her signature and the date of issuance. A decision and order shall be based

upon the record made before the administrative law judge.

[65 FR 80054, Dec. 20, 2000, as amended at 72 FR 4205, Jan. 30, 2007]

§ 725.478 Filing and service of decision and order.

On the date of issuance of a decision and order under § 725.477, the administrative law judge shall serve the decision and order on all parties to the claim by certified mail. On the same date, the original record of the claim shall be sent to the DCMWC in Washington, D.C. Upon receipt by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

§ 725.479 Finality of decisions and orders.

(a) A decision and order shall become effective when filed in the office of the district director (see § 725.478), and unless proceedings for suspension or setting aside of such order are instituted within 30 days of such filing, the order shall become final at the expiration of the 30th day after such filing (see § 725.481).

(b) Any party may, within 30 days after the filing of a decision and order under § 725.478, request a reconsideration of such decision and order by the administrative law judge. The procedures to be followed in the reconsideration of a decision and order shall be determined by the administrative law judge.

(c) The time for appeal to the Benefits Review Board shall be suspended during the consideration of a request for reconsideration. After the administrative law judge has issued and filed a denial of the request for reconsideration, or a revised decision and order in accordance with this part, any dissatisfied party shall have 30 days within which to institute proceedings to set aside the decision and order on reconsideration.

(d) Regardless of any defect in service, actual receipt of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.

§ 725.480 Modification of decisions and orders.

A party who is dissatisfied with a decision and order which has become final in accordance with § 725.479 may request a modification of the decision and order if the conditions set forth in § 725.310 are met.

§ 725.481 Right to appeal to the Benefits Review Board.

Any party dissatisfied with a decision and order issued by an administrative law judge may, before the decision and order becomes final (see § 725.479), appeal the decision and order to the Benefits Review Board. A notice of appeal shall be filed with the Board. Proceedings before the Board shall be conducted in accordance with part 802 of this title.

§ 725.482 Judicial review.

(a) Any person adversely affected or aggrieved by a final order of the Benefits Review Board may obtain a review of that order in the U.S. court of appeals for the circuit in which the injury occurred by filing in such court within 60 days following the issuance of such Board order a written petition praying that the order be modified or set aside. The payment of the amounts required by an award shall not be stayed pending final decision in any such proceeding unless ordered by the court. No stay shall be issued unless the court finds that irreparable injury would otherwise ensue to an operator or carrier.

(b) The Director, Office of Workers' Compensation Program, as designee of the Secretary of Labor responsible for the administration and enforcement of the Act, shall be considered the proper party to appear and present argument on behalf of the Secretary of Labor in all review proceedings conducted pursuant to this part and the Act, either as petitioner or respondent.

§ 725.483 Costs in proceedings brought without reasonable grounds.

If a United States court having jurisdiction of proceedings regarding any claim or final decision and order, determines that the proceedings have been instituted or continued before such court without reasonable ground,

the costs of such proceedings shall be assessed against the party who has so instituted or continued such proceedings.

Subpart G—Responsible Coal Mine Operators

§ 725.490 Statutory provisions and scope.

(a) One of the major purposes of the black lung benefits amendments of 1977 was to provide a more effective means of transferring the responsibility for the payment of benefits from the Federal government to the coal industry with respect to claims filed under this part. In furtherance of this goal, a Black Lung Disability Trust Fund financed by the coal industry was established by the Black Lung Benefits Revenue Act of 1977. The primary purpose of the Fund is to pay benefits with respect to all claims in which the last coal mine employment of the miner on whose account the claim was filed occurred before January 1, 1970. With respect to most claims in which the miner's last coal mine employment occurred after January 1, 1970, individual coal mine operators will be liable for the payment of benefits. The 1981 amendments to the Act relieved individual coal mine operators from the liability for payment of certain special claims involving coal mine employment on or after January 1, 1970, where the claim was previously denied and subsequently approved under section 435 of the Act. See § 725.496 for a detailed description of these special claims. Where no such operator exists or the operator determined to be liable is in default in any case, the fund shall pay the benefits due and seek reimbursement as is appropriate. See also § 725.420 for the fund's role in the payment of interim benefits in certain contested cases. In addition, the Black Lung Benefits Reform Act of 1977 amended certain provisions affecting the scope of coverage under the Act and describing the effects of particular corporate transactions on the liability of operators.

(b) The provisions of this subpart define the term ''operator'' and prescribe the manner in which the identity of an operator which may be liable for the payment of benefits—referred to herein as a ''responsible operator''—will be determined.

§ 725.491 Operator defined.

(a) For purposes of this part, the term ''operator'' shall include:

(1) Any owner, lessee, or other person who operates, controls, or supervises a coal mine, or any independent contractor performing services or construction at such mine; or

(2) Any other person who:

(i) Employs an individual in the transportation of coal or in coal mine construction in or around a coal mine, to the extent such individual was exposed to coal mine dust as a result of such employment (see § 725.202);

(ii) In accordance with the provisions of § 725.492, may be considered a successor operator; or

(iii) Paid wages or a salary, or provided other benefits, to an individual in exchange for work as a miner (see § 725.202).

(b) The terms ''owner,'' ''lessee,'' and ''person'' shall include any individual, partnership, association, corporation, firm, subsidiary of a corporation, or other organization, as appropriate, except that an officer of a corporation shall not be considered an ''operator'' for purposes of this part. Following the issuance of an order awarding benefits against a corporation that has not secured its liability for benefits in accordance with section 423 of the Act and § 726.4, such order may be enforced against the president, secretary, or treasurer of the corporation in accordance with subpart I of this part.

(c) The term ''independent contractor'' shall include any person who contracts to perform services. Such contractor's status as an operator shall not be contingent upon the amount or percentage of its work or business related to activities in or around a mine, nor upon the number or percentage of its employees engaged in such activities.

(d) For the purposes of determining whether a person is or was an operator that may be found liable for the payment of benefits under this part, there shall be a rebuttable presumption that during the course of an individual's employment with such employer, such

individual was regularly and continuously exposed to coal mine dust during the course of employment. The presumption may be rebutted by a showing that the employee was not exposed to coal mine dust for significant periods during such employment.

(e) The operation, control, or supervision referred to in paragraph (a)(1) of this section may be exercised directly or indirectly. Thus, for example, where a coal mine is leased, and the lease empowers the lessor to make decisions with respect to the terms and conditions under which coal is to be extracted or prepared, such as, but not limited to, the manner of extraction or preparation or the amount of coal to be produced, the lessor may be considered an operator. Similarly, any parent entity or other controlling business entity may be considered an operator for purposes of this part, regardless of the nature of its business activities.

(f) Neither the United States, nor any State, nor any instrumentality or agency of the United States or any State, shall be considered an operator.

§ 725.492 Successor operator defined.

(a) Any person who, on or after January 1, 1970, acquired a mine or mines, or substantially all of the assets thereof, from a prior operator, or acquired the coal mining business of such prior operator, or substantially all of the assets thereof, shall be considered a ''successor operator'' with respect to any miners previously employed by such prior operator.

(b) The following transactions shall also be deemed to create successor operator liability:

(1) If an operator ceases to exist by reason of a reorganization which involves a change in identity, form, or place of business or organization, however effected;

(2) If an operator ceases to exist by reason of a liquidation into a parent or successor corporation; or

(3) If an operator ceases to exist by reason of a sale of substantially all its assets, or as a result of merger, consolidation, or division.

(c) In any case in which a transaction specified in paragraph (b), or substantially similar to a transaction specified in paragraph (b), took place, the resulting entity shall be considered a ''successor operator'' with respect to any miners previously employed by such prior operator.

(d) This section shall not be construed to relieve a prior operator of any liability if such prior operator meets the conditions set forth in § 725.494. If the prior operator does not meet the conditions set forth in § 725.494, the following provisions shall apply:

(1) In any case in which a prior operator transferred a mine or mines, or substantially all of the assets thereof, to a successor operator, or sold its coal mining business or substantially all of the assets thereof, to a successor operator, and then ceased to exist within the terms of paragraph (b), the successor operator as identified in paragraph (a) shall be primarily liable for the payment of benefits to any miners previously employed by such prior operator.

(2) In any case in which a prior operator transferred mines, or substantially all of the assets thereof, to more than one successor operator, the successor operator that most recently acquired a mine or mines or assets from the prior operator shall be primarily liable for the payment of benefits to any miners previously employed by such prior operator.

(3) In any case in which a mine or mines, or substantially all the assets thereof, have been transferred more than once, the successor operator that most recently acquired such mine or mines or assets shall be primarily liable for the payment of benefits to any miners previously employed by the original prior operator. If the most recent successor operator does not meet the criteria for a potentially liable operator set forth in § 725.494, the next most recent successor operator shall be liable.

(e) An ''acquisition,'' for purposes of this section, shall include any transaction by which title to the mine or mines, or substantially all of the assets thereof, or the right to extract or prepare coal at such mine or mines, becomes vested in a person other than the prior operator.

§ 725.493 Employment relationship defined.

(a)(1) In determining the identity of a responsible operator under this part, the terms ''employ'' and ''employment'' shall be construed as broadly as possible, and shall include any relationship under which an operator retains the right to direct, control, or supervise the work performed by a miner, or any other relationship under which an operator derives a benefit from the work performed by a miner. Any individuals who participate with one or more persons in the mining of coal, such as owners, proprietors, partners, and joint venturers, whether they are compensated by wages, salaries, piece rates, shares, profits, or by any other means, shall be deemed employees. It is the specific intention of this paragraph to disregard any financial arrangement or business entity devised by the actual owners or operators of a coal mine or coal mine-related enterprise to avoid the payment of benefits to miners who, based upon the economic reality of their relationship to this enterprise, are, in fact, employees of the enterprise.

(2) The payment of wages or salary shall be prima facie evidence of the right to direct, control, or supervise an individual's work. The Department intends that where the operator who paid a miner's wages or salary meets the criteria for a potentially liable operator set forth in § 725.494, that operator shall be primarily liable for the payment of any benefits due the miner as a result of such employment. The absence of such payment, however, will not negate the existence of an employment relationship. Thus, the Department also intends that where the person who paid a miner's wages may not be considered a potentially liable operator, any other operator who retained the right to direct, control or supervise the work performed by the miner, or who benefitted from such work, may be considered a potentially liable operator.

(b) This paragraph contains examples of relationships that shall be considered employment relationships for purposes of this part. The list is not intended to be exclusive.

(1) In any case in which an operator may be considered a successor operator, as determined in accordance with § 725.492, any employment with a prior operator shall also be deemed to be employment with the successor operator. In a case in which the miner was not independently employed by the successor operator, the prior operator shall remain primarily liable for the payment of any benefits based on the miner's employment with the prior operator. In a case in which the miner was independently employed by the successor operator after the transaction giving rise to successor operator liability, the successor operator shall be primarily liable for the payment of any benefits.

(2) In any case in which the operator which directed, controlled or supervised the miner is no longer in business and such operator was a subsidiary of a parent company, a member of a joint venture, a partner in a partnership, or was substantially owned or controlled by another business entity, such parent entity or other member of a joint venture or partner or controlling business entity may be considered the employer of any employees of such operator.

(3) In any claim in which the operator which directed, controlled or supervised the miner is a lessee, the lessee shall be considered primarily liable for the claim. The liability of the lessor may be established only after it has been determined that the lessee is unable to provide for the payment of benefits to a successful claimant. In any case involving the liability of a lessor for a claim arising out of employment with a lessee, any determination of lessor liability shall be made on the basis of the facts present in the case in accordance with the following considerations:

(i) Where a coal mine is leased, and the lease empowers the lessor to make decisions with respect to the terms and conditions under which coal is to be extracted or prepared, such as, but not limited to, the manner of extraction or preparation or the amount of coal to be produced, the lessor shall be considered the employer of any employees of the lessee.

(ii) Where a coal mine is leased to a self-employed operator, the lessor shall

be considered the employer of such self-employed operator and its employees if the lease or agreement is executed or renewed after August 18, 1978 and such lease or agreement does not require the lessee to guarantee the payment of benefits which may be required under this part and part 726 of this subchapter.

(iii) Where a lessor previously operated a coal mine, it may be considered an operator with respect to employees of any lessee of such mine, particularly where the leasing arrangement was executed or renewed after August 18, 1978 and does not require the lessee to secure benefits provided by the Act.

(4) A self-employed operator, depending upon the facts of the case, may be considered an employee of any other operator, person, or business entity which substantially controls, supervises, or is financially responsible for the activities of the self-employed operator.

§ 725.494 Potentially liable operators.

An operator may be considered a ''potentially liable operator'' with respect to a claim for benefits under this part if each of the following conditions is met:

(a) The miner's disability or death arose at least in part out of employment in or around a mine or other facility during a period when the mine or facility was operated by such operator, or by a person with respect to which the operator may be considered a successor operator. For purposes of this section, there shall be a rebuttable presumption that the miner's disability or death arose in whole or in part out of his or her employment with such operator. Unless this presumption is rebutted, the responsible operator shall be liable to pay benefits to the claimant on account of the disability or death of the miner in accordance with this part. A miner's pneumoconiosis, or disability or death therefrom, shall be considered to have arisen in whole or in part out of work in or around a mine if such work caused, contributed to or aggravated the progression or advancement of a miner's loss of ability to perform his or her regular coal mine employment or comparable employment.

(b) The operator, or any person with respect to which the operator may be considered a successor operator, was an operator for any period after June 30, 1973.

(c) The miner was employed by the operator, or any person with respect to which the operator may be considered a successor operator, for a cumulative period of not less than one year (§ 725.101(a)(32)).

(d) The miner's employment with the operator, or any person with respect to which the operator may be considered a successor operator, included at least one working day (§ 725.101(a)(32)) after December 31, 1969.

(e) The operator is capable of assuming its liability for the payment of continuing benefits under this part. An operator will be deemed capable of assuming its liability for a claim if one of the following three conditions is met:

(1) The operator obtained a policy or contract of insurance under section 423 of the Act and part 726 of this subchapter that covers the claim, except that such policy shall not be considered sufficient to establish the operator's capability of assuming liability if the insurance company has been declared insolvent and its obligations for the claim are not otherwise guaranteed;

(2) The operator qualified as a self-insurer under section 423 of the Act and part 726 of this subchapter during the period in which the miner was last employed by the operator, provided that the operator still qualifies as a self-insurer or the security given by the operator pursuant to § 726.104(b) is sufficient to secure the payment of benefits in the event the claim is awarded; or

(3) The operator possesses sufficient assets to secure the payment of benefits in the event the claim is awarded in accordance with § 725.606.

§ 725.495 Criteria for determining a responsible operator.

(a)(1) The operator responsible for the payment of benefits in a claim adjudicated under this part (the ''responsible operator'') shall be the potentially liable operator, as determined in accordance with § 725.494, that most recently employed the miner.

(2) If more than one potentially liable operator may be deemed to have employed the miner most recently, then the liability for any benefits payable as a result of such employment shall be assigned as follows:

(i) First, to the potentially liable operator that directed, controlled, or supervised the miner;

(ii) Second, to any potentially liable operator that may be considered a successor operator with respect to miners employed by the operator identified in paragraph (a)(2)(i) of this section; and

(iii) Third, to any other potentially liable operator which may be deemed to have been the miner's most recent employer pursuant to § 725.493.

(3) If the operator that most recently employed the miner may not be considered a potentially liable operator, as determined in accordance with § 725.494, the responsible operator shall be the potentially liable operator that next most recently employed the miner. Any potentially liable operator that employed the miner for at least one day after December 31, 1969 may be deemed the responsible operator if no more recent employer may be considered a potentially liable operator.

(4) If the miner's most recent employment by an operator ended while the operator was authorized to self-insure its liability under part 726 of this title, and that operator no longer possesses sufficient assets to secure the payment of benefits, the provisions of paragraph (a)(3) shall be inapplicable with respect to any operator that employed the miner only before he was employed by such self-insured operator. If no operator that employed the miner after his employment with the self-insured operator meets the conditions of § 725.494, the claim of the miner or his survivor shall be the responsibility of the Black Lung Disability Trust Fund.

(b) Except as provided in this section and § 725.408(a)(3), with respect to the adjudication of the identity of a responsible operator, the Director shall bear the burden of proving that the responsible operator initially found liable for the payment of benefits pursuant to § 725.410 (the ''designated responsible operator'') is a potentially liable operator. It shall be presumed, in the absence of evidence to the contrary, that the designated responsible operator is capable of assuming liability for the payment of benefits in accordance with § 725.494(e).

(c) The designated responsible operator shall bear the burden of proving either:

(1) That it does not possess sufficient assets to secure the payment of benefits in accordance with § 725.606; or

(2) That it is not the potentially liable operator that most recently employed the miner. Such proof must include evidence that the miner was employed as a miner after he or she stopped working for the designated responsible operator and that the person by whom he or she was employed is a potentially liable operator within the meaning of § 725.494. In order to establish that a more recent employer is a potentially liable operator, the designated responsible operator must demonstrate that the more recent employer possesses sufficient assets to secure the payment of benefits in accordance with § 725.606. The designated responsible operator may satisfy its burden by presenting evidence that the owner, if the more recent employer is a sole proprietorship; the partners, if the more recent employer is a partnership; or the president, secretary, and treasurer, if the more recent employer is a corporation that failed to secure the payment of benefits pursuant to part 726 of this subchapter, possess assets sufficient to secure the payment of benefits, provided such assets may be reached in a proceeding brought under subpart I of this part.

(d) In any case referred to the Office of Administrative Law Judges pursuant to § 725.421 in which the operator finally designated as responsible pursuant to § 725.418(d) is not the operator that most recently employed the miner, the record shall contain a statement from the district director explaining the reasons for such designation. If the reasons include the most recent employer's failure to meet the conditions of § 725.494(e), the record shall also contain a statement that the Office has searched the files it maintains pursuant to part 726, and that the

Office has no record of insurance coverage for that employer, or of authorization to self-insure, that meets the conditions of § 725.494(e)(1) or (e)(2). Such a statement shall be prima facie evidence that the most recent employer is not financially capable of assuming its liability for a claim. In the absence of such a statement, it shall be presumed that the most recent employer is financially capable of assuming its liability for a claim.

§ 725.496 Special claims transferred to the fund.

(a) The 1981 amendments to the Act amended section 422 of the Act and transferred liability for payment of certain special claims from operators and carriers to the fund. These provisions apply to claims which were denied before March 1, 1978, and which have been or will be approved in accordance with section 435 of the Act.

(b) Section 402(i) of the Act defines three classes of denied claims subject to the transfer provisions:

(1) Claims filed with and denied by the Social Security Administration before March 1, 1978;

(2) Claims filed with the Department of Labor in which the claimant was notified by the Department of an administrative or informal denial before March 1, 1977, and in which the claimant did not within one year of such notification either:

(i) Request a hearing; or

(ii) Present additional evidence; or

(iii) Indicate an intention to present additional evidence; or

(iv) Request a modification or reconsideration of the denial on the ground of a change in conditions or because of a mistake in a determination of fact;

(3) Claims filed with the Department of Labor and denied under the law in effect prior to the enactment of the Black Lung Benefits Reform Act of 1977, that is, before March 1, 1978, following a formal hearing before an administrative law judge or administrative review before the Benefits Review Board or review before a United States Court of Appeals.

(c) Where more than one claim was filed with the Social Security Administration and/or the Department of Labor prior to March 1, 1978, by or on behalf of a miner or a surviving dependent of a miner, unless such claims were required to be merged by the agency's regulations, the procedural history of each such claim must be considered separately to determine whether the claim is subject to the transfer of liability provisions.

(d) For a claim filed with and denied by the Social Security Administration prior to March 1, 1978, to come within the transfer provisions, such claim must have been or must be approved under the provisions of section 435 of the Act. No claim filed with and denied by the Social Security Administration is subject to the transfer of liability provisions unless a request was made by or on behalf of the claimant for review of such denied claim under section 435. Such review must have been requested by the filing of a valid election card or other equivalent document with the Social Security Administration in accordance with section 435(a) and its implementing regulations at 20 CFR 410.700 through 410.707.

(e) Where a claim filed with the Department of Labor prior to March 1, 1977, was subjected to repeated administrative or informal denials, the last such denial issued during the pendency of the claim determines whether the claim is subject to the transfer of liability provisions.

(f) Where a miner's claim comes within the transfer of liability provisions of the 1981 amendments the fund is also liable for the payment of any benefits to which the miner's dependent survivors are entitled after the miner's death. However, if the survivor's entitlement was established on a separate claim not subject to the transfer of liability provisions prior to approval of the miner's claim under section 435, the party responsible for the payment of such survivors' benefits shall not be relieved of that responsibility because the miner's claim was ultimately approved and found subject to the transfer of liability provisions.

§ 725.497 Procedures in special claims transferred to the fund.

(a) *General.* It is the purpose of this section to define procedures to expedite the handling and disposition of claims affected by the benefit liability

transfer provisions of Section 205 of the Black Lung Benefits Amendments of 1981.

(b) *Action by the Department.* The OWCP shall, in accordance with the criteria contained in § 725.496, review each claim which is or may be affected by the provisions of Section 205 of the Black Lung Benefits Amendments of 1981. Any party to a claim, adjudication officer, or adjudicative body may request that such a review be conducted and that the record be supplemented with any additional documentation necessary for an informed consideration of the transferability of the claim. Where the issue of the transferability of the claim can not be resolved by agreement of the parties and the evidence of record is not sufficient for a resolution of the issue, the hearing record may be reopened or the case remanded for the development of the additional evidence concerning the procedural history of the claim necessary to such resolution. Such determinations shall be made on an expedited basis.

(c) *Dismissal of operators.* If it is determined that a coal mine operator or insurance carrier which previously participated in the consideration or adjudication of any claim, may no longer be found liable for the payment of benefits to the claimant by reason of section 205 of the Black Lung Benefits Amendments of 1981, such operator or carrier shall be promptly dismissed as a party to the claim. The dismissal of an operator or carrier shall be concluded at the earliest possible time and in no event shall an operator or carrier participate as a necessary party in any claim for which only the fund may be liable.

(d) *Procedure following dismissal of an operator.* After it has been determined that an operator or carrier must be dismissed as a party in any claim in accordance with this section, the Director shall take such action as is authorized by the Act to bring about the proper and expeditious resolution of the claim in light of all relevant medical and other evidence. Action to be taken in this regard by the Director may include, but is not limited to, the assignment of the claim to the Black Lung Disability Trust Fund for the payment of benefits, the reimbursement of benefits previously paid by an operator or carrier if appropriate, the defense of the claim on behalf of the fund, or proceedings authorized by § 725.310.

(e) Any claimant whose claim has been subsequently denied in a modification proceeding will be entitled to expedited review of the modification decision. Where a formal hearing was previously held, the claimant may waive his right to a further hearing and ask that a decision be made on the record of the prior hearing, as supplemented by any additional documentary evidence which the parties wish to introduce and briefs of the parties, if desired. In any case in which the claimant waives his right to a second hearing, a decision and order must be issued within 30 days of the date upon which the parties agree the record has been completed.

Subpart H—Payment of Benefits

GENERAL PROVISIONS

§ 725.501 Payment provisions generally.

The provisions of this subpart govern the payment of benefits to claimants whose claims are approved for payment under section 415 and part C of title IV of the Act or approved after review under section 435 of the Act and part 727 of this subchapter (see § 725.4(d)).

§ 725.502 When benefit payments are due; manner of payment.

(a)(1) Except with respect to benefits paid by the fund pursuant to an initial determination issued in accordance with § 725.418 (see § 725.522), benefits under the Act shall be paid when they become due. Benefits shall be considered due after the issuance of an effective order requiring the payment of benefits by a district director, administrative law judge, Benefits Review Board, or court, notwithstanding the pendency of a motion for reconsideration before an administrative law judge or an appeal to the Board or court, except that benefits shall not be considered due where the payment of such benefits has been stayed by the Benefits Review Board or appropriate

court. An effective order shall remain in effect unless it is vacated by an administrative law judge on reconsideration, or, upon review under section 21 of the LHWCA, by the Benefits Review Board or an appropriate court, or is superseded by an effective order issued pursuant to § 725.310.

(2) A proposed order issued by a district director pursuant to § 725.418 becomes effective at the expiration of the thirtieth day thereafter if no party timely requests revision of the proposed decision and order or a hearing (see § 725.419). An order issued by an administrative law judge becomes effective when it is filed in the office of the district director (see § 725.479). An order issued by the Benefits Review Board shall become effective when it is issued. An order issued by a court shall become effective in accordance with the rules of the court.

(b)(1) While an effective order requiring the payment of benefits remains in effect, monthly benefits, at the rates set forth in § 725.520, shall be due on the fifteenth day of the month following the month for which the benefits are payable. For example, benefits payable for the month of January shall be due on the fifteenth day of February.

(2) Within 30 days after the issuance of an effective order requiring the payment of benefits, the district director shall compute the amount of benefits payable for periods prior to the effective date of the order, in addition to any interest payable for such periods (see § 725.608), and shall so notify the parties. Any computation made by the district director under this paragraph shall strictly observe the terms of the order. Benefits and interest payable for such periods shall be due on the thirtieth day following issuance of the district director's computation. A copy of the current table of applicable interest rates shall be attached to the computation.

(c) Benefits are payable for monthly periods and shall be paid directly to an eligible claimant or his or her representative payee (see § 725.510) beginning with the month during which eligibility begins. Benefit payments shall terminate with the month before the month during which eligibility terminates. If a claimant dies in the first month during which all requirements for eligibility are met, benefits shall be paid for that month.

§ 725.503 Date from which benefits are payable.

(a) In accordance with the provisions of section 6(a) of the Longshore Act as incorporated by section 422(a) of the Act, and except as provided in § 725.504, the provisions of this section shall be applicable in determining the date from which benefits are payable to an eligible claimant for any claim filed after March 31, 1980. Except as provided in paragraph (d) of this section, the date from which benefits are payable for any claim approved under part 727 shall be determined in accordance with § 727.302 (see § 725.4(d)).

(b) *Miner's claim.* Benefits are payable to a miner who is entitled beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. Where the evidence does not establish the month of onset, benefits shall be payable to such miner beginning with the month during which the claim was filed. In the case of a miner who filed a claim before January 1, 1982, benefits shall be payable to the miner's eligible survivor (if any) beginning with the month in which the miner died.

(c) *Survivor's claim.* Benefits are payable to a survivor who is entitled beginning with the month of the miner's death, or January 1, 1974, whichever is later.

(d) If a claim is awarded pursuant to section 22 of the Longshore Act and § 725.310, then the date from which benefits are payable shall be determined as follows:

(1) *Mistake in fact.* The provisions of paragraphs (b) or (c) of this section, as applicable, shall govern the determination of the date from which benefits are payable.

(2) *Change in conditions.* Benefits are payable to a miner beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment, provided that no benefits shall be payable for any month prior to the effective date of the most recent denial of the claim by a district director or administrative law judge. Where the evidence does not establish

the month of onset, benefits shall be payable to such miner from the month in which the claimant requested modification.

(e) In the case of a claim filed between July 1, 1973, and December 31, 1973, benefits shall be payable as provided by this section, except to the extent prohibited by § 727.303 (see § 725.4(d)).

(f) No benefits shall be payable with respect to a claim filed after December 31, 1973 (a part C claim), for any period of eligibility occurring before January 1, 1974.

(g) Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant.

§ 725.504 Payments to a claimant employed as a miner.

(a) In the case of a claimant who is employed as a miner (see § 725.202) at the time of a final determination of such miner's eligibility for benefits, no benefits shall be payable unless:

(1) The miner's eligibility is established under section 411(c)(3) of the Act; or

(2) the miner terminates his or her coal mine employment within 1 year from the date of the final determination of the claim.

(b) If the eligibility of a working miner is established under section 411(c)(3) of the Act, benefits shall be payable as is otherwise provided in this part. If eligibility cannot be established under section 411(c)(3), and the miner continues to be employed as a miner in any capacity for a period of less than 1 year after a final determination of the claim, benefits shall be payable beginning with the month during which the miner ends his or her coal mine employment. If the miner's employment continues for more than 1 year after a final determination of eligibility, such determination shall be considered a denial of benefits on the basis of the miner's continued employment, and the miner may seek benefits only as provided in § 725.310, if applicable, or by filing a new claim under this part. The provisions of Subparts E and F of this part shall be applicable to claims considered under this section as is appropriate.

(c) In any case where the miner returns to coal mine or comparable and gainful work, the payments to such miner shall be suspended and no benefits shall be payable (except as provided in section 411(c)(3) of the Act) for the period during which the miner continues to work. If the miner again terminates employment, the district director may require the miner to submit to further medical examination before authorizing the payment of benefits.

§ 725.505 Payees.

Benefits may be paid, as appropriate, to a beneficiary, to a qualified dependent, or to a representative authorized under this subpart to receive payments on behalf of such beneficiary or dependent.

§ 725.506 Payment on behalf of another; "legal guardian" defined.

Benefits are paid only to the beneficiary, his or her representative payee (see § 725.510) or his or her legal guardian. As used in this section, ''legal guardian'' means an individual who has been appointed by a court of competent jurisdiction or otherwise appointed pursuant to law to assume control of and responsibility for the care of the beneficiary, the management of his or her estate, or both.

§ 725.507 Guardian for minor or incompetent.

An adjudication officer may require that a legal guardian or representative be appointed to receive benefit payments payable to any person who is mentally incompetent or a minor and to exercise the powers granted to, or to perform the duties otherwise required of such person under the Act.

§ 725.510 Representative payee.

(a) If the district director determines that the best interests of a beneficiary are served thereby, the district director may certify the payment of such beneficiary's benefits to a representative payee.

(b) Before any amount shall be certified for payment to any representative payee for or on behalf of a beneficiary, such representative payee shall submit to the district director such evidence as may be required of his or

her relationship to, or his or her responsibility for the care of, the beneficiary on whose behalf payment is to be made, or of his or her authority to receive such a payment. The district director may, at any time thereafter, require evidence of the continued existence of such relationship, responsibility, or authority. If a person requesting representative payee status fails to submit the required evidence within a reasonable period of time after it is requested, no further payments shall be certified to him or her on behalf of the beneficiary unless the required evidence is thereafter submitted.

(c) All benefit payments made to a representative payee shall be available only for the use and benefit of the beneficiary, as defined in § 725.511.

§ 725.511 Use and benefit defined.

(a) Payments certified to a representative payee shall be considered as having been applied for the use and benefit of the beneficiary when they are used for the beneficiary's current maintenance—*i.e.*, to replace current income lost because of the disability of the beneficiary. Where a beneficiary is receiving care in an institution, current maintenance shall include the customary charges made by the institution and charges made for the current and foreseeable needs of the beneficiary which are not met by the institution.

(b) Payments certified to a representative payee which are not needed for the current maintenance of the beneficiary, except as they may be used under § 725.512, shall be conserved or invested on the beneficiary's behalf. Preferred investments are U.S. savings bonds which shall be purchased in accordance with applicable regulations of the U.S. Treasury Department (31 CFR part 315). Surplus funds may also be invested in accordance with the rules applicable to investment of trust estates by trustees. For example, surplus funds may be deposited in an interest or dividend bearing account in a bank or trust company or in a savings and loan association if the account is either federally insured or is otherwise insured in accordance with State law requirements. Surplus funds deposited in an interest or dividend bearing account in a bank or trust company or in a savings and loan association must be in a form of account which clearly shows that the representative payee has only a fiduciary, and not a personal, interest in the funds. The preferred forms of such accounts are as follows:

Name of beneficiary _____
by (Name of representative payee) representative payee,
or (Name of beneficiary)
by (Name of representative payee) trustee,

U.S. savings bonds purchased with surplus funds by a representative payee for an incapacitated adult beneficiary should be registered as follows: (Name of beneficiary) (Social Security No.), for whom (Name of payee) is representative payee for black lung benefits.

§ 725.512 Support of legally dependent spouse, child, or parent.

If current maintenance needs of a beneficiary are being reasonably met, a relative or other person to whom payments are certified as representative payee on behalf of the beneficiary may use part of the payments so certified for the support of the legally dependent spouse, a legally dependent child, or a legally dependent parent of the beneficiary.

§ 725.513 Accountability; transfer.

(a) The district director may require a representative payee to submit periodic reports including a full accounting of the use of all benefit payments certified to a representative payee. If a requested report or accounting is not submitted within the time allowed, the district director shall terminate the certification of the representative payee and thereafter payments shall be made directly to the beneficiary. A certification which is terminated under this section may be reinstated for good cause, provided that all required reports are supplied to the district director.

(b) A representative payee who has conserved or invested funds from payments under this part shall, upon the direction of the district director, transfer any such funds (including interest) to a successor payee appointed by the district director or, at the option of the district director, shall transfer such

funds to the Office for recertification to a successor payee or the beneficiary.

§ 725.514 Certification to dependent of augmentation portion of benefit.

(a) If the basic benefit of a miner or of a surviving spouse is augmented because of one or more dependents, and it appears to the district director that the best interests of such dependent would be served thereby, or that the augmented benefit is not being used for the use and benefit (as defined in this subpart) of the augmentee, the district director may certify payment of the amount of such augmentation (to the extent attributable to such dependent) to such dependent directly, or to a legal guardian or a representative payee for the use and benefit of such dependent.

(b) Any request to the district director to certify separate payment of the amount of an augmentation in accordance with paragraph (a) of this section shall be in writing on such form and in accordance with such instructions as are prescribed by the Office.

(c) The district director shall specify the terms and conditions of any certification authorized under this section and may terminate any such certification where appropriate.

(d) Any payment made under this section, if otherwise valid under the Act, is a complete settlement and satisfaction of all claims, rights, and interests in and to such payment, except that such payment shall not be construed to abridge the rights of any party to recoup any overpayment made.

§ 725.515 Assignment and exemption from claims of creditors.

(a) Except as provided by the Act and this part, no assignment, release, or commutation of benefits due or payable under this part by a responsible operator shall be valid, and all benefits shall be exempt from claims of creditors and from levy, execution, and attachment or other remedy or recovery or collection of a debt, which exemption may not be waived.

(b) Notwithstanding any other provision of law, benefits due from, or payable by, the Black Lung Disability Trust Fund under the Act and this part to a claimant shall be subject to legal process brought for the enforcement against the claimant of his or her legal obligations to provide child support or make alimony payments to the same extent as if the fund was a private person.

BENEFIT RATES

§ 725.520 Computation of benefits.

(a) *Basic rate.* The amount of benefits payable to a beneficiary for a month is determined, in the first instance, by computing the ''basic rate.'' The basic rate is equal to 37½ percent of the monthly pay rate for Federal employees in GS–2, step 1. That rate for a month is determined by:

(1) Ascertaining the lowest annual rate of pay (step 1) for Grade GS–2 of the General Schedule applicable to such month (see 5 U.S.C. 5332);

(2) Ascertaining the monthly rate thereof by dividing the amount determined in paragraph (a)(1) of this section by 12; and

(3) Ascertaining the basic rate under the Act by multiplying the amount determined in paragraph (a)(2) of this section by 0.375 (that is, by 37½ percent).

(b) *Basic benefit.* When a miner or surviving spouse is entitled to benefits for a month for which he or she has no dependents who qualify under this part and when a surviving child of a miner or spouse, or a parent, brother, or sister of a miner, is entitled to benefits for a month for which he or she is the only beneficiary entitled to benefits, the amount of benefits to which such beneficiary is entitled is equal to the basic rate as computed in accordance with this section (raised, if not a multiple of 10 cents, to the next high multiple of 10 cents). This amount is referred to as the ''basic benefit.''

(c) *Augmented benefit.* (1) When a miner or surviving spouse is entitled to benefits for a month for which he or she has one or more dependents who qualify under this part, the amount of benefits to which such miner or surviving spouse is entitled is increased. This increase is referred to as an ''augmentation.''

(2) The benefits of a miner or surviving spouse are augmented to take

account of a particular dependent beginning with the first month in which such dependent satisfies the conditions set forth in this part, and continues to be augmented through the month before the month in which such dependent ceases to satisfy the conditions set forth in this part, except in the case of a child who qualifies as a dependent because he or she is a student. In the latter case, such benefits continue to be augmented through the month before the first month during no part of which he or she qualifies as a student.

(3) The basic rate is augmented by 50 percent for one such dependent, 75 percent for two such dependents, and 100 percent for three or more such dependents.

(d) *Survivor benefits.* As used in this section, ''survivor'' means a surviving child of a miner or surviving spouse, or a surviving parent, brother, or sister of a miner, who establishes entitlement to benefits under this part.

(e) *Computation and rounding.* (1) Any computation prescribed by this section is made to the third decimal place.

(2) Monthly benefits are payable in multiples of 10 cents. Therefore, a monthly payment of amounts derived under paragraph (c)(3) of this section which is not a multiple of 10 cents is increased to the next higher multiple of 10 cents.

(3) Since a fraction of a cent is not a multiple of 10 cents, such an amount which contains a fraction in the third decimal place is raised to the next higher multiple of 10 cents.

(f) *Eligibility based on the coal mine employment of more than one miner.* Where an individual, for any month, is entitled (and/or qualifies as a dependent for purposes of augmentation of benefits) based on the disability or death due to pneumoconiosis arising out of the coal mine employment of more than one miner, the benefit payable to or on behalf of such individual shall be at a rate equal to the highest rate of benefits for which entitlement is established by reason of eligibility as a beneficiary, or by reason of his or her qualification as a dependent for augmentation of benefit purposes.

§ 725.521 Commutation of payments; lump sum awards.

(a) Whenever the district director determines that it is in the interest of justice, the liability for benefits or any part thereof as determined by a final adjudication, may, with the approval of the Director, be discharged by the payment of a lump sum equal to the present value of future benefit payments commuted, computed at 4 percent true discount compounded annually.

(b) Applications for commutation of future payments of benefits shall be made to the district director in the manner prescribed by the district director. If the district director determines that an award of a lump sum payment of such benefits would be in the interest of justice, he or she shall refer such application, together with the reasons in support of such determination, to the Director for consideration.

(c) The Director shall, in his or her discretion, grant or deny the application for commutation of payments. Such decision may be appealed to the Benefits Review Board.

(d) The computation of all commutations of such benefits shall be made by the OWCP. For this purpose the file shall contain the date of birth of the person on whose behalf commutation is sought, as well as the date upon which such commutation shall be effective.

(e) For purposes of determining the amount of any lump sum award, the probability of the death of the disabled miner and/or other persons entitled to benefits before the expiration of the period during which he or she is entitled to benefits, shall be determined in accordance with the most current United States Life Tables, as developed by the Department of Health, Education, and Welfare, and the probability of the remarriage of a surviving spouse shall be determined in accordance with the remarriage tables of the Dutch Royal Insurance Institution. The probability of the happening of any other contingency affecting the amount or duration of the compensation shall be disregarded.

(f) In the event that an operator or carrier is adjudicated liable for the

payment of benefits, such operator or carrier shall be notified of and given an opportunity to participate in the proceedings to determine whether a lump sum award shall be made. Such operator or carrier shall, in the event a lump sum award is made, tender full and prompt payment of such award to the claimant as though such award were a final payment of monthly benefits. Except as provided in paragraph (g) of this section, such lump sum award shall forever discharge such operator or carrier from its responsibility to make monthly benefit payments under the Act to the person who has requested such lump-sum award. In the event that an operator or carrier is adjudicated liable for the payment of benefits, such operator or carrier shall not be liable for any portion of a commuted or lump sum award predicated upon benefits due any claimant prior to January 1, 1974.

(g) In the event a lump-sum award is approved under this section, such award shall not operate to discharge an operator carrier, or the fund from any responsibility imposed by the Act for the payment of medical benefits to an eligible miner.

§ 725.522 Payments prior to final adjudication.

(a) If an operator or carrier fails or refuses to commence the payment of benefits within 30 days of issuance of an initial determination of eligibility by the district director (see § 725.420), or fails or refuses to commence the payment of any benefits due pursuant to an effective order by a district director, administrative law judge, Benefits Review Board, or court, the fund shall commence the payment of such benefits and shall continue such payments as appropriate. In the event that the fund undertakes the payment of benefits on behalf of an operator or carrier, the provisions of §§ 725.601 through 725.609 shall be applicable to such operator or carrier.

(b) If benefit payments are commenced prior to the final adjudication of the claim and it is later determined by an administrative law judge, the Board, or court that the claimant was ineligible to receive such payments, such payments shall be considered overpayments pursuant to § 725.540 and may be recovered in accordance with the provisions of this subpart.

SPECIAL PROVISIONS FOR OPERATOR PAYMENTS

§ 725.530 Operator payments; generally.

(a) Benefits payable by an operator or carrier pursuant to an effective order issued by a district director, administrative law judge, Benefits Review Board, or court, or by an operator that has agreed that it is liable for the payment of benefits to a claimant, shall be paid by the operator or carrier immediately when they become due (see § 725.502(b)). An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within 10 days of the date they become due is entitled to additional compensation equal to twenty percent of those benefits (see § 725.607). Arrangements for the payment of medical costs shall be made by such operator or carrier in accordance with the provisions of subpart J of this part.

(b) Benefit payments made by an operator or carrier shall be made directly to the person entitled thereto or a representative payee if authorized by the district director. The payment of a claimant's attorney's fee, if any is awarded, shall be made directly to such attorney. Reimbursement of the fund, including interest, shall be paid directly to the Secretary on behalf of the fund.

§ 725.531 Receipt for payment.

Any individual receiving benefits under the Act in his or her own right, or as a representative payee, or as the duly appointed agent for the estate of a deceased beneficiary, shall execute receipts for benefits paid by any operator which shall be produced by such operator for inspection whenever the district director requires. A canceled check shall be considered adequate receipt of payment for purposes of this section. No operator or carrier shall be

required to retain receipts for payments made for more than 5 years after the date on which such receipt was executed.

§ 725.532 Suspension, reduction, or termination of payments.

(a) No suspension, reduction, or termination in the payment of benefits is permitted unless authorized by the district director, administrative law judge, Board, or court. No suspension, reduction, or termination shall be authorized except upon the occurrence of an event which terminates a claimant's eligibility for benefits (see subpart B of this part) or as is otherwise provided in subpart C of this part, §§ 725.306 and 725.310, or this subpart (see also §§ 725.533 through 725.546).

(b) Any unauthorized suspension in the payment of benefits by an operator or carrier shall be treated as provided in subpart I.

(c) Unless suspension, reduction, or termination of benefits payments is required by an administrative law judge, the Benefits Review Board or a court, the district director, after receiving notification of the occurrence of an event that would require the suspension, reduction, or termination of benefits, shall follow the procedures for the determination of claims set forth in subparts E and F.

INCREASES AND REDUCTIONS OF BENEFITS

§ 725.533 Modification of benefits amounts; general.

(a) Under certain circumstances, the amount of monthly benefits as computed in § 725.520 or lump-sum award (§ 725.521) shall be modified to determine the amount actually to be paid to a beneficiary. With respect to any benefits payable for all periods of eligibility after January 1, 1974, a reduction of the amount of benefits payable shall be required on account of:

(1) Any compensation or benefits received under any State workers' compensation law because of death or partial or total disability due to pneumoconiosis; or

(2) Any compensation or benefits received under or pursuant to any Federal law including part B of title IV of the Act because of death or partial or total disability due to pneumoconiosis; or

(3) In the case of benefits to a parent, brother, or sister as a result of a claim filed at any time or benefits payable on a miner's claim which was filed on or after January 1, 1982, the excess earnings from wages and from net earnings from self-employment (see § 410.530 of this title) of such parent, brother, sister, or miner, respectively; or

(4) The fact that a claim for benefits from an additional beneficiary is filed, or that such claim is effective for a payment during the month of filing, or a dependent qualifies under this part for an augmentation portion of a benefit of a miner or widow for a period in which another dependent has previously qualified for an augmentation.

(b) An adjustment in a beneficiary's monthly benefit may be required because an overpayment or underpayment has been made to such beneficiary (see §§ 725.540–725.546).

(c) A suspension of a beneficiary's monthly benefits may be required when the Office has information indicating that reductions on account of excess earnings may reasonably be expected.

(d) Monthly benefit rates are payable in multiples of 10 cents. Any monthly benefit rate which, after the applicable computations, augmentations, and reductions is not a multiple of 10 cents, is increased to the next higher multiple of 10 cents. Since a fraction of a cent is not a multiple of 10 cents, a benefit rate which contains such a fraction in the third decimal is raised to the next higher multiple of 10 cents.

(e) Any individual entitled to a benefit, who is aware of any circumstances which could affect entitlement to benefits, eligibility for payment, or the amount of benefits, or result in the termination, suspension, or reduction of benefits, shall promptly report these circumstances to the Office. The Office may at any time require an individual receiving, or claiming entitlement to, benefits, either on his or her own behalf or on behalf of another, to submit a written statement giving pertinent information bearing upon the issue of whether or not an event has occurred which would cause such benefit to be terminated, or which would subject

such benefit to reductions or suspension under the provisions of the Act. The failure of an individual to submit any such report or statement, properly executed, to the Office shall subject such benefit to reductions, suspension, or termination as the case may be.

§ 725.534 Reduction of State benefits.

No benefits under section 415 of part B of title IV of the Act shall be payable to the residents of a State which, after December 31, 1969, reduces the benefits payable to persons eligible to receive benefits under section 415 of the Act under State laws applicable to its general work force with regard to workers' compensation (including compensation for occupational disease), unemployment compensation, or disability insurance benefits which are funded in whole or in part out of employer contributions.

§ 725.535 Reductions; receipt of State or Federal benefit.

(a) As used in this section the term ''State or Federal benefit'' means a payment to an individual on account of total or partial disability or death due to pneumoconiosis only under State or Federal laws relating to workers' compensation. With respect to a claim for which benefits are payable for any month between July 1 and December 31, 1973, ''State benefit'' means a payment to a beneficiary made on account of disability or death due to pneumoconiosis under State laws relating to workers' compensation (including compensation for occupational disease), unemployment compensation, or disability insurance.

(b) Benefit payments to a beneficiary for any month are reduced (but not below zero) by an amount equal to any payments of State or Federal benefits received by such beneficiary for such month.

(c) Where a State or Federal benefit is paid periodically but not monthly, or in a lump sum as a commutation of or a substitution for periodic benefits, the reduction under this section is made at such time or times and in such amounts as the Office determines will approximate as nearly as practicable the reduction required under paragraph (b) of this section. In making such a determination, a weekly State or Federal benefit is multiplied by 4⅓ and a biweekly benefit is multiplied by 2⅙ to ascertain the monthly equivalent for reduction purposes.

(d) Amounts paid or incurred or to be incurred by the individual for medical, legal, or related expenses in connection with this claim for State or Federal benefits (defined in paragraph (a) of this section) are excluded in computing the reduction under paragraph (b) of this section, to the extent that they are consistent with State or Federal Law. Such medical, legal, or related expenses may be evidenced by the State or Federal benefit awards, compromise agreement, or court order in the State or Federal benefit proceedings, or by such other evidence as the Office may require. Such other evidence may consist of:

(1) A detailed statement by the individual's attorney, physician, or the employer's insurance carrier; or

(2) Bills, receipts, or canceled checks; or

(3) Other evidence indicating the amount of such expenses; or

(4) Any combination of the foregoing evidence from which the amount of such expenses may be determinable. Such expenses shall not be excluded unless established by evidence as required by the Office.

§ 725.536 Reductions; excess earnings.

In the case of a surviving parent, brother, or sister, whose claim was filed at any time, or of a miner whose claim was filed on or after January 1, 1982, benefit payments are reduced as appropriate by an amount equal to the deduction which would be made with respect to excess earnings under the provisions of sections 203 (b), (f), (g), (h), (j), and (l) of the Social Security Act (42 U.S.C. 403 (b), (f), (g), (h), (j), and (l)), as if such benefit payments were benefits payable under section 202 of the Social Security Act (42 U.S.C. 402) (see §§ 404.428 through 404.456 of this title).

§ 725.537 Reductions; retroactive effect of an additional claim for benefits.

Except as provided in § 725.212(b), beginning with the month in which a person other than a miner files a claim

and becomes entitled to benefits, the benefits of other persons entitled to benefits with respect to the same miner, are adjusted downward, if necessary, so that no more than the permissible amount of benefits (the maximum amount for the number of beneficiaries involved) will be paid.

§ 725.538 Reductions; effect of augmentation of benefits based on subsequent qualification of individual.

(a) Ordinarily, a written request that the benefits of a miner or surviving spouse be augmented on account of a qualified dependent is made as part of the claim for benefits. However, it may also be made thereafter.

(b) In the latter case, beginning with the month in which such a request is filed on account of a particular dependent and in which such dependent qualifies for augmentation purposes under this part, the augmented benefits attributable to other qualified dependents (with respect to the same miner or surviving spouse), if any, are adjusted downward, if necessary, so that the permissible amount of augmented benefits (the maximum amount for the number of dependents involved) will not be exceeded.

(c) Where, based on the entitlement to benefits of a miner or surviving spouse, a dependent would have qualified for augmentation purposes for a prior month of such miner's or surviving spouse's entitlement had such request been filed in such prior month, such request is effective for such prior month. For any month before the month of filing such request, however, otherwise correct benefits previously certified by the Office may not be changed. Rather the amount of the augmented benefit attributable to the dependent filing such request in the later month is reduced for each month of the retroactive period to the extent that may be necessary. This means that for each month of the retroactive period, the amount payable to the dependent filing the later augmentation request is the difference, if any, between:

(1) The total amount of augmented benefits certified for payment for other dependents for that month, and

(2) The permissible amount of augmented benefits (the maximum amount for the number of dependents involved) payable for the month for all dependents, including the dependent filing later.

§ 725.539 More than one reduction event.

If a reduction for receipt of State or Federal benefits and a reduction on account of excess earnings are chargeable to the same month, the benefit for such month is first reduced (but not below zero) by the amount of the State or Federal benefits, and the remainder of the benefit for such month, if any, is then reduced (but not below zero) by the amount of excess earnings chargeable to such month.

OVERPAYMENTS; UNDERPAYMENTS

§ 725.540 Overpayments.

(a) *General.* As used in this subpart, the term ''overpayment'' includes:

(1) Payment where no amount is payable under this part;

(2) Payment in excess of the amount payable under this part;

(3) A payment under this part which has not been reduced by the amounts required by the Act (see § 725.533);

(4) A payment under this part made to a resident of a State whose residents are not entitled to benefits (see §§ 725.402 and 725.403);

(5) Payment resulting from failure to terminate benefits to an individual no longer entitled thereto;

(6) Duplicate benefits paid to a claimant on account of concurrent eligibility under this part and parts 410 or 727 (see § 725.4(d)) of this title or as provided in § 725.309.

(b) *Overpaid beneficiary is living.* If the beneficiary to whom an overpayment was made is living at the time of a determination of such overpayment, is entitled to benefits at the time of the overpayment, or at any time thereafter becomes so entitled, no benefit for any month is payable to such individual, except as provided in paragraph (c) of this section, until an amount equal to the amount of the overpayment has been withheld or refunded.

(c) *Adjustment by withholding part of a monthly benefit.* Adjustment under

paragraph (b) of this section may be effected by withholding a part of the monthly benefit payable to a beneficiary where it is determined that:

(1) Withholding the full amount each month would deprive the beneficiary of income required for ordinary and necessary living expenses;

(2) The overpayment was not caused by the beneficiary's intentionally false statement or representation, or willful concealment of, or deliberate failure to furnish, material information; and

(3) Recoupment can be effected in an amount of not less than $ 10 a month and at a rate which would not unreasonably extend the period of adjustment.

(d) *Overpaid beneficiary dies before adjustment.* If an overpaid beneficiary dies before adjustment is completed under the provisions of paragraph (b) of this section, recovery of the overpayment shall be effected through repayment by the estate of the deceased overpaid beneficiary, or by withholding of amounts due the estate of such deceased beneficiary, or both.

§ 725.541 Notice of waiver of adjustment or recovery of overpayment.

Whenever a determination is made that more than the correct amount of payment has been made, notice of the provisions of section 204(b) of the Social Security Act regarding waiver of adjustment or recovery shall be sent to the overpaid individual, to any other individual against whom adjustment or recovery of the overpayment is to be effected, and to any operator or carrier which may be liable to such overpaid individual.

§ 725.542 When waiver of adjustment or recovery may be applied.

There shall be no adjustment or recovery of an overpayment in any case where an incorrect payment has been made with respect to an individual:

(a) Who is without fault, and where

(b) Adjustment or recovery would either:

(1) Defeat the purpose of title IV of the Act, or

(2) Be against equity and good conscience.

§ 725.543 Standards for waiver of adjustment or recovery.

The standards for determining the applicability of the criteria listed in § 725.542 shall be the same as those applied by the Social Security Administration under §§ 404.506 through 404.512 of this title.

§ 725.544 Collection and compromise of claims for overpayment.

(a) *General effect of 31 U.S.C. 3711.* In accordance with 31 U.S.C. 3711 and applicable regulations, claims by the Office against an individual for recovery of an overpayment under this part not exceeding the sum of $100,000, exclusive of interest, may be compromised, or collection suspended or terminated, where such individual or his or her estate does not have the present or prospective ability to pay the full amount of the claim within a reasonable time (see paragraph (c) of this section), or the cost of collection is likely to exceed the amount of recovery (see paragraph (d) of this section), except as provided under paragraph (b) of this section.

(b) *When there will be no compromise, suspension, or termination of collection of a claim for overpayment.* (1) In any case where the overpaid individual is alive, a claim for overpayment will not be compromised, nor will there be suspension or termination of collection of the claim by the Office, if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such individual or on the part of any other party having any interest in the claim.

(2) In any case where the overpaid individual is deceased:

(i) A claim for overpayment in excess of $ 5,000 will not be compromised, nor will there be suspension or termination of collection of the claim by the Office if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such deceased individual; and

(ii) A claim for overpayment, regardless of the amount, will not be compromised, nor will there be suspension or termination of collection of the claim by the Office if there is an indication that any person other than the deceased overpaid individual had a part

in the fraudulent action which resulted in the overpayment.

(c) *Inability to pay claim for recovery of overpayment.* In determining whether the overpaid individual is unable to pay a claim for recovery of an overpayment under this part, the Office shall consider the individual's age, health, present and potential income (including inheritance prospects), assets (e.g., real property, savings account), possible concealment or improper transfer of assets, and assets or income of such individual which may be available in enforced collection proceedings. The Office will also consider exemptions available to such individual under the pertinent State or Federal law in such proceedings. In the event the overpaid individual is deceased, the Office shall consider the available assets of the estate, taking into account any liens or superior claims against the estate.

(d) *Cost of collection or litigative probabilities.* Where the probable costs of recovering an overpayment under this part would not justify enforced collection proceedings for the full amount of the claim, or where there is doubt concerning the Office's ability to establish its claim as well as the time which it will take to effect such collection, a compromise or settlement for less than the full amount may be considered.

(e) *Amount of compromise.* The amount to be accepted in compromise of a claim for overpayment under this part shall bear a reasonable relationship to the amount which can be recovered by enforced collection proceedings, giving due consideration to the exemption available to the overpaid individual under State or Federal law and the time which collection will take.

(f) *Payment.* Payment of the amount the Office has agreed to accept as a compromise in full settlement of a claim for recovery of an overpayment under this part shall be made within the time and in the manner set by the Office. A claim for the overpayment shall not be considered compromised or settled until the full payment of the compromised amount has been made within the time and manner set by the Office. Failure of the overpaid individual or his or her estate to make such payment as provided shall result in reinstatement of the full amount of the overpayment less any amounts paid prior to such default.

§ 725.545 Underpayments.

(a) *General.* As used in this subpart, the term ''underpayment'' includes a payment in an amount less than the amount of the benefit due for such month, and nonpayment where some amount of such benefits is payable.

(b) *Underpaid individual is living.* If an individual to whom an underpayment was made is living, the deficit represented by such underpayment shall be paid to such individual either in a single payment (if he or she is not entitled to a monthly benefit or if a single payment is requested by the claimant in writing) or by increasing one or more monthly benefit payments to which such individual becomes entitled.

(c) *Underpaid individual dies before adjustment of underpayment.* If an individual to whom an underpayment was made dies before receiving payment of the deficit or negotiating the check or checks representing payment of the deficit, such payment shall be distributed to the living person (or persons) in the highest order of priority as follows:

(1) The deceased individual's surviving spouse who was either:

(i) Living in the same household with the deceased individual at the time of such individual's death; or

(ii) In the case of a deceased miner, entitled for the month of death to black lung benefits as his or her surviving spouse or surviving divorced spouse.

(2) In the case of a deceased miner or spouse his or her child entitled to benefits as the surviving child of such miner or surviving spouse for the month in which such miner or spouse died (if more than one such child, in equal shares to each such child).

(3) In the case of a deceased miner, his parent entitled to benefits as the surviving parent of such miner for the month in which such miner died (if more than one such parent, in equal shares to each such parent).

(4) The surviving spouse of the deceased individual who does not qualify under paragraph (c)(1) of this section.

(5) The child or children of the deceased individual who do not qualify

under paragraph (c)(2) of this section (if more than one such child, in equal shares to each such child).

(6) The parent or parents of the deceased individual who do not qualify under paragraph (c)(3) of this section (if more than one such parent, in equal shares to each such parent).

(7) The legal representative of the estate of the deceased individual as defined in paragraph (e) of this section.

(d) *Deceased beneficiary*. In the event that a person, who is otherwise qualified to receive payments as the result of a deficit caused by an underpayment under the provisions of paragraph (c) of this section, dies before receiving payment or before negotiating the check or checks representing such payment, his or her share of the underpayment shall be divided among the remaining living person(s) in the same order or priority. In the event that there is (are) no other such person(s), the underpayment shall be paid to the living person(s) in the next lower order of priority under paragraph (c) of this section.

(e) *Definition of legal representative*. The term ''legal representative,'' for the purpose of qualifying for receipt of an underpayment, generally means the executor or the administrator of the estate of the deceased beneficiary. However, it may also include an individual, institution or organization acting on behalf of an unadministered estate, provided the person can give the Office good acquittance (as defined in paragraph (f) of this section). The following persons may qualify as legal representative for purposes of this section, provided they can give the Office good acquittance:

(1) A person who qualifies under a State's ''small estate'' statute; or

(2) A person resident in a foreign country who under the laws and customs of that country, has the right to receive assets of the estate; or

(3) A public administrator; or

(4) A person who has the authority under applicable law to collect the assets of the estate of the deceased beneficiary.

(f) *Definition of ''good acquittance.''* A person is considered to give the Office ''good acquittance'' when payment to that person will release the Office from further liability for such payment.

§ 725.546 Relation to provisions for reductions or increases.

The amount of an overpayment or an underpayment is the difference between the amount to which the beneficiary was actually entitled and the amount paid. Overpayment and underpayment simultaneously outstanding against the same beneficiary shall first be adjusted against one another before adjustment pursuant to the other provisions of this subpart.

§ 725.547 Applicability of overpayment and underpayment provisions to operator or carrier.

(a) The provisions of this subpart relating to overpayments and underpayments shall be applicable to overpayments and underpayments made by responsible operators or their insurance carriers, as appropriate.

(b) No operator or carrier may recover, or make an adjustment of, an overpayment without prior application to, and approval by, the Office which shall exercise full supervisory authority over the recovery or adjustment of all overpayments.

§ 725.548 Procedures applicable to overpayments and underpayments.

(a) In any case involving either overpayments or underpayments, the Office may take any necessary action, and district directors may issue appropriate orders to protect the rights of the parties.

(b) Disputes arising out of orders so issued shall be resolved by the procedures set out in subpart F of this part.

Subpart I—Enforcement of Liability; Reports

§ 725.601 Enforcement generally.

(a) The Act, together with certain incorporated provisions from the Longshoremen's and Harbor Workers' Compensation Act, contains a number of provisions which subject an operator or other employer, claimants and others to penalties for failure to comply with certain provisions of the Act, or failure to commence and continue prompt periodic payments to a beneficiary.

(b) It is the policy and intent of the Department to vigorously enforce the provisions of this part through the use of the remedies provided by the Act. Accordingly, if an operator refuses to pay benefits with respect to a claim for which the operator has been adjudicated liable, the Director shall invoke and execute the lien on the property of the operator as described in § 725.603. Enforcement of this lien shall be pursued in an appropriate U.S. district court. If the Director determines that the remedy provided by § 725.603 may not be sufficient to guarantee the continued compliance with the terms of an award or awards against the operator, the Director shall in addition seek an injunction in the U.S. district court to prohibit future noncompliance by the operator and such other relief as the court considers appropriate (see § 725.604). If an operator unlawfully suspends or terminates the payment of benefits to a claimant, the district director shall declare the award in default and proceed in accordance with § 725.605. In all cases payments in addition to compensation (see § 725.607) and interest (see § 725.608) shall be sought by the Director or awarded by the district director.

(c) In certain instances the remedies provided by the Act are concurrent; that is, more than one remedy might be appropriate in any given case. In such a case, the Director shall select the remedy or remedies appropriate for the enforcement action. In making this selection, the Director shall consider the best interests of the claimant as well as those of the fund.

§ 725.602 Reimbursement of the fund.

(a) In any case in which the fund has paid benefits, including medical benefits, on behalf of an operator or other employer which is determined liable therefore, or liable for a part thereof, such operator or other employer shall simultaneously with the first payment of benefits made to the beneficiary, reimburse the fund (with interest) for the full amount of all benefit payments made by the fund with respect to the claim.

(b) In any case where benefit payments have been made by the fund, the fund shall be subrogated to the rights of the beneficiary. The Secretary of Labor may, as appropriate, exercise such subrogation rights.

§ 725.603 Payments by the fund on behalf of an operator; liens.

(a) If an amount is paid out of the fund to an individual entitled to benefits under this part or part 727 of this subchapter (see § 725.4(d)) on behalf of an operator or other employer which is or was required to pay or secure the payment of all or a portion of such amount (see § 725.522), the operator or other employer shall be liable to the United States for repayment to the fund of the amount of benefits properly attributable to such operator or other employer.

(b) If an operator or other employer liable to the fund refuses to pay, after demand, the amount of such liability, there shall be a lien in favor of the United States upon all property and rights to property, whether real or personal, belonging to such operator or other employer. The lien arises on the date on which such liability is finally determined, and continues until it is satisfied or becomes unenforceable by reason of lapse of time.

(c)(1) Except as otherwise provided under this section, the priority of the lien shall be determined in the same manner as under section 6323 of the Internal Revenue Code (26 U.S.C.).

(2) In the case of a bankruptcy or insolvency proceeding, the lien imposed under this section shall be treated in the same manner as a lien for taxes due and owing to the United States for purposes of the Bankruptcy Act or section 3466 of the Revised Statutes (31 U.S.C. 191).

(3) For purposes of applying section 6323(a) of the Internal Revenue Code (26 U.S.C.) to determine the priority between the lien imposed under this section and the Federal tax lien, each lien shall be treated as a judgment lien arising as of the time notice of such lien is filed.

(4) For purposes of the section, notice of the lien imposed hereunder shall be filed in the same manner as under section 6323(f) (disregarding paragraph (4) thereof) and (g) of the Internal Revenue Code (26 U.S.C.).

(5) In any case where there has been a refusal or neglect to pay the liability imposed under this section, the Secretary of Labor may bring a civil action in a district court of the United States to enforce the lien of the United States under this section with respect to such liability or to subject any property, of whatever nature, of the operator, or in which it has any right, title, or interest, to the payment of such liability.

(6) The liability imposed by this paragraph may be collected at a proceeding in court if the proceeding is commenced within 6 years after the date upon which the liability was finally determined, or prior to the expiration of any period for collection agreed upon in writing by the operator and the United States before the expiration of such 6-year period. This period of limitation shall be suspended for any period during which the assets of the operator are in the custody or control of any court of the United States, or of any State, or the District of Columbia, and for 6 months thereafter, and for any period during which the operator is outside the United States if such period of absence is for a continuous period of at least 6 months.

§ 725.604 Enforcement of final awards.

Notwithstanding the provisions of § 725.603, if an operator or other employer or its officers or agents fails to comply with an order awarding benefits that has become final, any beneficiary of such award or the district director may apply for the enforcement of the order to the Federal district court for the judicial district in which the injury occurred (or to the U.S. District Court for the District of Columbia if the injury occurred in the District). If the court determines that the order was made and served in accordance with law, and that such operator or other employer or its officers or agents have failed to comply therewith, the court shall enforce obedience to the order by writ of injunction or by other proper process, mandatory or otherwise, to enjoin upon such operator or other employer and its officers or agents compliance with the order.

§ 725.605 Defaults.

(a) Except as is otherwise provided in this part, no suspension, termination or other failure to pay benefits awarded to a claimant is permitted. If an employer found liable for the payment of such benefits fails to make such payments within 30 days after any date on which such benefits are due and payable, the person to whom such benefits are payable may, within one year after such default, make application to the district director for a supplementary order declaring the amount of the default.

(b) If after investigation, notice and hearing as provided in subparts E and F of this part, a default is found, the district director or the administrative law judge, if a hearing is requested, shall issue a supplementary order declaring the amount of the default, if any. In cases where a lump-sum award has been made, if the payment in default is an installment, the district director or administrative law judge, may, in his or her discretion, declare the whole of the award as the amount in default. The applicant may file a certified copy of such supplementary order with the clerk of the Federal district court for the judicial district in which the operator has its principal place of business or maintains an office or for the judicial district in which the injury occurred. In case such principal place of business or office is in the District of Columbia, a copy of such supplementary order may be filed with the clerk of the U.S. District Court for the District of Columbia. Such supplementary order shall be final and the court shall, upon the filing of the copy, enter judgment for the amount declared in default by the supplementary order if such supplementary order is in accordance with law. Review of the judgment may be had as in civil suits for damages at common law. Final proceedings to execute the judgment may be had by writ of execution in the form used by the court in suits at common law in actions of assumpsit. No fee shall be required for filing the supplementary order nor for entry of judgment thereon, and the applicant shall not be liable for costs in a proceeding for review of the judgment unless the court shall otherwise direct. The court

shall modify such judgment to conform to any later benefits order upon presentation of a certified copy thereof to the court.

(c) In cases where judgment cannot be satisfied by reason of the employer's insolvency or other circumstances precluding payment, the district director shall make payment from the fund, and in addition, provide any necessary medical, surgical, and other treatment required by subpart J of this part. A defaulting employer shall be liable to the fund for payment of the amounts paid by the fund under this section; and for the purpose of enforcing this liability, the fund shall be subrogated to all the rights of the person receiving such payments or benefits.

§ 725.606 Security for the payment of benefits.

(a) Following the issuance of an effective order by a district director (see § 725.418), administrative law judge (see § 725.479), Benefits Review Board, or court that requires the payment of benefits by an operator that has failed to secure the payment of benefits in accordance with section 423 of the Act and § 726.4 of this subchapter, or by a coal mine construction or transportation employer, the Director may request that the operator secure the payment of all benefits ultimately payable on the claim. Such operator or other employer shall thereafter immediately secure the payment of benefits in accordance with the provisions of this section, and provide proof of such security to the Director. Such security may take the form of an indemnity bond, a deposit of cash or negotiable securities in compliance with §§ 726.106(c) and 726.107 of this subchapter, or any other form acceptable to the Director.

(b) The amount of security initially required by this section shall be determined as follows:

(1) In a case involving an operator subject to section 423 of the Act and § 726.4 of this subchapter, the amount of the security shall not be less than $175,000, and may be a higher amount as determined by the Director, taking into account the life expectancies of the claimant and any dependents using the most recent life expectancy tables published by the Social Security Administration; or

(2) In a case involving a coal mine construction or transportation employer, the amount of the security shall be determined by the Director, taking into account the life expectancies of the claimant and any dependents using the most recent life expectancy tables published by the Social Security Administration.

(c) If the operator or other employer fails to provide proof of such security to the Director within 30 days of its receipt of the Director's request to secure the payment of benefits issued under paragraph (a) of this section, the appropriate adjudication officer shall issue an order requiring the operator or other employer to make a deposit of negotiable securities with a Federal Reserve Bank in the amount required by paragraph (b). Such securities shall comply with the requirements of §§ 726.106(c) and 726.107 of this subchapter. In a case in which the effective order was issued by a district director, the district director shall be considered the appropriate adjudication officer. In any other case, the administrative law judge who issued the most recent decision in the case, or such other administrative law judge as the Chief Administrative Law Judge shall designate, shall be considered the appropriate adjudication officer, and shall issue an order under this paragraph on motion of the Director. The administrative law judge shall have jurisdiction to issue an order under this paragraph notwithstanding the pendency of an appeal of the award of benefits with the Benefits Review Board or court.

(d) An order issued under this section shall be considered effective when issued. Disputes regarding such orders shall be resolved in accordance with subpart F of this part.

(e) Notwithstanding any further review of the order in accordance with subpart F of this part, if an operator or other employer subject to an order issued under this section fails to comply with such order, the appropriate adjudication officer shall certify such non-compliance to the appropriate United States district court in accordance with § 725.351(c).

(f) Security posted in accordance with this section may be used to make payment of benefits that become due with respect to the claim in accordance with § 725.502. In the event that either the order awarding compensation or the order issued under this section is vacated or reversed, the operator or other employer may apply to the appropriate adjudication officer for an order authorizing the return of any amounts deposited with a Federal Reserve Bank and not yet disbursed, and such application shall be granted. If at any time the Director determines that additional security is required beyond that initially required by paragraph (b) of this section, he may request the operator or other employer to increase the amount. Such request shall be treated as if it were issued under paragraph (a) of this section.

(g) If a coal mine construction or transportation employer fails to comply with an order issued under paragraph (c), and such employer is a corporation, the provisions of § 725.609 shall be applicable to the president, secretary, and treasurer of such employer.

§ 725.607 Payments in addition to compensation.

(a) If any benefits payable under the terms of an award by a district director (§ 725.419(d)), a decision and order filed and served by an administrative law judge (§ 725.478), or a decision filed by the Board or a U.S. court of appeals, are not paid by an operator or other employer ordered to make such payments within 10 days after such payments become due, there shall be added to such unpaid benefits an amount equal to 20 percent thereof, which shall be paid to the claimant at the same time as, but in addition to, such benefits, unless review of the order making such award is sought as provided in section 21 of the LHWCA and an order staying payments has been issued.

(b) If, on account of an operator's or other employer's failure to pay benefits as provided in paragraph (a) of this section, benefit payments are made by the fund, the eligible claimant shall nevertheless be entitled to receive such additional compensation to which he or she may be eligible under paragraph (a) of this section, with respect to all amounts paid by the fund on behalf of such operator or other employer.

(c) The fund shall not be liable for payments in addition to compensation under any circumstances.

§ 725.608 Interest.

(a)(1) In any case in which an operator fails to pay benefits that are due (§ 725.502), the beneficiary shall also be entitled to simple annual interest, computed from the date on which the benefits were due. The interest shall be computed through the date on which the operator paid the benefits, except that the beneficiary shall not be entitled to interest for any period following the date on which the beneficiary received payment of any benefits from the fund pursuant to § 725.522.

(2) In any case in which an operator is liable for the payment of retroactive benefits, the beneficiary shall also be entitled to simple annual interest on such benefits, computed from 30 days after the date of the first determination that such an award should be made. The first determination that such an award should be made may be a district director's initial determination of entitlement, an award made by an administrative law judge or a decision by the Board or a court, whichever is the first such determination of entitlement made upon the claim.

(3) In any case in which an operator is liable for the payment of additional compensation (§ 725.607), the beneficiary shall also be entitled to simple annual interest computed from the date upon which the beneficiary's right to additional compensation first arose.

(4) In any case in which an operator is liable for the payment of medical benefits, the beneficiary or medical provider to whom such benefits are owed shall also be entitled to simple annual interest, computed from the date upon which the services were rendered, or from 30 days after the date of the first determination that the miner is generally entitled to medical benefits, whichever is later. The first determination that the miner is generally entitled to medical benefits may be a district director's initial determination of entitlement, an award made by

an administrative law judge or a decision by the Board or a court, whichever is the first such determination of general entitlement made upon the claim. The interest shall be computed through the date on which the operator paid the benefits, except that the beneficiary or medical provider shall not be entitled to interest for any period following the date on which the beneficiary or medical provider received payment of any benefits from the fund pursuant to § 725.522 or subpart I of this part.

(b) If an operator or other employer fails or refuses to pay any or all benefits due pursuant to an award of benefits or an initial determination of eligibility made by the district director and the fund undertakes such payments, such operator or other employer shall be liable to the fund for simple annual interest on all payments made by the fund for which such operator is determined liable, computed from the first date on which such benefits are paid by the fund, in addition to such operator's liability to the fund, as is otherwise provided in this part. Interest payments owed pursuant to this paragraph shall be paid directly to the fund.

(c) In any case in which an operator is liable for the payment of an attorney's fee pursuant to § 725.367, and the attorney's fee is payable because the award of benefits has become final, the attorney shall also be entitled to simple annual interest, computed from the date on which the attorney's fee was awarded. The interest shall be computed through the date on which the operator paid the attorney's fee.

(d) The rates of interest applicable to paragraphs (a), (b), and (c) of this section shall be computed as follows:

(1) For all amounts outstanding prior to January 1, 1982, the rate shall be 6% simple annual interest;

(2) For all amounts outstanding for any period during calendar year 1982, the rate shall be 15% simple annual interest; and

(3) For all amounts outstanding during any period after calendar year 1982, the rate shall be simple annual interest at the rate established by section 6621 of the Internal Revenue Code (26 U.S.C.) which is in effect for such period.

(e) The fund shall not be liable for the payment of interest under any circumstances, other than the payment of interest on advances from the United States Treasury as provided by section 9501(c) of the Internal Revenue Code (26 U.S.C.).

§ 725.609 Enforcement against other persons.

In any case in which an award of benefits creates obligations on the part of an operator or insurer that may be enforced under the provisions of this subpart, such obligations may also be enforced, in the discretion of the Secretary or district director, as follows:

(a) In a case in which the operator is a sole proprietorship or partnership, against any person who owned, or was a partner in, such operator during any period commencing on or after the date on which the miner was last employed by the operator;

(b) In a case in which the operator is a corporation that failed to secure its liability for benefits in accordance with section 423 of the Act and § 726.4, and the operator has not secured its liability for the claim in accordance with § 725.606, against any person who served as the president, secretary, or treasurer of such corporation during any period commencing on or after the date on which the miner was last employed by the operator;

(c) In a case in which the operator is no longer capable of assuming its liability for the payment of benefits (§ 725.494(e)), against any operator which became a successor operator with respect to the liable operator (§ 725.492) after the date on which the claim was filed, beginning with the most recent such successor operator;

(d) In a case in which the operator is no longer capable of assuming its liability for the payment of benefits (§ 725.494(e)), and such operator was a subsidiary of a parent company or a product of a joint venture, or was substantially owned or controlled by another business entity, against such parent entity, any member of such joint venture, or such controlling business entity; or

(e) Against any other person who has assumed or succeeded to the obligations of the operator or insurer by operation of any state or federal law, or by any other means.

§ 725.620 Failure to secure benefits; other penalties.

(a) If an operator fails to discharge its insurance obligations under the Act, the provisions of subpart D of part 726 of this subchapter shall apply.

(b) Any employer who knowingly transfers, sells, encumbers, assigns, or in any manner disposes of, conceals, secrets, or destroys any property belonging to such employer, after one of its employees has been injured within the purview of the Act, and with intent to avoid the payment of benefits under the Act to such miner or his or her dependents, shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than $1,000, or by imprisonment for not more than one year, or by both. In any case where such employer is a corporation, the president, secretary, and treasurer thereof shall be also severally liable for such penalty or imprisonment as well as jointly liable with such corporation for such fine.

(c) No agreement by a miner to pay any portion of a premium paid to a carrier by such miner's employer or to contribute to a benefit fund or department maintained by such employer for the purpose of providing benefits or medical services and supplies as required by this part shall be valid; and any employer who makes a deduction for such purpose from the pay of a miner entitled to benefits under the Act shall be guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not more than $1,000.

(d) No agreement by a miner to waive his or her right to benefits under the Act and the provisions of this part shall be valid.

(e) This section shall not affect any other liability of the employer under this part.

§ 725.621 Reports.

(a) Upon making the first payment of benefits and upon suspension, reduction, or increase of payments, the operator or other employer responsible for making payments shall immediately notify the district director of the action taken, in accordance with a form prescribed by the Office.

(b) Within 16 days after final payment of benefits has been made by an employer, such employer shall so notify the district director, in accordance with a form prescribed by the Office, stating that such final payment, has been made, the total amount of benefits paid, the name of the beneficiary, and such other information as the Office deems pertinent.

(c) The Director may from time to time prescribe such additional reports to be made by operators, other employers, or carriers as the Director may consider necessary for the efficient administration of the Act.

(d) Any employer who fails or refuses to file any report required of such employer under this section shall be subject to a civil penalty not to exceed $500 for each failure or refusal, which penalty shall be determined in accordance with the procedures set forth in subpart D of part 726 of this subchapter, as appropriate. The maximum penalty applicable to any violation of this paragraph that takes place after January 19, 2001 shall be $550.

(e) No request for information or response to such request shall be considered a report for purposes of this section or the Act, unless it is so designated by the Director or by this section.

Subpart J—Medical Benefits and Vocational Rehabilitation

§ 725.701 Availability of medical benefits.

(a) A miner who is determined to be eligible for benefits under this part or part 727 of this subchapter (see § 725.4(d)) is entitled to medical benefits as set forth in this subpart as of the date of his or her claim, but in no event before January 1, 1974. No medical benefits shall be provided to the survivor or dependent of a miner under this part.

(b) A responsible operator, other employer, or where there is neither, the fund, shall furnish a miner entitled to

benefits under this part with such medical, surgical, and other attendance and treatment, nursing and hospital services, medicine and apparatus, and any other medical service or supply, for such periods as the nature of the miner's pneumoconiosis and disability requires.

(c) The medical benefits referred to in paragraphs (a) and (b) of this section shall include palliative measures useful only to prevent pain or discomfort associated with the miner's pneumoconiosis or attendant disability.

(d) The costs recoverable under this subpart shall include the reasonable cost of travel necessary for medical treatment (to be determined in accordance with prevailing United States government mileage rates) and the reasonable documented cost to the miner or medical provider incurred in communicating with the employer, carrier, or district director on matters connected with medical benefits.

(e) If a miner receives a medical service or supply, as described in this section, for any pulmonary disorder, there shall be a rebuttable presumption that the disorder is caused or aggravated by the miner's pneumoconiosis. The party liable for the payment of benefits may rebut the presumption by producing credible evidence that the medical service or supply provided was for a pulmonary disorder apart from those previously associated with the miner's disability, or was beyond that necessary to effectively treat a covered disorder, or was not for a pulmonary disorder at all.

(f) Evidence that the miner does not have pneumoconiosis or is not totally disabled by pneumoconiosis arising out of coal mine employment is insufficient to defeat a request for coverage of any medical service or supply under this subpart. In determining whether the treatment is compensable, the opinion of the miner's treating physician may be entitled to controlling weight pursuant to § 718.104(d). A finding that a medical service or supply is not covered under this subpart shall not otherwise affect the miner's entitlement to benefits.

§ 725.702 Claims for medical benefits only under section 11 of the Reform Act.

(a) Section 11 of the Reform Act directs the Secretary of Health, Education and Welfare to notify each miner receiving benefits under part B of title IV of the Act that he or she may file a claim for medical treatment benefits described in this subpart. Section 725.308(b) provides that a claim for medical treatment benefits shall be filed on or before December 31, 1980, unless the period is enlarged for good cause shown. This section sets forth the rules governing the processing, adjudication, and payment of claims filed under section 11.

(b)(1) A claim filed pursuant to the notice described in paragraph (a) of this section shall be considered a claim for medical benefits only, and shall be filed, processed, and adjudicated in accordance with the provisions of this part, except as provided in this section. While a claim for medical benefits must be treated as any other claim filed under part C of title IV of the Act, the Department shall accept the Social Security Administration's finding of entitlement as its initial determination.

(2) In the case of a part B beneficiary whose coal mine employment terminated before January 1, 1970, the Secretary shall make an immediate award of medical benefits. Where the part B beneficiary's coal mine employment terminated on or after January 1, 1970, the Secretary shall immediately authorize the payment of medical benefits and thereafter inform the responsible operator, if any, of the operator's right to contest the claimant's entitlement for medical benefits.

(c) A miner on whose behalf a claim is filed under this section (see § 725.301) must have been alive on March 1, 1978, in order for the claim to be considered.

(d) The criteria contained in subpart C of part 727 of this subchapter (see § 725.4(d)) are applicable to claims for medical benefits filed under this section.

(e) No determination made with respect to a claim filed under this section shall affect any determination previously made by the Social Security Administration. The Social Security

Administration may, however, reopen a previously approved claim if the conditions set forth in § 410.672(c) of this chapter are present. These conditions are generally limited to fraud or concealment.

(f) If medical benefits are awarded under this section, such benefits shall be payable by a responsible coal mine operator (see subpart G of this part), if the miner's last employment occurred on or after January 1, 1970, and in all other cases by the fund. An operator which may be required to provide medical treatment benefits to a miner under this section shall have the right to participate in the adjudication of the claim as is otherwise provided in this part.

(g) Any miner whose coal mine employment terminated after January 1, 1970, may be required to submit to a medical examination requested by an identified operator. The unreasonable refusal to submit to such an examination shall have the same consequences as are provided under § 725.414.

(h) If a miner is determined eligible for medical benefits in accordance with this section, such benefits shall be provided from the date of filing, except that such benefits may also include payments for any unreimbursed medical treatment costs incurred personally by such miner during the period from January 1, 1974, to the date of filing which are attributable to medical care required as a result of the miner's total disability due to pneumoconiosis. No reimbursement for health insurance premiums, taxes attributable to any public health insurance coverage, or other deduction or payments made for the purpose of securing third party liability for medical care costs is authorized by this section. If a miner seeks reimbursement for medical care costs personally incurred before the filing of a claim under this section, the district director shall require documented proof of the nature of the medical service provided, the identity of the medical provider, the cost of the service, and the fact that the cost was paid by the miner, before reimbursement for such cost may be awarded.

§ 725.703 Physician defined.

The term ''physician'' includes only doctors of medicine (MD) and osteopathic practitioners within the scope of their practices as defined by State law. No treatment or medical services performed by any other practitioner of the healing arts is authorized by this part, unless such treatment or service is authorized and supervised both by a physician as defined in this section and the district director.

§ 725.704 Notification of right to medical benefits; authorization of treatment.

(a) Upon notification to a miner of such miner's entitlement to benefits, the Office shall provide the miner with a list of authorized treating physicians and medical facilities in the area of the miner's residence. The miner may select a physician from this list or may select another physician with approval of the Office. Where emergency services are necessary and appropriate, authorization by the Office shall not be required.

(b) The Office may, on its own initiative, or at the request of a responsible operator, order a change of physicians or facilities, but only where it has been determined that the change is desirable or necessary in the best interest of the miner. The miner may change physicians or facilities subject to the approval of the Office.

(c) If adequate treatment cannot be obtained in the area of the claimant's residence, the Office may authorize the use of physicians or medical facilities outside such area as well as reimbursement for travel expenses and overnight accommodations.

§ 725.705 Arrangements for medical care.

(a) *Operator liability*. If an operator has been determined liable for the payment of benefits to a miner, the Office shall notify such operator or insurer of the names, addresses, and telephone numbers of the authorized providers of medical benefits chosen by an entitled miner, and shall require the operator or insurer to:

(1) Notify the miner and the providers chosen that such operator will be responsible for the cost of medical

services provided to the miner on account of the miner's total disability due to pneumoconiosis;

(2) Designate a person or persons with decisionmaking authority with whom the Office, the miner and authorized providers may communicate on matters involving medical benefits provided under this subpart and notify the Office, miner and providers of such designation;

(3) Make arrangements for the direct reimbursement of providers for their services.

(b) *Fund liability*. If there is no operator found liable for the payment of benefits, the Office shall make necessary arrangements to provide medical care to the miner, notify the miner and medical care facility selected of the liability of the fund, designate a person or persons with whom the miner or provider may communicate on matters relating to medical care, and make arrangements for the direct reimbursement of the medical provider.

§ 725.706 Authorization to provide medical services.

(a) Except as provided in paragraph (b) of this section, medical services from an authorized provider which are payable under § 725.701 shall not require prior approval of the Office or the responsible operator.

(b) Except where emergency treatment is required, prior approval of the Office or the responsible operator shall be obtained before any hospitalization or surgery, or before ordering an apparatus for treatment where the purchase price exceeds $300. A request for approval of non-emergency hospitalization or surgery shall be acted upon expeditiously, and approval or disapproval will be given by telephone if a written response cannot be given within 7 days following the request. No employee of the Department of Labor, other than a district director or the Chief, Branch of Medical Analysis and Services, DCMWC, is authorized to approve a request for hospitalization or surgery by telephone.

(c) Payment for medical services, treatment, or an apparatus shall be made at no more than the rate prevailing in the community in which the providing physician, medical facility or supplier is located.

§ 725.707 Reports of physicians and supervision of medical care.

(a) Within 30 days following the first medical or surgical treatment provided under § 725.701, the treating physician or facility shall furnish to the Office and the responsible operator, if any, a report of such treatment.

(b) In order to permit continuing supervision of the medical care provided to the miner with respect to the necessity, character and sufficiency of any medical care furnished or to be furnished, the treating physician, facility, employer or carrier shall provide such reports in addition to those required by paragraph (a) of this section as the Office may from time to time require. Within the discretion of the district director, payment may be refused to any medical provider who fails to submit any report required by this section.

§ 725.708 Disputes concerning medical benefits.

(a) Whenever a dispute develops concerning medical services under this part, the district director shall attempt to informally resolve such dispute. In this regard the district director may, on his or her own initiative or at the request of the responsible operator order the claimant to submit to an examination by a physician selected by the district director.

(b) If no informal resolution is accomplished, the district director shall refer the case to the Office of Administrative Law Judges for hearing in accordance with this part. Any such hearing shall be scheduled at the earliest possible time and shall take precedence over all other requests for hearing except for prior requests for hearing arising under this section and as provided by § 727.405 of this subchapter (see § 725.4(d)). During the pendency of such adjudication, the Director may order the payment of medical benefits prior to final adjudication under the same conditions applicable to benefits awarded under § 725.522.

(c) In the development or adjudication of a dispute over medical benefits, the adjudication officer is authorized

to take whatever action may be necessary to protect the health of a totally disabled miner.

(d) Any interested medical provider may, if appropriate, be made a party to a dispute over medical benefits.

§ 725.710 Objective of vocational rehabilitation.

The objective of vocational rehabilitation is the return of a miner who is totally disabled for work in or around a coal mine and who is unable to utilize those skills which were employed in the miner's coal mine employment to gainful employment commensurate with such miner's physical impairment. This objective may be achieved through a program of re-evaluation and redirection of the miner's abilities, or retraining in another occupation, and selective job placement assistance.

§ 725.711 Requests for referral to vocational rehabilitation assistance.

Each miner who has been determined entitled to receive benefits under part C of title IV of the Act shall be informed by the OWCP of the availability and advisability of vocational rehabilitation services. If such miner chooses to avail himself or herself of vocational rehabilitation, his or her request shall be processed and referred by OWCP vocational rehabilitation advisors pursuant to the provisions of §§ 702.501 through 702.508 of this chapter as is appropriate.

PART 726—BLACK LUNG BENEFITS; REQUIREMENTS FOR COAL MINE OPERATOR'S INSURANCE

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SOURCE: 65 FR 80097, Dec. 20, 2000, unless otherwise noted.

Subpart A—General

§ 726.1 Statutory insurance requirements for coal mine operators.

Section 423 of title IV of the Federal Coal Mine Health and Safety Act as amended (hereinafter the Act) requires each coal mine operator who is operating or has operated a coal mine in a State which is not included in the list published by the Secretary (see part 722 of this subchapter) to secure the payment of benefits for which he may be found liable under section 422 of the Act and the provisions of this subchapter by either:

(a) Qualifying as a self-insurer, or

(b) By subscribing to and maintaining in force a commercial insurance contract (including a policy or contract procured from a State agency).

§ 726.2 Purpose and scope of this part.

(a) This part provides rules directing and controlling the circumstances under which a coal mine operator shall fulfill his insurance obligations under the Act.

(b) This Subpart A sets forth the scope and purpose of this part and generally describes the statutory framework within which this part is operative.

(c) Subpart B of this part sets forth the criteria a coal mine operator must meet in order to qualify as a self-insurer.

(d) Subpart C of this part sets forth the rules and regulations of the Secretary governing contracts of insurance entered into by coal mine operators and commercial insurance sources for the payment of black lung benefits under part C of the Act.

(e) Subpart D of this part sets forth the rules governing the imposition of civil money penalties on coal mine operators that fail to secure their liability under the Act.

§ 726.3 Relationship of this part to other parts in this subchapter.

(a) This part 726 implements and effectuates responsibilities for the payment of black lung benefits placed upon coal mine operators by sections 415 and 422 of the Act and the regulations of the Secretary in this subchapter, particularly those set forth in part 725 of this subchapter. All definitions, usages, procedures, and other rules affecting the responsibilities of coal mine operators prescribed in part 725 of this subchapter are hereby made applicable, as appropriate, to this part 726.

(b) If the provisions of this part appear to conflict with any provision of any other part in this subchapter, the apparently conflicting provisions should be read harmoniously to the fullest extent possible. If a harmonious interpretation is not possible, the provisions of this part should be applied to govern the responsibilities and obligations of coal mine operators to secure the payment of black lung benefits as prescribed by the Act. The provisions of this part do not apply to matters falling outside the scope of this part.

§ 726.4 Who must obtain insurance coverage.

(a) Section 423 of part C of title IV of the Act requires each operator of a coal mine or former operator in any State which does meet the requirements prescribed by the Secretary pursuant to section 411 of part C of title IV of the Act to self-insure or obtain a policy or contract of insurance to guarantee the

payment of benefits for which such operator may be adjudicated liable under section 422 of the Act. In enacting sections 422 and 423 of the Act Congress has unambiguously expressed its intent that coal mine operators bear the cost of providing the benefits established by part C of title IV of the Act. Section 3 of the Act defines an ''operator'' as any owner, lessee, or other person who operates, controls, or supervises a coal mine.

(b) Section 422(i) of the Act clearly recognizes that any individual or business entity who is or was a coal mine operator may be found liable for the payment of pneumoconiosis benefits after December 31, 1973. Within this framework it is clear that the Secretary has wide latitude for determining which operator shall be liable for the payment of part C benefits. Comprehensive standards have been promulgated in subpart G of part 725 of this subchapter for the purpose of guiding the Secretary in making such determination. It must be noted that pursuant to these standards any parent or subsidiary corporation, any individual or corporate partner, or partnership, any lessee or lessor of a coal mine, any joint venture or participant in a joint venture, any transferee or transferor of a corporation or other business entity, any former, current, or future operator or any other form of business entity which has had or will have a substantial and reasonably direct interest in the operation of a coal mine may be determined liable for the payment of pneumoconiosis benefits after December 31, 1973. The failure of any such business entity to self-insure or obtain a policy or contract of insurance shall in no way relieve such business entity of its obligation to pay pneumoconiosis benefits in respect of any case in which such business entity's responsibility for such payments has been properly adjudicated. Any business entity described in this section shall take appropriate steps to insure that any liability imposed by part C of the Act on such business entity shall be dischargeable.

§ 726.5 Effective date of insurance coverage.

Pursuant to section 422(c) of part C of title IV of the Act, no coal mine operator shall be responsible for the payment of any benefits whatsoever for any period prior to January 1, 1974. However, coal mine operators shall be liable as of January 1, 1974, for the payment of benefits in respect of claims which were filed under section 415 of part B of title IV of the Act after July 1, 1973. Section 415(a)(3) requires the Secretary to notify any operator who may be liable for the payment of benefits under part C of title IV beginning on January 1, 1974, of the pendency of a section 415 claim. Section 415(a)(5) declares that any operator who has been notified of the pendency of a section 415 claim shall be bound by the determination of the Secretary as to such operator's liability and as to the claimant's entitlement to benefits as if the claim were filed under part C of title IV of the Act and section 422 thereof had been applicable to such operator. Therefore, even though no benefit payments shall be required of an operator prior to January 1, 1974, the liability for these payments may be finally adjudicated at any time after July 1, 1973. Neither the failure of an operator to exercise his right to participate in the adjudication of such a claim nor the failure of an operator to obtain insurance coverage in respect of claims filed after June 30, 1973, but before January 1, 1974, shall excuse such operator from his liability for the payment of benefits to such claimants under part C of title IV of the Act.

§ 726.6 The Office of Workers' Compensation Programs.

The Office of Workers' Compensation Programs (hereinafter the Office or OWCP) is that division of the U.S. Department of Labor which has been empowered by the Secretary of Labor to carry out his or her functions under section 415 and part C of title IV of the Act. As noted throughout this part 726 the Office shall perform a number of functions with respect to the regulation of both the self-insurance and commercial insurance programs. All correspondence with or submissions to the Office should be addressed as follows: Division of Coal Mine Workers'

Compensation, Office of Workers' Compensation Programs, U.S. Department of Labor, Washington, DC 20210.

[77 FR 37286, June 21, 2012]

§ 726.7 Forms, submission of information.

Any information required by this part 726 to be submitted to the Office of Workmen's Compensation Programs or any other office or official of the Department of Labor, shall be submitted on such forms or in such manner as the Secretary deems appropriate and has authorized from time to time for such purposes.

§ 726.8 Definitions.

In addition to the definitions provided in part 725 of this subchapter, the following definitions apply to this part:

(a) *Director* means the Director, Office of Workers' Compensation Programs, and includes any official of the Office of Workers' Compensation Programs authorized by the Director to perform any of the functions of the Director under this part and part 725 of this subchapter.

(b) *Person* includes any individual, partnership, corporation, association, business trust, legal representative, or organized group of persons.

(c) *Secretary* means the Secretary of Labor or such other official as the Secretary shall designate to carry out any responsibility under this part.

(d) The terms *employ* and *employment* shall be construed as broadly as possible, and shall include any relationship under which an operator retains the right to direct, control, or supervise the work performed by a miner, or any other relationship under which an operator derives a benefit from the work performed by a miner. Any individuals who participate with one or more persons in the mining of coal, such as owners, proprietors, partners, and joint venturers, whether they are compensated by wages, salaries, piece rates, shares, profits, or by any other means, shall be deemed employees. It is the specific intention of this paragraph to disregard any financial arrangement or business entity devised by the actual owners or operators of a coal mine or coal mine-related enterprise to avoid the payment of benefits to miners who, based upon the economic reality of their relationship to this enterprise, are, in fact, employees of the enterprise.

Subpart B—Authorization of Self-Insurers

§ 726.101 Who may be authorized to self-insure.

(a) Pursuant to section 423 of part C of title IV of the Act, authorization to self-insure against liability incurred by coal mine operators on account of the total disability or death of miners due to pneumoconiosis may be granted or denied in the discretion of the Secretary. The provisions of this subpart describe the minimum requirements established by the Secretary for determining whether any particular coal mine operator shall be authorized as a self-insurer.

(b) The minimum requirements which must be met by any operator seeking authorization to self-insure are as follows:

(1) The operator must, at the time of application, have been in the business of mining coal for at least the 3 consecutive years prior to such application; and,

(2) The operator must demonstrate the administrative capacity to fully service such claims as may be filed against him; and,

(3) The operator's average current assets over the preceding 3 years (in computing average current assets such operator shall not include the amount of any negotiable securities which he may be required to deposit to secure his obligations under the Act) must exceed current liabilities by the sum of—

(i) The estimated aggregate amount of black lung benefits (including medical benefits) which such operator may expect to be required to pay during the ensuing year; and,

(ii) The annual premium cost for any indemnity bond purchased; and

(4) Such operator must obtain security, in a form approved by the Office (see § 726.104) and in an amount to be determined by the Office (see § 726.105); and

(5) No operator with fewer than 5 full-time employee-miners shall be permitted to self-insure.

(c) No operator who is unable to meet the requirements of this section should apply for authorization to self-insure and no application for self-insurance shall be approved by the Office until such time as the amount prescribed by the Office has been secured in accordance with this subpart.

§ 726.102 Application for authority to become a self-insurer; how filed; information to be submitted.

(a) *How filed.* Application for authority to become a self-insurer shall be addressed to the Office and be made on a form provided by the Office. Such application shall be signed by the applicant over his typewritten name and if the applicant is not an individual, by the principal officer of the applicant duly authorized to make such application over his typewritten name and official designation and shall be sworn to by him. If the applicant is a corporation, the corporate seal shall be affixed. The application shall be filed with the Office in Washington, D.C.

(b) *Information to be submitted.* Each application for authority to self-insure shall contain:

(1) A statement of the employer's payroll report for each of the preceding 3 years;

(2) A statement of the average number of employees engaged in employment within the purview of the Act for each of the preceding 3 years;

(3) A list of the mine or mines to be covered by any particular self-insurance agreement. Each such mine or mines listed shall be described by name and reference shall be made to the Federal Identification Number assigned such mine by the Bureau of Mines, U.S. Department of the Interior;

(4) A certified itemized statement of the gross and net assets and liabilities of the operator for each of the 3 preceding years in such manner as prescribed by the Office;

(5) A statement demonstrating the applicant's administrative capacity to provide or procure adequate servicing for a claim including both medical and dollar claims; and

(6) In addition to the aforementioned, the Office may in its discretion, require the applicant to submit such further information or such evidence as the Office may deem necessary to have in order to enable it to give adequate consideration to such application.

(c) *Who may file.* An application for authorization to self-insure may be filed by any parent or subsidiary corporation, partner or partnership, party to a joint venture or joint venture, individual, or other business entity which may be determined liable for the payment of black lung benefits under part C of title IV of the Act, regardless of whether such applicant is directly engaged in the business of mining coal. However, in each case for which authorization to self-insure is granted, the agreement and undertaking filed pursuant to § 726.110 and the security deposit shall be respectively filed by and deposited in the name of the applicant only.

§ 726.103 Application for authority to self-insure; effect of regulations contained in this part.

As appropriate, each of the regulations, interpretations and requirements contained in this part 726 including those described in subpart C of this part shall be binding upon each applicant under this subpart, and the applicant's consent to be bound by all requirements of the said regulations shall be deemed to be included in and a part of the application, as fully as though written therein.

§ 726.104 Action by the Office upon application of operator.

(a) Upon receipt of a completed application for authorization to self-insure, the Office shall, after examination of the information contained in the application, either deny the request or determine the amount of security which must be given by the applicant to guarantee the payment of benefits and the discharge of all other obligations which may be required of such applicant under the Act.

(b) The applicant shall thereafter be notified that he may give security in the amount fixed by the Office (see § 726.105):

(1) In the form of an indemnity bond with sureties satisfactory to the Office;

(2) By a deposit of negotiable securities with a Federal Reserve Bank in

compliance with §§ 726.106(c) and 726.107;

(3) In the form of a letter of credit issued by a financial institution satisfactory to the Office (except that a letter of credit shall not be sufficient by itself to satisfy a self-insurer's obligations under this part); or

(4) By funding a trust pursuant to section 501(c)(21) of the Internal Revenue Code (26 U.S.C.).

(c) Any applicant who cannot meet the security deposit requirements imposed by the Office should proceed to obtain a commercial policy or contract of insurance. Any applicant for authorization to self-insure whose application has been rejected or who believes that the security deposit requirements imposed by the Office are excessive may, in writing, request that the Office review its determination. A request for review should contain such information as may be necessary to support the request that the amount of security required be reduced.

(d) Upon receipt of any such request, the Office shall review its previous determination in light of any new or additional information submitted and inform the applicant whether or not a reduction in the amount of security initially required is warranted.

§ 726.105 Fixing the amount of security.

The Office shall require the amount of security which it deems necessary and sufficient to secure the performance by the applicant of all obligations imposed upon him as an operator by the Act. In determining the amount of security required, the factors that the Office will consider include, but are not limited to, the operator's net worth, the existence of a guarantee by a parent corporation, and the operator's existing liability for benefits. The Office shall also consider such other factors as it considers relevant to any particular case. The amount of security which shall be required may be increased or decreased when experience or changed conditions so warrant.

§ 726.106 Type of security.

(a) The Office shall determine the type or types of security which an applicant shall or may procure. (See § 726.104(b).)

(b) In the event the indemnity bond option is selected, the bond shall be in such form and contain such provisions as the Office may prescribe: *Provided,* That only corporations may act as sureties on such indemnity bonds. In each case in which the surety on any such bond is a surety company, such company must be one approved by the U.S. Treasury Department under the laws of the United States and the applicable rules and regulations governing bonding companies (see Department of Treasury's Circular—570).

(c) An applicant for authorization to self-insure based on a deposit of negotiable securities, in the amount fixed by the Office, shall deposit any negotiable securities acceptable as security for the deposit of public moneys of the United States under regulations issued by the Secretary of the Treasury. (See 31 CFR part 225.) The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States.

§ 726.107 Deposits of negotiable securities with Federal Reserve banks or the Treasurer of the United States; authority to sell such securities; interest thereon.

Deposits of securities provided for by the regulations in this part shall be made with any Federal Reserve bank or any branch of a Federal Reserve bank designated by the Office, or the Treasurer of the United States, and shall be held subject to the order of the Office with power in the Office, in its discretion in the event of default by the said self-insurer, to collect the interest as it may become due, to sell the securities or any of them as may be required to discharge the obligations of the self-insurer under the Act and to apply the proceeds to the payment of any benefits or medical expenses for which the self-insurer may be liable. The Office may, however, whenever it deems it unnecessary to resort to such securities for the payment of benefits, authorize the self-insurer to collect interest on the securities deposited by him.

§ 726.108 Withdrawal of negotiable securities.

No withdrawal of negotiable securities deposited by a self-insurer, shall be made except upon authorization by the Office. A self-insurer discontinuing business, or discontinuing operations within the purview of the Act, or providing security for the payment of benefits by commercial insurance under the provisions of the Act may apply to the Office for the withdrawal of securities deposited under the regulations in this part. With such application shall be filed a sworn statement setting forth:

(a) A list of all outstanding cases in which benefits are being paid, with the names of the miners and other beneficiaries, giving a statement of the amounts of benefits paid and the periods for which such benefits have been paid; and

(b) A similar list of all pending cases in which no benefits have as yet been paid. In such cases withdrawals may be authorized by the Office of such securities as in the opinion of the Office may not be necessary to provide adequate security for the payment of outstanding and potential liabilities of such self-insurer under the Act.

§ 726.109 Increase or reduction in the amount of security.

Whenever in the opinion of the Office the amount of security given by the self-insurer is insufficient to afford adequate security for the payment of benefits and medical expenses under the Act, the self-insurer shall, upon demand by the Office, file such additional security as the Office may require. The Office may reduce the amount of security at any time on its own initiative, or upon the application of a self-insurer, when it believes the facts warrant a reduction. A self-insurer seeking a reduction shall furnish such information as the Office may request relative to his current affairs, the nature and hazard of the work of his employees, the amount of the payroll of his employees engaged in coal mine employment within the purview of the Act, his financial condition, and such other evidence as may be deemed material, including a record of benefit payments he has made.

§ 726.110 Filing of agreement and undertaking.

(a) In addition to the requirement that adequate security be procured as set forth in this subpart, the applicant for the authorization to self-insure shall, as a condition precedent to receiving such authorization, execute and file with the Office an agreement and undertaking in a form prescribed and provided by the Office in which the applicant shall agree:

(1) To pay when due, as required by the Act, all benefits payable on account of total disability or death of any of its employee-miners;

(2) To furnish medical, surgical, hospital, and other attendance, treatment, and care as required by the Act;

(3) To provide security in a form approved by the Office (see § 726.104) and in an amount established by the Office (see § 726.105), as elected in the application;

(4) To authorize the Office to sell any negotiable securities so deposited or any part thereof, and to pay from the proceeds thereof such benefits, medical, and other expenses and any accrued penalties imposed by law as the Office may find to be due and payable.

(b) When an applicant has provided the requisite security, he shall send to the Office in Washington, D.C. a completed agreement and undertaking, together with satisfactory proof that his obligations and liabilities under the Act have been secured.

§ 726.111 Notice of authorization to self-insure.

Upon receipt of a completed agreement and undertaking and satisfactory proof that adequate security has been provided, an applicant for authorization to self-insure shall be notified by the Office in writing that he is authorized to self-insure to meet the obligations imposed upon him by section 415 and part C of title IV of the Act.

§ 726.112 Reports required of self-insurer; examination of accounts of self-insurer.

(a) Each operator who has been authorized to self-insure under this part shall submit to the Office reports containing such information as the Office

may from time to time require or prescribe.

(b) Whenever it deems it to be necessary, the Office may inspect or examine the books of account, records, and other papers of a self-insurer for the purpose of verifying any financial statement submitted to the Office by the self-insurer or verifying any information furnished to the Office in any report required by this section, or any other section of the regulations in this part, and such self-insurer shall permit the Office or its duly authorized representative to make such an inspection or examination as the Office shall require. In lieu of this requirement the Office may in its discretion accept an adequate report of a certified public accountant.

(c) Failure to submit or make available any report or information requested by the Office from an authorized self-insurer pursuant to this section may, in appropriate circumstances result in a revocation of the authorization to self-insure.

§ 726.113 Disclosure of confidential information.

Any financial information or records, or other information relating to the business of an authorized self-insurer or applicant for the authorization of self-insurance obtained by the Office shall be exempt from public disclosure to the extent provided in 5 U.S.C. 552(b) and the applicable regulations of the Department of Labor promulgated thereunder. (See 29 CFR part 70.)

§ 726.114 Period of authorization as self-insurer; reauthorization.

(a) No initial authorization to self-insure shall be granted for a period in excess of 18 months. A self-insurer who has made an adequate deposit of negotiable securities in compliance with §§ 726.106(c) and 726.107 will be reauthorized for the ensuing fiscal year without additional security if the Office finds that his experience as a self-insurer warrants such action. If the Office determines that such self-insurer's experience indicates a need for the deposit of additional security, no reauthorization shall be issued for the ensuing fiscal year until the Office receives satisfactory proof that the requisite amount of additional securities has been deposited. A self-insurer who currently has on file an indemnity bond will receive from the Office each year a bond form for execution in contemplation of reauthorization, and the submission of such bond duly executed in the amount indicated by the Office will be deemed and treated as such self-insurer's application for reauthorization for the ensuing fiscal year.

(b) In each case for which there is an approved change in the amount of security provided, a new agreement and undertaking shall be executed.

(c) Each operator authorized to self-insure under this part shall apply for reauthorization for any period during which it engages in the operation of a coal mine and for additional periods after it ceases operating a coal mine. Upon application by the operator, accompanied by proof that the security it has posted is sufficient to secure all benefits potentially payable to miners formerly employed by the operator, the Office shall issue a certification that the operator is exempt from the requirements of this part based on its prior operation of a coal mine. The provisions of subpart D of this part shall be applicable to any operator that fails to apply for reauthorization in accordance with the provisions of this section.

§ 726.115 Revocation of authorization to self-insure.

The Office may for good cause shown suspend or revoke the authorization of any self-insurer. Failure by a self-insurer to comply with any provision or requirement of law or of the regulations in this part, or with any lawful order or communication of the Office, or the failure or insolvency of the surety on his indemnity bond, or impairment of financial responsibility of such self-insurer, may be deemed good cause for such suspension or revocation.

Subpart C—Insurance Contracts

§ 726.201 Insurance contracts—generally.

Each operator of a coal mine who has not obtained authorization as a self-insurer shall purchase a policy or enter

into a contract with a commercial insurance carrier or State agency. Pursuant to authority contained in sections 422(a) and 423(b) and (c) of part C of title IV of the Act, this subpart describes a number of provisions which are required to be incorporated in a policy or contract of insurance obtained by a coal mine operator for the purpose of meeting the responsibility imposed upon such operator by the Act in respect of the total disability or death of miners due to pneumoconiosis.

§ 726.202 Who may underwrite an operator's liability.

Each coal mine operator who is not authorized to self-insure shall insure and keep insured the payment of benefits as required by the Act with any stock company or mutual company or association, or with any other person, or fund, including any State fund while such company, association, person, or fund is authorized under the law of any State to insure workmen's compensation.

§ 726.203 Federal Coal Mine Health and Safety Act endorsement.

(a) The following form of endorsement shall be attached and applicable to the standard workmen's compensation and employer's liability policy prepared by the National Council on Compensation Insurance affording coverage under the Federal Coal Mine Health and Safety Act of 1969, as amended:

It is agreed that: (1) With respect to operations in a State designated in item 3 of the declarations, the unqualified term ''workmen's compensation law'' includes part C of title IV of the Federal Coal Mine Health and Safety Act of 1969, 30 U.S.C. section 931–936, and any laws amendatory thereto, or supplementary thereto, which may be or become effective while this policy is in force, and definition (a) of Insuring Agreement III is amended accordingly; (2) with respect to such insurance as is afforded by this endorsement, (a) the States, if any, named below, shall be deemed to be designated in item 3 of the declaration; (b) Insuring Agreement IV(2) is amended to read ''by disease caused or aggravated by exposure of which the last day of the last exposure, in the employment of the insured, to conditions causing the disease occurs during the policy period, or occurred prior to (effective date) and claim based on such disease is first filed against the insured during the policy period.''

(b) The term ''effective date'' as used in paragraph (a) of this section shall be construed to mean the effective date of the first policy or contract of insurance procured by an operator for purposes of meeting the obligations imposed on such operator by section 423 of part C of title IV of the Act.

(c) The Act contains a number of provisions and imposes a number of requirements on operators which differ in varying degrees from traditional workmen's compensation concepts. To avoid unnecessary administrative delays and expense which might be occasioned by the drafting of an entirely new standard workmen's compensation policy specially tailored to the Act, the Office has determined that the existing standard workmen's compensation policy subject to the endorsement provisions contained in paragraph (a) of this section shall be acceptable for purposes of writing commercial insurance coverage under the Act. However, to avoid undue disputes over the meaning of certain policy provisions and in accordance with the authority contained in section 423(b)(3) of the Act, the Office has determined that the following requirements shall be applicable to all commercial insurance policies obtained by an operator for the purpose of insuring any liability incurred pursuant to the Act:

(1) *Operator liability.* (i) Section 415 and part C of title IV of the Act provide coverage for total disability or death due to pneumoconiosis to all claimants who meet the eligibility requirements imposed by the Act. Section 422 of the Act and the regulations duly promulgated thereunder (part 725 of this subchapter) set forth the conditions under which a coal mine operator may be adjudicated liable for the payment of benefits to an eligible claimant for any period subsequent to December 31, 1973.

(ii) Section 422(c) of the Act prescribes that except as provided in 422(i) (see paragraph (c)(2) of this section) an operator may be adjudicated liable for the payment of benefits in any case if the total disability or death due to pneumoconiosis upon which the claim is predicated arose at least in part out

of employment in a mine in any period during which it was operated by such operator. The Act does not require that such employment which contributed to or caused the total disability or death due to pneumoconiosis occur subsequent to any particular date in time. The Secretary in establishing a formula for determining the operator liable for the payment of benefits (see subpart D of part 725 of this subchapter) in respect of any particular claim, must therefore, within the framework and intent of title IV of the Act find in appropriate cases that an operator is liable for the payment of benefits for some period after December 31, 1973, even though the employment upon which an operator's liability is based occurred prior to July 1, 1973, or prior to the effective date of the Act or the effective date of any amendments thereto, or prior to the effective date of any policy or contract of insurance obtained by such operator. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate these requirements in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(2) *Successor liability*. Section 422(i) of part C of title IV of the Act requires that a coal mine operator who after December 30, 1969, acquired his mine or substantially all of the assets thereof from a person who was an operator of such mine on or after December 30, 1969, shall be liable for and shall secure the payment of benefits which would have been payable by the prior operator with respect to miners previously employed in such mine if the acquisition had not occurred and the prior operator had continued to operate such mine. In the case of an operator who is determined liable for the payment of benefits under section 422(i) of the Act and part 725 of this subchapter, such liability shall accrue to such operator regardless of the fact that the miner on whose total disability or death the claim is predicated was never employed by such operator in any capacity. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate this requirement in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(3) *Medical eligibility*. Pursuant to section 422(h) of part C of title IV of the Act and the regulations described therein (see subpart D of part 410 of this title) benefits shall be paid to eligible claimants on account of total disability or death due to pneumoconiosis and in cases where the miner on whose death a claim is predicated was totally disabled by pneumoconiosis at the time of his death regardless of the cause of such death. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate these requirements in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(4) *Payment of benefits, rates*. Section 422(c) of the Act by incorporating section 412(a) of the Act requires the payment of benefits at a rate equal to 50 per centum of the minimum monthly payment to which a Federal employee in grade GS–2, who is totally disabled is entitled at the time of payment under Chapter 81 of title 5, United States Code. These benefits are augmented on account of eligible dependents as appropriate (see section 412(a) of part B of title IV of the Act). Since the dollar amount of benefits payable to any beneficiary is required to be computed at the time of payment such amounts may be expected to increase from time to time as changes in the GS–2 grade are enacted into law. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act, the requirement that the payment of benefits to eligible beneficiaries shall be made in such dollar amounts as are prescribed by section 412(a) of the Act computed at the time of payment.

(5) *Compromise and waiver of benefits*. Section 422(a) of part C of title IV of the Act by incorporating sections 15(b) and 16 of the Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. 915(b) and 916) prohibits the

compromise and/or waiver of claims for benefits filed or benefits payable under section 415 and part C of title IV of the Act. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate these prohibitions in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(6) *Additional requirements.* In addition to the requirements described in paragraph (c)(1) through (5) of this section, the endorsement provisions contained in paragraph (a) of this section shall, to the fullest extent possible, be construed to bring any policy or contract of insurance entered into by an operator for the purpose of insuring such operator's liability under part C of title IV of the Act into conformity with the legal requirements placed upon such operator by section 415 and part C of title IV of the Act and parts 720 and 725 of this subchapter.

(d) Nothing in this section shall relieve any operator or carrier of the duty to comply with any State workmen's compensation law, except insofar as such State law is in conflict with the provisions of this section.

§ 726.204 Statutory policy provisions.

Pursuant to section 423(b) of part C of title IV of the Act each policy or contract of insurance obtained to comply with the requirements of section 423(a) of the Act must contain or shall be construed to contain—

(a) A provision to pay benefits required under section 422 of the Act, notwithstanding the provisions of the State workmen's compensation law which may provide for lesser payments; and,

(b) A provision that insolvency or bankruptcy of the operator or discharge therein (or both) shall not relieve the carrier from liability for such payments.

§ 726.205 Other forms of endorsement and policies.

Forms of endorsement or policies other than that described in § 726.203 may be entered into by operators to insure their liability under the Act. However, any form of endorsement or policy which materially alters or attempts to materially alter an operator's liability for the payment of any benefits under the Act shall be deemed insufficient to discharge such operator's duties and responsibilities as prescribed in part C of title IV of the Act. In any event, the failure of an operator to obtain an adequate policy or contract of insurance shall not affect such operator's liability for the payment of any benefits for which he is determined liable.

§ 726.206 Terms of policies.

A policy or contract of insurance shall be issued for the term of 1 year from the date that it becomes effective, but if such insurance be not needed except for a particular contract or operation, the term of the policy may be limited to the period of such contract or operation.

§ 726.207 Discharge by the carrier of obligations and duties of operator.

Every obligation and duty in respect of payment of benefits, the providing of medical and other treatment and care, the payment or furnishing of any other benefit required by the Act and in respect of the carrying out of the administrative procedure required or imposed by the Act or the regulations in this part or part 725 of this subchapter upon an operator shall be discharged and carried out by the carrier as appropriate. Notice to or knowledge of an operator of the occurrence of total disability or death due to pneumoconiosis shall be notice to or knowledge of such carrier. Jurisdiction of the operator by a district director, administrative law judge, the Office, or appropriate appellate authority under the Act shall be jurisdiction of such carrier. Any requirement under any benefits order, finding, or decision shall be binding upon such carrier in the same manner and to the same extent as upon the operator.

REPORTS BY CARRIER

§ 726.208 Report by carrier of issuance of policy or endorsement.

Each carrier shall report to the Office each policy and endorsement issued, canceled, or renewed by it to an operator. The report shall be made in

such manner and on such form as the Office may require.

§ 726.209 Report; by whom sent.

The report of issuance, cancellation, or renewal of a policy and endorsement provided for in § 726.208 shall be sent by the home office of the carrier, except that any carrier may authorize its agency or agencies to make such reports to the Office.

§ 726.210 Agreement to be bound by report.

Every carrier seeking to write insurance under the provisions of the Act shall be deemed to have agreed that the acceptance by the Office of a report of the issuance or renewal of a policy of insurance, as provided for by § 726.208 shall bind the carrier to full liability for the obligations under the Act of the operator named in said report. It shall be no defense to this agreement that the carrier failed or delayed to issue, cancel, or renew the policy to the operator covered by this report.

§ 726.211 Name of one employer only shall be given in each report.

A separate report of the issuance or renewal of a policy and endorsement, provided for by § 726.208, shall be made for each operator covered by a policy. If a policy is issued or renewed insuring more than one operator, a separate report for each operator so covered shall be sent to the Office with the name of only one operator on each such report.

§ 726.212 Notice of cancellation.

Cancellation of a contract or policy of insurance issued under authority of the Act shall not become effective otherwise than as provided by 33 U.S.C. 936(b); and notice of a proposed cancellation shall be given to the Office and to the operator in accordance with the provisions of 33 U.S.C. 912(c), 30 days before such cancellation is intended to be effective (see section 422(a) of part C of title IV of the Act).

§ 726.213 Reports by carriers concerning the payment of benefits.

Pursuant to 33 U.S.C. 914(c) as incorporated by section 422(a) of part C of title IV of the Act and § 726.207 each carrier issuing a policy or contract of insurance under the Act shall upon making the first payment of benefits and upon the suspension of any payment in any case, immediately notify the Office in accordance with a form prescribed by the Office that payment of benefit has begun or has been suspended as the case may be. In addition, each such carrier shall at the request of the Office submit to the Office such additional information concerning policies or contracts of insurance issued to guarantee the payment of benefits under the Act and any benefits paid thereunder, as the Office may from time to time require to carry out its responsibilities under the Act.

Subpart D—Civil Money Penalties

§ 726.300 Purpose and scope.

Any operator which is required to secure the payment of benefits under section 423 of the Act and § 726.4 and which fails to secure such benefits, shall be subject to a civil penalty of not more than $1,000 for each day during which such failure occurs. If the operator is a corporation, the president, secretary, and treasurer of the operator shall also be severally liable for the penalty based on the operator's failure to secure the payment of benefits. This subpart defines those terms necessary for administration of the civil money penalty provisions, describes the criteria for determining the amount of penalty to be assessed, and sets forth applicable procedures for the assessment and contest of penalties.

§ 726.301 Definitions.

In addition to the definitions provided in part 725 of this subchapter and § 726.8, the following definitions apply to this subpart:

(a) *Division Director* means the Director, Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, or such other official authorized by the Division Director to perform any of the functions of the Division Director under this subpart.

(b) *President, secretary, or treasurer* means the officers of a corporation as designated pursuant to the laws and regulations of the state in which the corporation is incorporated or, if that

state does not require the designation of such officers, the employees of a company who are performing the work usually performed by such officers in the state in which the corporation's principal place of business is located.

(c) *Principal* means any person who has an ownership interest in an operator that is not a corporation, and shall include, but is not limited to, partners, sole proprietors, and any other person who exercises control over the operation of a coal mine.

[65 FR 80097, Dec. 20, 2000, as amended at 77 FR 37287, June 21, 2012]

§ 726.302 Determination of penalty.

(a) The following method shall be used for determining the amount of any penalty assessed under this subpart.

(b) The penalty shall be determined by multiplying the daily base penalty amount or amounts, determined in accordance with the formula set forth in this section, by the number of days in the period during which the operator is subject to the security requirements of section 423 of the Act and § 726.4, and fails to secure its obligations under the Act. The period during which an operator is subject to liability for a penalty for failure to secure its obligations shall be deemed to commence on the first day on which the operator met the definition of the term ''operator'' as set forth in § 725.101 of this subchapter. The period shall be deemed to continue even where the operator has ceased coal mining and any related activity, unless the operator secured its liability for all previous periods through a policy or policies of insurance obtained in accordance with subpart C of this part or has obtained a certification of exemption in accordance with the provisions of § 726.114.

(c)(1) A daily base penalty amount shall be determined for all periods up to and including the 10th day after the operator's receipt of the notification sent by the Director pursuant to § 726.303, during which the operator failed to secure its obligations under section 423 of the Act and § 726.4.

(2)(i) The daily base penalty amount shall be determined based on the number of persons employed in coal mine employment by the operator, or engaged in coal mine employment on behalf of the operator, on each day of the period defined by this section, and shall be computed as follows:

Employees	Penalty (per day)
Less than 25	$100
25–50	200
51–100	300
More than 100	400

(ii) For any period after the operator has ceased coal mining and any related activity, the daily penalty amount shall be computed based on the largest number of persons employed in coal mine employment by the operator, or engaged in coal mine employment on behalf of the operator, on any day while the operator was engaged in coal mining or any related activity. For purposes of this section, it shall be presumed, in the absence of evidence to the contrary, that any person employed by an operator is employed in coal mine employment.

(3) In any case in which the operator had prior notice of the applicability of the Black Lung Benefits Act to its operations, the daily base penalty amounts set forth in paragraph (c)(2)(i) of this section shall be doubled. Prior notice may be inferred where the operator, or an entity in which the operator or any of its principals had an ownership interest, or an entity in which the operator's president, secretary, or treasurer were employed:

(i) Previously complied with section 423 of the Act and § 726.4;

(ii) Was notified of its obligation to comply with section 423 of the Act and § 726.4; or

(iii) Was notified of its potential liability for a claim filed under the Black Lung Benefits Act pursuant to § 725.407 of this subchapter.

(4) Commencing with the 11th day after the operator's receipt of the notification sent by the Director pursuant to § 726.303, the daily base penalty amounts set forth in paragraph (c)(2)(i) shall be increased by $100.

(5) In any case in which the operator, or any of its principals, or an entity in which the operator's president, secretary, or treasurer were employed, has been the subject of a previous penalty assessment under this part, the daily

base penalty amounts shall be increased by $300, up to a maximum daily base penalty amount of $1,000. The maximum daily base penalty amount applicable to any violation of § 726.4 that takes place after January 19, 2001 shall be $1,100.

(d) The penalty shall be subject to reduction for any period during which the operator had a reasonable belief that it was not required to comply with section 423 of the Act and § 726.4 or a reasonable belief that it had obtained insurance coverage to comply with section 423 of the Act and § 726.4. A notice of contest filed in accordance with § 726.307 shall not be sufficient to establish a reasonable belief that the operator was not required to comply with the Act and regulations.

§ 726.303 Notification; investigation.

(a) If the Director determines that an operator has violated the provisions of section 423 of the Act and § 726.4, he or she shall notify the operator of its violation and request that the operator immediately secure the payment of benefits. Such notice shall be sent by certified mail.

(b) The Director shall also direct the operator to supply information relevant to the assessment of a penalty. Such information, which shall be supplied within 30 days of the Director's request, may include:

(1) The date on which the operator commenced its operation of a coal mine;

(2) The number of persons employed by the operator since it began operating a coal mine and the dates of their employment; and

(3) The identity and last known address:

(i) In the case of a corporation, of all persons who served as president, secretary, and treasurer of the operator since it began operating a coal mine; or

(ii) In the case of an operator which is not incorporated, of all persons who were principals of the operator since it began operating a coal mine;

(c) In conducting any investigation of an operator under this subpart, the Division Director shall have all of the powers of a district director, as set forth at § 725.351(a) of this subchapter. For purposes of § 725.351(c), the Division Director shall be considered to sit in the District of Columbia.

§ 726.304 Notice of initial assessment.

(a) After an operator receives notification under § 726.303 and fails to secure its obligations for the period defined in § 726.302(b), and following the completion of any investigation, the Director may issue a notice of initial penalty assessment in accordance with the criteria set forth in § 726.302.

(b)(1) A copy of such notice shall be sent by certified mail to the operator. If the operator is a corporation, a copy shall also be sent by certified mail to each of the persons who served as president, secretary, or treasurer of the operator during any period in which the operator was in violation of section 423 of the Act and § 726.4.

(2) Where service by certified mail is not accepted by any person, the notice shall be deemed received by that person on the date of attempted delivery. Where service is not accepted, the Director may exercise discretion to serve the notice by regular mail.

§ 726.305 Contents of notice.

The notice required by § 726.304 shall:

(a) Identify the operator against whom the penalty is assessed, as well as the name of any other person severally liable for such penalty;

(b) Set forth the determination of the Director as to the amount of the penalty and the reason or reasons therefor;

(c) Set forth the right of each person identified in paragraph (a) of this section to contest the notice and request a hearing before the Office of Administrative Law Judges;

(d) Set forth the method for each person identified in paragraph (a) to contest the notice and request a hearing before the Office of Administrative Law Judges; and

(e) Inform any affected person that in the absence of a timely contest and request for hearing received within 30 days of the date of receipt of the notice, the Director's assessment will become final and unappealable as to that person.

§ 726.306 Finality of administrative assessment.

Except as provided in § 726.307(c), if any person identified as potentially liable for the assessment does not, within 30 days after receipt of notice, contest the assessment, the Director's assessment shall be deemed final as to that person, and collection and recovery of the penalty may be instituted pursuant to § 726.320.

§ 726.307 Form of notice of contest and request for hearing.

(a) Any person desiring to contest the Director's notice of initial assessment shall request an administrative hearing pursuant to this part. The notice of contest shall be made in writing to the Director, Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, United States Department of Labor. The notice of contest must be received no later than 30 days after the date of receipt of the notice issued under § 726.304. No additional time shall be added where service of the notice is made by mail.

(b) The notice of contest shall:

(1) Be dated;

(2) Be typewritten or legibly written;

(3) State the specific issues to be contested. In particular, the person must indicate his agreement or disagreement with:

(i) The Director's determination that the person against whom the penalty is assessed is an operator subject to the requirements of section 423 of the Act and § 726.4, or is the president, secretary, or treasurer of an operator, if the operator is a corporation.

(ii) The Director's determination that the operator violated section 423 of the Act and § 726.4 for the time period in question; and

(iii) The Director's determination of the amount of penalty owed;

(4) Be signed by the person making the request or an authorized representative of such person; and

(5) Include the address at which such person or authorized representative desires to receive further communications relating thereto.

(c) A notice of contest filed by the operator shall be deemed a notice of contest on behalf of all other persons to the Director's determinations that the operator is subject to section 423 of the Act and § 726.4 and that the operator violated those provisions for the time period in question, and to the Director's determination of the amount of penalty owed. An operator may not contest the Director's determination that a person against whom the penalty is assessed is the president, secretary, or treasurer of the operator.

(d) Failure to specifically identify an issue as contested pursuant to paragraph (b)(3) of this section shall be deemed a waiver of the right to contest that issue.

[65 FR 80097, Dec. 20, 2000, as amended at 77 FR 37287, June 21, 2012]

§ 726.308 Service and computation of time.

(a) Service of documents under this part shall be made by delivery to the person, an officer of a corporation, or attorney of record, or by mailing the document to the last known address of the person, officer, or attorney. If service is made by mail, it shall be considered complete upon mailing. Unless otherwise provided in this subpart, service need not be made by certified mail. If service is made by delivery, it shall be considered complete upon actual receipt by the person, officer, or attorney; upon leaving it at the person's, officer's or attorney's office with a clerk or person in charge; upon leaving it at a conspicuous place in the office if no one is in charge; or by leaving it at the person's or attorney's residence.

(b) If a complaint has been filed pursuant to § 726.309, two copies of all documents filed in any administrative proceeding under this subpart shall be served on the attorneys for the Department of Labor. One copy shall be served on the Associate Solicitor, Black Lung Benefits Division, Room N–2117, Office of the Solicitor, U.S. Department of Labor, 200 Constitution Ave., NW., Washington, DC 20210, and one copy on the attorney representing the Department in the proceeding.

(c) The time allowed a party to file any response under this subpart shall be computed beginning with the day following the action requiring a response, and shall include the last day

of the period, unless it is a Saturday, Sunday, or federally-observed holiday, *see* § 725.311 of Part 725 of this subchapter, in which case the time period shall include the next business day.

§ 726.309 Referral to the Office of Administrative Law Judges.

(a) Upon receipt of a timely notice of contest filed in accordance with § 726.307, the Director, by the Associate Solicitor for Black Lung Benefits or the Regional Solicitor for the Region in which the violation occurred, may file a complaint with the Office of Administrative Law Judges. The Director may, in the complaint, reduce the total penalty amount requested. A copy of the notice of initial assessment issued by the Director and all notices of contest filed in accordance with § 726.307 shall be attached. A notice of contest shall be given the effect of an answer to the complaint for purposes of the administrative proceeding, subject to any amendment that may be permitted under this subpart and 29 CFR part 18.

(b) A copy of the complaint and attachments thereto shall be served by counsel for the Director on the person who filed the notice of contest.

(c) The Director, by counsel, may withdraw a complaint filed under this section at any time prior to the date upon which the decision of the Department becomes final by filing a motion with the Office of Administrative Law Judges or the Secretary, as appropriate. If the Director makes such a motion prior to the date on which an administrative law judge renders a decision in accordance § 726.313, the dismissal shall be without prejudice to further assessment against the operator for the period in question.

§ 726.310 Appointment of Administrative Law Judge and notification of hearing date.

Upon receipt from the Director of a complaint filed pursuant to § 726.309, the Chief Administrative Law Judge shall appoint an Administrative Law Judge to hear the case. The Administrative Law Judge shall notify all interested parties of the time and place of the hearing.

§ 726.311 Evidence.

(a) Except as specifically provided in this subpart, and to the extent they do not conflict with the provisions of this subpart, the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges established by the Secretary at 29 CFR part 18 shall apply to administrative proceedings under this subpart.

(b) Notwithstanding 29 CFR 18.1101(b)(2), subpart B of the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges shall apply to administrative proceedings under this part, except that documents contained in Department of Labor files and offered on behalf of the Director shall be admissible in proceedings under this subpart without regard to their compliance with the Rules of Practice and Procedure.

§ 726.312 Burdens of proof.

(a) The Director shall bear the burden of proving the existence of a violation, and the time period for which the violation occurred. To prove a violation, the Director must establish:

(1) That the person against whom the penalty is assessed is an operator, or is the president, secretary, or treasurer of an operator, if such operator is a corporation.

(2) That the operator violated section 423 of the Act and § 726.4. The filing of a complaint shall be considered *prima facie* evidence that the Director has searched the records maintained by OWCP and has determined that the operator was not authorized to self-insure its liability under the Act for the time period in question, and that no insurance carrier reported coverage of the operator for the time period in question.

(b) The Director need not produce further evidence in support of his burden of proof with respect to the issues set forth in paragraph (a) if no party contested them pursuant to § 726.307(b)(3).

(c) The Director shall bear the burden of proving the size of the operator as required by § 726.302, except that if the Director has requested the operator to supply information with respect to its size under § 726.303 and the operator

has not fully complied with that request, it shall be presumed that the operator has more than 100 employees engaged in coal mine employment. The person or persons liable for the assessment shall thereafter bear the burden of proving the actual number of employees engaged in coal mine employment.

(d) The Director shall bear the burden of proving the operator's receipt of the notification required by § 726.303, the operator's prior notice of the applicability of the Black Lung Benefits Act to its operations, and the existence of any previous assessment against the operator, the operator's principals, or the operator's officers.

(e) The person or persons liable for an assessment shall bear the burden of proving the applicability of the mitigating factors listed in § 726.302(d).

§ 726.313 Decision and order of Administrative Law Judge.

(a) The Administrative Law Judge shall render a decision on the issues referred by the Director.

(b) The decision of the Administrative Law Judge shall be limited to determining, where such issues are properly before him or her:

(1) Whether the operator has violated section 423 of the Act and § 726.4;

(2) Whether other persons identified by the Director as potentially severally liable for the penalty were the president, treasurer, or secretary of the corporation during the time period in question; and

(3) The appropriateness of the penalty assessed by the Director in light of the factors set forth in § 726.302. The Administrative Law Judge shall not render determinations on the legality of a regulatory provision or the constitutionality of a statutory provision.

(c) The decision of the Administrative Law Judge shall include a statement of findings and conclusions, with reasons and bases therefor, upon each material issue presented on the record. The decision shall also include an appropriate order which may affirm, reverse, or modify, in whole or in part, the determination of the Director.

(d) The Administrative Law Judge shall serve copies of the decision on each of the parties by certified mail.

(e) The decision of the Administrative Law Judge shall be deemed to have been issued on the date that it is rendered, and shall constitute the final order of the Secretary unless there is a request for reconsideration by the Administrative Law Judge pursuant to paragraph (f) of this section or a petition for review filed pursuant to § 726.314.

(f) Any party may request that the Administrative Law Judge reconsider his or her decision by filing a motion within 30 days of the date upon which the decision of the Administrative Law Judge is issued. A timely motion for reconsideration shall suspend the running of the time for any party to file a petition for review pursuant to § 726.314.

(g) Following issuance of the decision and order, the Chief Administrative Law Judge shall promptly forward the complete hearing record to the Director.

§ 726.314 Review by the Secretary.

(a) The Director or any party aggrieved by a decision of the Administrative Law Judge may petition the Secretary for review of the decision by filing a petition within 30 days of the date on which the decision was issued. Any other party may file a cross-petition for review within 15 days of its receipt of a petition for review or within 30 days of the date on which the decision was issued, whichever is later. Copies of any petition or cross-petition shall be served on all parties and on the Chief Administrative Law Judge.

(b) A petition filed by one party shall not affect the finality of the decision with respect to other parties.

(c) If any party files a timely motion for reconsideration, any petition for review, whether filed prior to or subsequent to the filing of the timely motion for reconsideration, shall be dismissed without prejudice as premature. The 30-day time limit for filing a petition for review by any party shall commence upon issuance of a decision on reconsideration.

§ 726.315 Contents.

Any petition or cross-petition for review shall:

(a) Be dated;

(b) Be typewritten or legibly written;

(c) State the specific reason or reasons why the party petitioning for review believes the Administrative Law Judge's decision is in error;

(d) Be signed by the party filing the petition or an authorized representative of such party; and

(e) Attach copies of the Administrative Law Judge's decision and any other documents admitted into the record by the Administrative Law Judge which would assist the Secretary in determining whether review is warranted.

§ 726.316 Filing and service.

(a) *Filing*. All documents submitted to the Secretary shall be filed with the Secretary of Labor, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, DC 20210.

(b) *Number of copies*. An original and four copies of all documents shall be filed.

(c) *Computation of time for delivery by mail*. Documents are not deemed filed with the Secretary until actually received by the Secretary either on or before the due date. No additional time shall be added where service of a document requiring action within a prescribed time was made by mail.

(d) *Manner and proof of service*. A copy of each document filed with the Secretary shall be served upon all other parties involved in the proceeding. Service under this section shall be by personal delivery or by mail. Service by mail is deemed effected at the time of mailing to the last known address.

§ 726.317 Discretionary review.

(a) Following receipt of a timely petition for review, the Secretary shall determine whether the decision warrants review, and shall send a notice of such determination to the parties and the Chief Administrative Law Judge. If the Secretary declines to review the decision, the Administrative Law Judge's decision shall be considered the final decision of the agency. The Secretary's determination to review a decision by an Administrative Law Judge under this subpart is solely within the discretion of the Secretary.

(b) The Secretary's notice shall specify:

(1) The issue or issues to be reviewed; and

(2) The schedule for submitting arguments, in the form of briefs or such other pleadings as the Secretary deems appropriate.

(c) Upon receipt of the Secretary's notice, the Director shall forward the record to the Secretary.

§ 726.318 Final decision of the Secretary.

The Secretary's review shall be based upon the hearing record. The findings of fact in the decision under review shall be conclusive if supported by substantial evidence in the record as a whole. The Secretary's review of conclusions of law shall be *de novo*. Upon review of the decision, the Secretary may affirm, reverse, modify, or vacate the decision, and may remand the case to the Office of Administrative Law Judges for further proceedings. The Secretary's final decision shall be served upon all parties and the Chief Administrative Law Judge, in person or by mail to the last known address.

§ 726.319 Retention of official record.

The official record of every completed administrative hearing held pursuant to this part shall be maintained and filed under the custody and control of the Director.

§ 726.320 Collection and recovery of penalty.

(a) When the determination of the amount of any civil money penalty provided for in this part becomes final, in accordance with the administrative assessment thereof, or pursuant to the decision and order of an Administrative Law Judge, or following the decision of the Secretary, the amount of the penalty as thus determined is immediately due and payable to the U.S. Department of Labor on behalf of the Black Lung Disability Trust Fund. The person against whom such penalty has been assessed or imposed shall promptly remit the amount thereof, as finally determined, to the Secretary by certified check or by money order, made payable to the order of U.S. Department of Labor, Black Lung Program. Such remittance shall be delivered or mailed to the Director.

(b) If such remittance is not received within 30 days after it becomes due and payable, it may be recovered in a civil action brought by the Secretary in any court of competent jurisdiction, in which litigation the Secretary shall be represented by the Solicitor of Labor.

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