Chapter 10 Section 8.1

TRICARE Reserve Component (RC) Member Benefits

Issue Date: June 5, 2009
Authority: 32 CFR 199.4(f)(2)(i)(H), Public Law 108-375, Sections 704 and 705
Revision: C-9, October 20, 2017

1.0 DESCRIPTION

1.1 The provisions of this section apply to family members who become eligible for TRICARE as a result of their RC sponsor (including those with delayed effective date active duty orders up to 180 days) being called or ordered to active duty for more than 30 days in support of a federal contingency operation and choose to participate in TRICARE Standard or Extra (through December 31, 2017) or enroll in TRICARE Select (starting January 1, 2018), rather than enroll in TRICARE Prime. The seven RCs include Army National Guard and the Air National Guard.

1.2 These provisions help ensure timely access to health care and maintain clinically appropriate continuity of health care to family members of RC sponsors, limit the out-of-pocket health care expenses for those family members, and remove potential barriers to health care access by RC families.

2.0 BACKGROUND

2.1 Section 704 of the National Defense Authorization Act for Fiscal Year 2005 (NDAA FY 2005) (Public Law 108-375) established the authority to waive the annual TRICARE Standard deductible for RC family members who became eligible for TRICARE as a result of their sponsor's activation in support of a contingency operation for more than 30 days. By law, the TRICARE Standard deductible for Active Duty Family Members (ADFMs) is $150 per individual, $300 per family ($50/$100 for E-4s and below). Waiving the TRICARE deductible appropriately limits out-of-pocket expenses for these RC family members, many of whom may have already paid toward annual deductibles under their civilian health plans.

2.2 Section 705 of the NDAA FY 2005 established the authority to increase TRICARE payments up to 115% of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charge (CMAC), less the applicable patient cost-share if not previously waived under the provisions of Section 704, for covered inpatient and outpatient health services received from a provider that does not participate (accept assignment) under TRICARE. This allows this group of RC family members to continue to see civilian providers with whom they have established relationships while promoting access and clinically appropriate continuity of care.

2.3 The provisions outlined above were previously provided to RC family members under the provisions of the Operation Noble Eagle/Operation Enduring Freedom Reservist and National Guard Benefits Demonstration (TRICARE Operations Manual (TOM), Chapter 18) and are now permanent. That

demonstration was effective for claims for services provided on or after September 14, 2001, and before November 1, 2009.

2.4 Section 748(b) of the NDAA FY 2017 (Public Law 114-328) eliminated the requirement that the active duty be in support of a contingency operation to get the benefits in this section. Section 701 replaces TRICARE Standard/Extra with TRICARE Select effective January 1, 2018. See TRICARE Reimbursement Manual (TRM), Chapter 2.

3.0 POLICY

3.1 This benefit is authorized for family members of RC members who are called or ordered to active duty for a period of more than 30 days.

Note: This special benefit does not apply to Prime beneficiaries.

3.2 Through December 31, 2017, claims are to be paid from financially underwritten funds. On claims for care from non-participating professional providers, contractors shall allow the lesser of the billed charges or the balance billing limit (115% of the allowable charge). If the charges on a claim from a non-participating professional provider are exempt from the balance billing limit, the contractor shall allow the billed charges. This applies to all claims from non-participating professional providers for services rendered to Standard beneficiaries. In double coverage situations, normal double coverage requirements shall apply.

3.3 Starting January 1, 2018, TRICARE Select cost-shares apply.

3.4 In order to protect beneficiaries from incurring greater out-of-pocket costs under these special procedures, the beneficiary cost-share for these claims will be limited to what it would have been in the absence of the higher allowable amount under this benefit. That is, the cost-share is 20% of the lesser of the CMAC or the billed charge. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

3.5 The TRICARE Encounter Data (TED) record for each claim received subsequent to policy specified in paragraph 3.1 must reflect the Special Processing Code **EF**.

3.6 TED records submitted for non-participating professional claims that are reimbursed at the lesser of the balance billing limit or the billed charge are to be identified with Pricing Rate Code **W**, but only if the allowed amount is greater than the CMAC. If the billed charge equals or is less than the CMAC, Pricing Rate Code **W** is not to be used. On the other hand, when the claim is reimbursed as billed because the billed charge is greater than the CMAC but less than the balance billing limit, or the charges are exempt from the balance billing limit, Pricing Rate Code **W** is to be used.

3.7 The TRICARE Standard/Extra deductible (effective January 1, 2018, the TRICARE Select deductible) is waived for all beneficiaries identified by HCDP Special Entitlement codes **02** or **03**.

3.8 Starting January 1, 2018, family members will have their deductibles waived and apply the TRICARE Select cost-shares. Paragraphs 3.4 through 3.7 apply.

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