

management procedures established pursuant to this section.

(3) The provider must be a Participating Provider under CHAMPUS for all claims.

(4) The provider must meet all other qualification requirements, and agree to all other rules and procedures, that are established, publicly announced, and uniformly applied by the commander (or other authorized official).

(5) The provider must sign a preferred provider network agreement covering all applicable requirements. Such agreements will be for a duration of one year, are renewable, and may be canceled by the provider or the MTF Commander (or other authorized official) upon appropriate notice to the other party. The Director, OCHAMPUS shall establish an agreement model or other guidelines to promote uniformity in the agreements.

(r) *General fraud, abuse, and conflict of interest requirements under TRICARE program.* All fraud, abuse, and conflict of interest requirements for the basic CHAMPUS program, as set forth in this part 199 (see especially applicable provisions of §199.9) are applicable to the TRICARE program. Some methods and procedures for implementing and enforcing these requirements may differ from the methods and procedures followed under the basic CHAMPUS program in areas in which the TRICARE program has not been implemented.

(s) *Partial implementation.* The Assistant Secretary of Defense (Health Affairs) may authorize the partial implementation of the TRICARE program. The following are examples of partial implementation:

(1) The TRICARE Extra Plan and the TRICARE Standard Plan may be offered without the TRICARE Prime Plan.

(2) In remote sites, where complete implementation of TRICARE is impracticable, TRICARE Prime may be offered to a limited group of beneficiaries. In such cases, normal requirements of TRICARE Prime which the Assistant Secretary of Defense (Health Affairs) determines are impracticable may be waived.

(3) The TRICARE program may be limited to particular services, such as mental health services.

(t) *Inclusion of Department of Veterans Affairs Medical Centers in TRICARE networks.* TRICARE preferred provider networks may include Department of Veterans Affairs health facilities pursuant to arrangements, made with the approval of the Assistant Secretary of Defense (Health Affairs), between those centers and the Director, OCHAMPUS, or designated TRICARE contractor.

(u) *Care provided outside the United States to dependents of active duty members.* The Assistant Secretary of Defense (Health Affairs) may, in conjunction with implementation of the TRICARE program, authorize a special CHAMPUS program for dependents of active duty members who accompany the members in their assignments in foreign countries. Under this special program, a preferred provider network will be established through contracts or agreements with selected health care providers. Under the network, CHAMPUS covered services will be provided to the covered dependents with all CHAMPUS requirements for deductibles and copayments waived. The use of this authority by the Assistant Secretary of Defense (Health Affairs) for any particular geographical area will be announced in the FEDERAL REGISTER. The announcement will include a description of the preferred provider network program and other pertinent information.

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

[60 FR 52095, Oct. 5, 1995, as amended at 63 FR 9142, Feb. 24, 1998; 63 FR 48447, Sept. 10, 1998; 64 FR 13913, Mar. 23, 1999]

§ 199.18 Uniform HMO Benefit.

(a) *In general.* There is established a Uniform HMO Benefit. The purpose of the Uniform HMO benefit is to establish a health benefit option modeled on

health maintenance organization plans. This benefit is intended to be uniform wherever offered throughout the United States and to be included in all managed care programs under the MHSS. Most care purchased from civilian health care providers (outside an MTF) will be under the rules of the Uniform HMO Benefit or the Basic CHAMPUS Program (see § 199.4). The Uniform HMO Benefit shall apply only as specified in this section or other sections of this part, and shall be subject to any special applications indicated in such other sections.

(b) *Services covered under the uniform HMO benefit option.* (1) Except as specifically provided or authorized by this section, all CHAMPUS benefits provided, and benefit limitations established, pursuant to this part, shall apply to the Uniform HMO Benefit.

(2) Certain preventive care services not normally provided as part of basic program benefits under CHAMPUS are covered benefits when provided to Prime enrollees by providers in the civilian provider network. Standards for preventive care services shall be developed based on guidelines from the U.S. Department of Health and Human Services. Such standards shall establish a specific schedule, including frequency or age specifications for:

- (i) Laboratory and x-ray tests, including blood lead, rubella, cholesterol, fecal occult blood testing, and mammography;
- (ii) Pap smears;
- (iii) Eye exams;
- (iv) Immunizations;
- (v) Periodic health promotion and disease prevention exams;
- (vi) Blood pressure screening;
- (vii) Hearing exams;
- (viii) Sigmoidoscopy or colonoscopy;
- (ix) Serologic screening; and
- (x) Appropriate education and counseling services. The exact services offered shall be established under uniform standards established by the Assistant Secretary of Defense (Health Affairs).

(3) In addition to preventive care services provided pursuant to paragraph (b)(2) of this section, other benefit enhancements may be added and other benefit restrictions may be waived or relaxed in connection with

health care services provided to include the Uniform HMO Benefit. Any such other enhancements or changes must be approved by the Assistant Secretary of Defense (Health Affairs) based on uniform standards.

(c) *Enrollment fee under the uniform HMO benefit.* (1) The CHAMPUS annual deductible amount (see § 199.4(f)) is waived under the Uniform HMO Benefit during the period of enrollment. In lieu of a deductible amount, an annual enrollment fee is applicable. The specific enrollment fee requirements shall be published annually by the Assistant Secretary of Defense (Health Affairs), and shall be uniform within the following groups: dependents of active duty members in pay grades of E-4 and below; active duty dependents of sponsors in pay grades E-5 and above; and retirees and their dependents.

(2) *Amount of enrollment fees.* Beginning in fiscal year 1996, the annual enrollment fees are:

- (i) for dependents of active duty members in pay grades of E-4 and below, \$0;
- (ii) for active duty dependents of sponsors in pay grades E-5 and above, \$0; and
- (iii) for retirees and their dependents, \$230 individual, \$460 family.

(3) *Waiver of enrollment fee for certain beneficiaries.* The Assistant Secretary of Defense (Health Affairs) may waive the enrollment fee requirements of this section for beneficiaries described in 10 U.S.C. 1086(d)(2) (i.e., those who are eligible for Medicare on the basis of disability or end stage renal disease and who maintain enrollment in Part B of Medicare).

(d) *Outpatient cost sharing requirements under the uniform HMO benefit—*

(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements (see § 199.4(f)), special reduced cost sharing percentages or per service specific dollar amounts are required. The specific requirements shall be uniform and shall be published annually by the Assistant Secretary of Defense (Health Affairs).

(2) *Structure of outpatient cost sharing.* The special cost sharing requirements for outpatient services include the following specific structural provisions:

(i) For most physician office visits and other routine services, there is a per visit fee for each of the following groups: dependents of active duty members in pay grades E-1 through E-4; dependents of active duty members in pay grades of E-5 and above; and retirees and their dependents. This fee applies to primary care and specialty care visits, except as provided elsewhere in this paragraph (d)(2) of this section. It also applies to family health services, home health care visits, eye examinations, and immunizations. It does not apply to ancillary health services or to preventive health services described in paragraph (b)(2) of this section, or to maternity services under § 199.4(e)(16).

(ii) There is a copayment for outpatient mental health visits. It is a per visit fee for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents for individual visits. For group visits, there is a lower per visit fee for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(iii) There is a cost share of durable medical equipment, prosthetic devices, and other authorized supplies for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(iv) For emergency room services, there is a per visit fee for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(v) For ambulatory surgery services, there is a per service fee for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(vi) There is a copayment for prescription drugs per prescription, including medical supplies necessary for administration, for dependents of ac-

tive duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(vii) There is a copayment for ambulance services for dependents of active duty members in pay grades E-1 through E-4; for dependents of active duty members in pay grades of E-5 and above; and for retirees and their dependents.

(3) *Amount of outpatient cost sharing requirements.* Beginning in fiscal year 1996, the outpatient cost sharing requirements are as follows:

(i) For most physician office visits and other routine services, as described in paragraph (d)(2)(i) of this section, the per visit fee is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$6;

(B) For dependents of active duty members in pay grades of E-5 and above, \$12; and

(C) For retirees and their dependents, \$12.

(ii) For outpatient mental health visits, the per visit fee is as follows:

(A) For individual outpatient mental health visits:

(1) For dependents of active duty members in pay grades E-1 through E-4, \$10;

(2) For dependents of active duty members in pay grades of E-5 and above, \$20; and

(3) For retirees and their dependents, \$25.

(B) For group outpatient mental health visits, there is a lower per visit fee, as follows:

(1) For dependents of active duty members in pay grades E-1 through E-4, \$6;

(2) For dependents of active duty members in pay grades of E-5 and above, \$12; and

(3) For retirees and their dependents, \$17.

(iii) The cost share for durable medical equipment, prosthetic devices, and other authorized supplies is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, 10 percent of the negotiated fee;

(B) For dependents of active duty members in pay grades of E-5 and

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above, 15 percent of the negotiated fee; and

(C) For retirees and their dependents, 20 percent of the negotiated fee.

(iv) For emergency room services, the per visit fee is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$10;

(B) For dependents of active duty members in pay grades of E-5 and above, \$30; and

(C) For retirees and their dependents, \$30.

(v) For ambulatory surgery services, the per service fee is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$25;

(B) For dependents of active duty members in pay grades of E-5 and above, \$25; and

(C) For retirees and their dependents, \$25.

(vi) The copayment for each 30-day supply (or smaller quantity) of a prescription drug is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$5;

(B) For dependents of active duty members in pay grades of E-5 and above, \$5; and

(C) For retirees and their dependents, \$9.

(vii) The copayment for ambulance services is as follows:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$10;

(B) For dependents of active duty members in pay grades of E-5 and above, \$15; and

(C) For retirees and their dependents, \$20.

(e) *Inpatient cost sharing requirements under the uniform HMO benefit*—(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements (see §199.4(f)), special cost sharing amounts are required. The specific requirements shall be uniform and shall be published as a notice annually by the Assistant Secretary of Defense (Health Affairs).

(2) *Structure of cost sharing.* For services other than mental illness or substance use treatment, there is a nominal copayment for active duty dependents and for retired members, depend-

ents of retired members, and survivors. For inpatient mental health and substance use treatment, a separate per day charge is established.

(3) *Amount of inpatient cost sharing requirements.* Beginning in fiscal year 1996, the inpatient cost sharing requirements are as follows:

(i) For acute care admissions and other non-mental health/substance use treatment admissions, the per diem charge is as follows, with a minimum charge of \$25 per admission:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$11;

(B) For dependents of active duty members in pay grades of E-5 and above, \$11; and

(C) For retirees and their dependents, \$11.

(ii) For mental health/substance use treatment admissions, and for partial hospitalization services, the per diem charge is as follows, with a minimum charge of \$25 per admission:

(A) For dependents of active duty members in pay grades E-1 through E-4, \$20;

(B) For dependents of active duty members in pay grades of E-5 and above, \$20; and

(C) For retirees and their dependents, \$40.

(f) *Limit on out-of-pocket costs under the uniform HMO benefit.* (1) Total out-of-pocket costs per family of dependents of active duty members under the Uniform HMO Benefit may not exceed \$1,000 during the one-year enrollment period. Total out-of-pocket costs per family of retired members, dependents of retired members and survivors under the Uniform HMO Benefit may not exceed \$3,000 during the one-year enrollment period. For this purpose, out-of-pocket costs means all payments required of beneficiaries under paragraphs (c), (d), and (e) of this section. In any case in which a family reaches this limit, all remaining payments that would have been required of the beneficiary under paragraphs (c), (d), and (e) of this section will be made by the program in which the Uniform HMO Benefit is in effect.

(2) The limits established by paragraph (f)(1) of this section do not apply

to out-of-pocket costs incurred pursuant to paragraph (m)(1)(i) or (m)(2)(i) of § 199.17 under the point-of-service option of TRICARE Prime.

(g) *Updates.* The enrollment fees for fiscal year 1996 set under paragraph (c) of this section and the per service specific dollar amounts for fiscal year 1996 set under paragraphs (d) and (e) of this section may be updated for subsequent years to the extent necessary to maintain compliance with statutory requirements pertaining to government costs. This updating does not apply to cost sharing that is expressed as a percentage of allowable charges; these percentages will remain unchanged. The Secretary shall ensure that the TRICARE program complies with statutory cost neutrality requirements.

[60 FR 52101, Oct. 5, 1995, as amended at 63 FR 9143, Feb. 24, 1998; 63 FR 48448, Sept. 10, 1998]

§ 199.20 Continued Health Care Benefit Program (CHCBP).

(a) *Purpose.* The CHCBP is a premium based temporary health care coverage program that will be available to qualified beneficiaries (set forth in paragraph (d)(1) of this section). Medical coverage under this program will mirror the benefits offered via the basic CHAMPUS program. Premium costs for this coverage are payable by enrollees to a Third Party Administrator. The CHCBP is not part of the CHAMPUS program. However, as set forth in this section, it functions under most of the rules and procedures of CHAMPUS. Because the purpose of the CHCBP is to provide a continuation health care benefit for the Department of Defense and the other Uniformed Services (e.g., NOAA, PHS, and the Coast Guard) health care beneficiaries losing eligibility, it will be administered so that it appears, to the maximum extent possible, to be part of CHAMPUS.

(b) *General provisions.* Except for any provisions the Director, OCHAMPUS may exclude, the general provisions of § 199.1 shall apply to the CHCBP as they do to CHAMPUS.

(c) *Definitions.* Except as may be specifically provided in this section, to the extent terms defined in § 199.2 are relevant to the administration of the CHCBP, the definitions contained in

that section shall apply to the CHCBP as they do to CHAMPUS.

(d) *Eligibility and enrollment—(1) Eligibility.* Enrollment in the CHCBP is open to the following individuals:

(i) Members of Uniformed Services, who:

(A) Are discharged or released from active duty (or full time National Guard duty), whether voluntarily or involuntarily, under other than adverse conditions;

(B) Immediately preceding that discharge or release, were entitled to medical and dental care under 10 U.S.C. 1074(a) (except in the case of a member discharged or released from full-time National Guard duty); and,

(C) After that discharge or release and any period of transitional health care provided under 10 U.S.C. 1145(a) would not otherwise be eligible for any benefit under 10 U.S.C. chapter 55.

(ii) A person who:

(A) Ceases to meet requirements for being considered an unmarried dependent child of a member or former member of the armed forces under 10 U.S.C. 1072(2)(D);

(B) On the day before ceasing to meet those requirements, was covered under a health benefits plan under 10 U.S.C. chapter 55, or transitional health care under 10 U.S.C. 1145(a) as a dependent of the member or former member; and,

(C) Would not otherwise be eligible for any benefits under 10 U.S.C. chapter 55.

(iii) A person who:

(A) Is an unremarried former spouse of a member or former member of the armed forces;

(B) On the day before the date of the final decree of divorce, dissolution, or annulment was covered under a health benefits plan under 10 U.S.C. chapter 55, or transitional health care under 10 U.S.C. 1145(a) as a dependent of the member or former member; and,

(C) Is not a dependent of the member or former member under 10 U.S.C. 1072(2)(F) or (G) or ends a one-year period of dependency under 10 U.S.C. 1072(2)(H).

(2) *Effective date.* Except for the special transitional provisions in paragraph (r) of this section, eligibility in the CHCBP is limited to individuals who lost their entitlement to regular