Part 199.17

TRICARE Program

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(a) Establishment. The TRICARE program is established for the purpose of implementing a comprehensive managed health care program for the delivery and financing of health care services in the Military Health System.

(1) *Purpose.* The TRICARE program implements a number of improvements primarily through modernized managed care support contracts that include special arrangements with civilian sector health care providers and better coordination between military medical treatment facilities (MTFs) and these civilian providers to deliver an integrated, health care delivery system that provides beneficiaries with access to high quality healthcare. Implementation of these improvements, to include enhanced access, improved health outcomes, increased efficiencies and elimination of waste, in addition to improving and maintaining operational medical force readiness, includes adoption of special rules and procedures not ordinarily followed under CHAMPUS or MTF requirements. This section establishes those special rules and procedures.

(2) *Statutory authority.* Many of the provisions of this section are authorized by statutory authorities other than those which authorize the usual operation of the CHAMPUS program, especially 10 U.S.C. 1079 and 1086. The TRICARE program also relies upon other available statutory authorities, including 10 U.S.C. 1075 (TRICARE Select), 10 U.S.C. 1075a (TRICARE Prime cost sharing), 10 U.S.C. 1095f (referrals and preauthorizations under TRICARE Prime), 10 U.S.C. 1099 (health care enrollment system), 10 U.S.C. 1097 (contracts for medical care for retirees, dependents and survivors: Alternative delivery of health care), and 10 U.S.C. 1096 (resource sharing agreements).

(3) *Scope of the program.* The TRICARE program is applicable to all the uniformed services. TRICARE Select and TRICARE-for-Life shall be available in all areas, including overseas as authorized in paragraph (u) of this section. The geographic availability of TRICARE Prime is generally limited as provided in this section. The Assistant Secretary of Defense (Health Affairs) may also authorize modifications to TRICARE program rules and procedures as may be appropriate to the area involved.

(4) *Rules and procedures affected.* Much of this section relates to rules and procedures applicable to the delivery and financing of health care services provided by civilian providers outside military treatment facilities. This section provides that certain rules, procedures, rights and obligations set forth elsewhere in this part (and usually applicable to CHAMPUS) are different under the TRICARE program. To the extent that TRICARE program rules, procedures, rights and obligations set forth in this section are not different from or otherwise in conflict with those set forth elsewhere in this part as applicable to CHAMPUS, the CHAMPUS provisions are incorporated into the TRICARE program. In addition, some rules, procedures, rights and obligations relating to health care services in military treatment facilities are also different under the TRICARE program. In such cases, provisions of this section take precedence and are binding.

(5) *Implementation based on local action.* The TRICARE program is not automatically implemented in all respects in all areas where it is potentially applicable. Therefore, not all provisions of this section are automatically implemented. Rather, implementation of the TRICARE program and this section requires an official action by the Director, Defense Health Agency. Public notice of the initiation of portions of the TRICARE program will be achieved through appropriate communication and media methods and by way of an official announcement by the Director identifying the military medical treatment facility catchment area or other geographical area covered.

(6) *Major features of the TRICARE program.* The major features of the TRICARE program, described in this section, include the following:

(i) *Beneficiary categories.* Under the TRICARE program, health care beneficiaries are generally classified into one of several categories:

(A) Active duty members, who are covered by 10 U.S.C. 1074(a).

(B) Active duty family members, who are beneficiaries covered by 10 U.S.C. 1079 (also referred to in this section as "active duty family category").

(C) Retirees and their family members (also referred to in this section as "retired category"), who are beneficiaries covered by 10 U.S.C. 1086(c) other than those beneficiaries eligible for Medicare Part A.

(D) Medicare eligible retirees and Medicare eligible retiree family members who are beneficiaries covered by 10 U.S.C. 1086(d) as each become individually eligible for Medicare Part A and enroll in Medicare Part B.

(E) Military treatment facility (MTF) only beneficiaries are beneficiaries eligible for health care services in military treatment facilities, but not eligible for a TRICARE plan covering non-MTF care.

(ii) *Health plans available.* The major TRICARE health plans are as follows:

(A) *TRICARE Prime.* "TRICARE Prime" is a health maintenance organization (HMO)-like program. It generally features use of military treatment facilities and substantially reduced out-of-pocket costs for care provided outside MTFs. Beneficiaries generally agree to use military treatment facilities and designated civilian provider networks and to follow certain managed care rules and procedures. The primary purpose of TRICARE Prime is to support the effective operation of an MTF, which exists to support the medical readiness of the armed forces and the readiness of medical personnel. TRICARE Prime will be offered in areas where the Director determines that it is appropriate to support the effective operation of one or more MTFs.

(B) *TRICARE Select.* "TRICARE Select" is a self-managed, preferred provider organization (PPO) program. It allows beneficiaries to use the TRICARE provider civilian network, with reduced out-of-pocket costs compared to care from non-network providers, as well as military treatment facilities (where they exist and when space is available). TRICARE Select enrollees will not have restrictions on their freedom of choice with respect to authorized health care providers. However, when a TRICARE Select beneficiary receives services covered under the basic program from an authorized health care provider who is not part of the TRICARE provider network that care is covered by TRICARE but is subject to higher cost sharing amounts for "out-of-network" care. Those amounts are the same as under the basic program under Sec. 199.4.

(C) *TRICARE for Life.* "TRICARE for Life" is the Medicare wraparound coverage plan under 10 U.S.C. 1086(d). Rules applicable to this plan are unaffected by this section; they are generally set forth in Secs. 199.3 (Eligibility), 199.4 (Basic Program Benefits), and 199.8 (Double Coverage).

(D) *TRICARE Standard.* "TRICARE Standard" generally referred to the basic CHAMPUS program of benefits under Sec. 199.4. While the law required termination of TRICARE Standard as a distinct TRICARE plan December 31, 2017, the CHAMPUS basic program benefits under Sec. 199.4 continues as the baseline of benefits common to the TRICARE Prime and TRICARE Select plans.

(iii) *Comprehensive enrollment system.* The TRICARE program includes a comprehensive enrollment system for all categories of beneficiaries except TRICARE-for-Life beneficiaries. When eligibility for enrollment for TRICARE Prime and/or TRICARE Select exists, a beneficiary must enroll in one of the plans. Refer to paragraph (o) of this section for TRICARE program enrollment procedures.

(7) *Preemption of State laws.* (i) Pursuant to 10 U.S.C. 1103 the Department of Defense has determined that in the administration of 10 U.S.C. chapter 55, preemption of State and local laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods is necessary to achieve important Federal interests, including but not limited to the assurance of uniform national health programs for military families and the operation of such programs at the lowest possible cost to the Department of Defense, that have a direct and substantial effect on the conduct of military affairs and national security policy of the United States.

(ii) Based on the determination set forth in paragraph (a)(7)(i) of this section, any State or local law relating to health insurance, prepaid health plans, or other health care delivery or financing methods is preempted and does not apply in connection with TRICARE regional contracts. Any such law, or regulation pursuant to such law, is without any force or effect, and State or local governments have no legal authority to enforce them in relation to the TRICARE regional contracts. (However, the Department of Defense may by contract establish legal obligations of the part of TRICARE contractors to conform with requirements similar or identical to requirements of State or local laws or regulations).

(iii) The preemption of State and local laws set forth in paragraph (a)(7)(ii) of this section includes State and local laws imposing premium taxes on health or dental insurance carriers or underwriters or other plan managers, or similar taxes on such entities. Such laws are laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods, within the meaning of the statutes identified in paragraph (a)(7)(i) of this section. Preemption, however, does not apply to taxes, fees, or other payments on net income or profit realized by such entities in the conduct of business relating to DoD health services contracts, if those taxes, fees or other payments are applicable to a broad range of business activity. For purposes of assessing the effect of Federal preemption of State and local taxes and fees in connection with DoD health and dental services contracts, interpretations shall be consistent with those applicable to the Federal Employees Health Benefits Program under 5 U.S.C. 8909(f).

(b) TRICARE Prime and TRICARE Select health plans in general. The two primary plans for beneficiaries in the active duty family category and the retired category (which does not include most Medicare-eligible retirees/dependents) are TRICARE Prime and TRICARE Select. This paragraph (b) further describes the TRICARE Prime and TRICARE Select health plans.

(1) *TRICARE Prime.* TRICARE Prime is a managed care option that provides enhanced medical services to beneficiaries at reduced cost-sharing amounts for eneficiaries whose care is managed by a designated primary care manager and provided by an MTF or network provider. TRICARE Prime is

offered in a location in which an MTF is located (other than a facility limited to members of the armed forces) that has been designated by the Director as a Prime Service Area. In addition, where TRICARE Prime is offered it may be limited to active duty family members if the Director determines it is not practicable to offer TRICARE Prime to retired category beneficiaries. TRICARE Prime is not offered in areas where the Director determines it is impracticable. If TRICARE Prime is not offered in a geographical area, certain active duty family members residing in the area may be eligible to enroll in TRICARE Prime Remote program under paragraph (g) of this section.

(2) *TRICARE Select.* TRICARE Select is the self-managed option under which beneficiaries may receive authorized basic program benefits from any TRICARE authorized provider. The TRICARE Select health care plan also provides enhanced program benefits to beneficiaries with access to a preferred provider network with broad geographic availability within the United States at reduced out-of-pocket expenses. However, when a beneficiary receives services from an authorized health care provider who is not part of the TRICARE provider network, only basic program benefits (not enhanced Select care) are covered by TRICARE and the beneficiary is subject to higher cost sharing amounts for "out-of-network" care. Those amounts are the same as under the basic program under Sec. 199.4.

(c) Eligibility for enrollment in TRICARE Prime and TRICARE Select. Beneficiaries in the active duty family category and the retired category are eligible to enroll in TRICARE Prime and/or TRICARE Select as outlined in this paragraph (c). A retiree or retiree family member who becomes eligible for Medicare Part A is not eligible to enroll in TRICARE Select; however, as provided in this paragraph (c), some Medicare eligible retirees/family members may be allowed to enroll in TRICARE Prime where available. In general, when a retiree or retiree family member becomes individually eligible for Medicare Part A and enrolls in Medicare Part B, he/she is automatically eligible for TRICARE-for-Life and is required to enroll in the Defense Enrollment Eligibility Reporting System (DEERS) to verify eligibility. Further, some rules and procedures are different for dependents of active duty members and retirees, dependents, and survivors.

(1) *Active duty members.* Active duty members are required to enroll in Prime where it is offered. Active duty members shall have first priority for enrollment in Prime.

(2) *Dependents of active duty members.* Beneficiaries in the active duty family member category are eligible to enroll in Prime (where offered) or Select.

(3) *Survivors of deceased members.*(i) The surviving spouse of a member who dies while on active duty for a period of more than 30 days is eligible to enroll in Prime (where offered) or Select for a 3 year period beginning on the date of the member's death under the same rules and provisions as dependents of active duty members.

(ii) A dependent child or unmarried person (as described in Sec. 199.3(b)(2)(ii) or (iv)) of a member who dies while on active duty for a period of more than 30 days whose death occurred on or after October 7, 2001, is eligible to enroll in Prime (where offered) or Select and is subject to the same rules and provisions of dependents of active duty members for a period of three years from the date the active duty sponsor dies or until the surviving eligible dependent:

(A) Attains 21 years of age; or

(B) Attains 23 years of age or ceases to pursue a full-time course of study prior to attaining 23 years of age, if, at 21 years of age, the eligible surviving dependent is enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education approved by the

Secretary of Defense and was, at the time of the sponsor's death, in fact dependent on the member for over onehalf of such dependent's support.

(4) *Retired, dependents of retirees, and survivors (other than survivors of deceased members covered under paragraph (c)(3) of this section).* All retirees, dependents of retirees, and survivors who are not eligible for Medicare Part A are eligible to enroll in Select. dditionally, retirees, dependents of retirees, and survivors who are not eligible for Medicare Part A based on age are also eligible to enroll in TRICARE Prime in locations where it is offered and where an MTF has, in the judgment of the Director, a significant number of health care providers, including specialty care providers, and sufficient capability to support the efficient operation of TRICARE Prime for projected retired beneficiary enrollees in that location.

(d) Health benefits under TRICARE Prime--(1) *Military treatment facility (MTF) care*--(i) *In general.* All participants in Prime are eligible to receive care in military treatment facilities. Participants in Prime will be given priority for such care over other beneficiaries. Among the following beneficiary groups, access priority for care in military treatment facilities where TRICARE is implemented as follows:

(A) Active duty service members;

(B) Active duty service members' dependents and survivors of service members who died on active duty, who are enrolled in TRICARE Prime;

(C) Retirees, their dependents and survivors, who are enrolled in TRICARE Prime;

(D) Active duty service members' dependents and survivors of deceased members, who are not enrolled in TRICARE Prime; and

(E) Retirees, their dependents and survivors who are not enrolled in TRICARE Prime. For purposes of this paragraph (d)(1), survivors of members who died while on active duty are considered as among dependents of active duty service members.

(ii) *Special provisions.* Enrollment in Prime does not affect access priority for care in military treatment facilities for several miscellaneous beneficiary groups and special circumstances. Those include Secretarial designees, NATO and other foreign military personnel and dependents authorized care through international agreements, civilian employees under workers' compensation programs or under safety programs, members on the Temporary Disability Retired List (for statutorily required periodic medical examinations), members of the reserve components not on active duty (for covered medical services), military prisoners, active duty dependents unable to enroll in Prime and temporarily away from place of residence, and others as designated by the Assistant Secretary of Defense (Health Affairs). Additional exceptions to the normal Prime enrollment access priority rules may be granted for other categories of individuals, eligible for treatment in the MTF, whose access to care is necessary to provide an adequate clinical case mix to support graduate medical education programs or readiness-related medical skills sustainment activities, to the extent approved by the ASD(HA).

(2) *Non-MTF care for active duty members.* Under Prime, non-MTF care needed by active duty members continues to be arranged under the supplemental care program and subject to the rules and procedures of that program, including those set forth in Sec. 199.16.

(3) *Civilian sector Prime benefits.* Health benefits for Prime enrollees for care received from civilian providers are those under Sec. 199.4 and the additional benefits identified in paragraph (f) of this section.

(e) Health benefits under the TRICARE extra plan--(1) *Civilian sector care.* The health benefits under TRICARE Select for enrolled beneficiaries received from civilian providers are those under Sec. 199.4, and, in addition, those in paragraph (f) of this section when received from a civilian network provider.

(2) *Military treatment facility (MTF) care.* All TRICARE Select enrolled beneficiaries continue to be eligible to receive care in military treatment facilities on a space available basis.

(f) Benefits under TRICARE Prime and TRICARE Select--(1) *In general.* Except as specifically provided or authorized by this section, all benefits provided, and benefit limitations established, pursuant to this part, shall apply to TRICARE Prime and TRICARE Select.

(2) *Preventive care services.* Certain preventive care services not normally provided as part of basic program benefits under Sec. 199.4 are covered benefits when provided to Prime or Select enrollees by providers in the civilian provider network. Such additional services are authorized under 10 U.S.C. 1097, including preventive care services not part of the entitlement under 10 U.S.C. 1074d and services that would otherwise be excluded under 10 U.S.C. 1079(a)(10). Other authority for such additional services includes section 706 of the National Defense Authorization Act for Fiscal Year 2017. The specific set of such services shall be established by the Director and announced annually before the open season enrollment period. 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 services that may include, but are not limited to:

(i) Laboratory and imaging tests, including blood lead, rubella, cholesterol, fecal occult blood testing, and mammography;

(ii) Cancer screenings (including cervical, breast, lung, prostate, and colon cancer screenings);

(iii) Immunizations;

(iv) Periodic health promotion and disease prevention exams;

(v) Blood pressure screening;

(vi) Hearing exams;

(vii) Sigmoidoscopy or colonoscopy;

(viii) Serologic screening; and

(ix) Appropriate education and counseling services. The exact services offered shall be established under uniform standards established by the Director.

(3) *Treatment of obesity.* Under the authority of 10 U.S.C. 1097 and sections 706 and 729 of the National Defense Authorization Act for Fiscal Year 2017, notwithstanding 10 U.S.C. 1079(a)(10), treatment of obesity is covered under TRICARE Prime and TRICARE Select even if it is the sole or major

condition treated. Such services must be provided by a TRICARE network provider and be medically necessary and appropriate in the context of the particular patient's treatment.

(4) *High value services.* Under the authority of 10 U.S.C. 1097 and other authority, including sections 706 and 729 of the NDAA-17, for purposes of improving population-based health outcomes and incentivizing medical intervention programs to address chronic diseases and other conditions and healthy lifestyle interventions, the Director may waive or reduce cost sharing requirements for TRICARE Prime and TRICARE Select enrollees for care received from network providers for certain health care services designated for this purpose. The specific services designated for this purpose will be those the Director determines provide especially high value in terms of better health outcomes. The specific services affected for any plan year will be announced by the Director prior to the open season enrollment period for that plan year. Services affected by actions of the Director under this paragraph (f)(4) may be associated with actions taken for high value medications under Sec. 199.21(j)(3) for select pharmaceutical agents to be cost-shared at a reduced or zero dollar rate.

(5) *Other services.* In addition to services provided pursuant to paragraphs (f)(2) through (4) 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 TRICARE Prime and TRICARE Select enrollees. Any such other enhancements or changes must be approved by the Director based on uniform standards.

(g) TRICARE Prime Remote for Active Duty Family Members-- (1) *In general.* In geographic areas in which TRICARE Prime is not offered and in which eligible family members reside, there is offered under 10 U.S.C. 1079(p) TRICARE Prime Remote for Active Duty Family Members as an enrollment option. TRICARE Prime Remote for Active Duty Family Members (TPRADFM) will generally follow the rules and procedures of TRICARE Prime, except as provided in this paragraph (g) and otherwise except to the extent the Director determines them to be infeasible because of the remote area.

(2) *Active duty family member.* For purposes of this paragraph (g), the term "active duty family member" means one of the following dependents of an active duty member of the Uniformed Services:

(i) Spouse, child, or unmarried person, as defined in Sec. 199.3(b)(2)(i), (ii), or (iv);

(ii) For a 3-year period, the surviving spouse of a member who dies while on active duty for a period of more than 30 days whose death occurred on or after October 7, 2001; and

(iii) The surviving dependent child or unmarried person, as defined in Sec. 199.3(b)(2)(ii) or (iv), of a member who dies while on active duty for a period of more than 30 days whose death occurred on or after October 7, 2001. Active duty family member status is for a period of 3 years from the date the active duty sponsor dies or until the surviving eligible dependent:

(A) Attains 21 years of age; or

(B) Attains 23 years of age or ceases to pursue a full-time course of study prior to attaining 23 years of age, if, at 21 years of age, the eligible surviving dependent is enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education approved by the Secretary of Defense and was, at the time of the sponsor's death, in fact dependent on the member for over one half of such dependent's support.

(3) *Eligibility.* (i) An active duty family member is eligible for TRICARE Prime Remote for Active Duty Family Members if he or she is eligible for CHAMPUS and, on or after December 2, 2003, meets the criteria of paragraphs (g)(3)(i)(A) and (B) or paragraph (g)(3)(i)(C) of this section or on or after October 7, 2001, meets the criteria of paragraph (g)(3)(i)(D) or (E) of this section:

(A) The family member's active duty sponsor has been assigned permanent duty as a recruiter; as an instructor at an educational institution, an administrator of a program, or to provide administrative services in support of a program of instruction for the Reserve Officers' Training Corps; as a full-time adviser to a unit of a reserve component; or any other permanent duty designated by the Director that the Director determines is more than 50 miles, or approximately one hour driving time, from the nearest military treatment facility that is adequate to provide care.

(B) The family members and active duty sponsor, pursuant to the assignment of duty described in paragraph (g)(3)(i)(A) of this section, reside at a location designated by the Director, that the Director determines is more than 50 miles, or approximately one hour driving time, from the nearest military medical treatment facility adequate to provide care.

(C) The family member, having resided together with the active duty sponsor while the sponsor served in an assignment described in paragraph (g)(3)(i)(A) of this section, continues to reside at the same location after the sponsor relocates without the family member pursuant to orders for a permanent change of duty station, and the orders do not authorize dependents to accompany the sponsor to the new duty station at the expense of the United States.

(D) For a 3 year period, the surviving spouse of a member who dies while on active duty for a period of more than 30 days whose death occurred on or after October 7, 2001.

(E) The surviving dependent child or unmarried person as defined in Sec. 199.3(b)(2)(ii) or (iv), of a member who dies while on active duty for a period of more than 30 days whose death occurred on or after October 7, 2001, for three years from the date the active duty sponsor dies or until the surviving eligible dependent:

(1) Attains 21 years of age; or

(2) Attains 23 years of age or ceases to pursue a full-time course of study prior to attaining 23 years of age, if, at 21 years of age, the eligible surviving dependent is enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education approved by the Secretary of Defense and was, at the time of the sponsor's death, in fact dependent on the member for over one half of such dependent's support.

(ii) A family member who is a dependent of a reserve component member is eligible for TRICARE Prime Remote for Active Duty Family Members if he or she is eligible for CHAMPUS and meets all of the following additional criteria:

(A) The reserve component member has been ordered to active duty for a period of more than 30 days.

(B) The family member resides with the member.

(C) The Director, determines the residence of the reserve component member is more than 50 miles, or approximately one hour driving time, from the nearest military medical treatment facility that is

adequate to provide care.

(D) "Resides with" is defined as the TRICARE Prime Remote residence address at which the family resides with the activated reservist upon activation.

(4) *Enrollment.* TRICARE Prime Remote for Active Duty Family Members requires enrollment under procedures set forth in paragraph (o) of this section or as otherwise established by the Director.

(5) *Health care management requirements under TRICARE Prime Remote for Active Duty Family Members.* The additional health care management requirements applicable to Prime enrollees under paragraph (n) of this section are applicable under TRICARE Prime Remote for Active Duty Family Members unless the Director determines they are infeasible because of the particular remote location. Enrollees will be given notice of the applicable management requirements in their remote location.

(6) *Cost sharing.* Beneficiary cost sharing requirements under TRICARE Prime Remote for Active Duty Family Members are the same as those under TRICARE Prime under paragraph (m) of this section, except that the higher point-of-service option cost sharing and deductible shall not apply to routine primary health care services in cases in which, because of the remote location, the beneficiary is not assigned a primary care manager or the Director determines that care from a TRICARE network provider is not available within the TRICARE access standards under paragraph (p)(5) of this section. The higher point-of-service option cost sharing and deductible shall apply to specialty health care services received by any TRICARE Prime Remote for Active Duty Family Members enrollee unless an appropriate referral/preauthorization is obtained as required by paragraph (n) of this section under TRICARE Prime. In the case of pharmacy services under Sec. 199.21, where the Director determines that no TRICARE network retail pharmacy has been established within a reasonable distance of the residence of the TRICARE Prime Remote for Active Duty Family Members enrollee, cost sharing applicable to TRICARE network retail pharmacies will be applicable to all CHAMPUS eligible pharmacies in the remote area.

(h) Resource sharing agreements. Under the TRICARE program, any military medical treatment facility (MTF) commander may establish resource sharing agreements with the applicable managed care support contractor for the purpose of providing for the sharing of resources between the two parties. Internal resource sharing and external resource sharing agreements are authorized. The provisions of this paragraph (h) shall apply to resource sharing agreements under the TRICARE program.

(1) In connection with internal resource sharing agreements, beneficiary cost sharing requirements shall be the same as those applicable to health care services provided in facilities of the uniformed services.

(2) Under internal resource sharing agreements, the double coverage requirements of Sec. 199.8 shall be replaced by the Third Party Collection procedures of 32 CFR part 220, to the extent permissible under such part. In such a case, payments made to a resource sharing agreement provider through the TRICARE managed care support contractor shall be deemed to be payments by the MTF concerned.

(3) Under internal or external resource sharing agreements, the commander of the MTF concerned may authorize the provision of services, pursuant to the agreement, to Medicare-eligible beneficiaries, if such services are not reimbursable by Medicare, and if the commander determines that this will promote the most cost-effective provision of services under the TRICARE program.

(4) Under external resource sharing agreements, there is no cost sharing applicable to services

provided by military facility personnel. Cost sharing for non-MTF institutional and related ancillary charges shall be as applicable to services provided under TRICARE Prime or TRICARE Select, as appropriate.

(i) General quality assurance, utilization review, and preauthorization requirements under the TRICARE program. All quality assurance, utilization review, and preauthorization requirements for the basic CHAMPUS program, as set forth in this part (see especially applicable provisions in Secs. 199.4 and 199.15), are applicable to Prime and Select except as provided in this chapter. Pursuant to an agreement between a military medical treatment facility and TRICARE managed care support contractor, quality assurance, utilization review, and preauthorization requirements and procedures applicable to health care services outside the military medical treatment facility may be made applicable, in whole or in part, to health care services inside the military medical treatment facility.

(j) Pharmacy services. Pharmacy services under Prime and Select are as provided in the Pharmacy Benefits Program (see Sec. 199.21).

(k) Design of cost sharing structures under TRICARE Prime and TRICARE Select--(1) *In general.* The design of the cost sharing structures under TRICARE Prime and TRICARE Select includes several major factors: beneficiary category (e.g., active duty family member category or retired category, and there are some special rules for survivors of active duty deceased sponsors and medically retired members and their dependents); date of initial military affiliation (i.e., before or on or after January 1, 2018), category of health care service received, and network or non-network status of the provider.

(2) *Categories of health care services.* This paragraph (k)(2) describes the categories of health care services relevant to determining copayment amounts.

(i) *Preventive care visits.* These are outpatient visits and related services described in paragraph (f)(2) of this section. There are no cost sharing requirements for preventive care listed under Secs. 199.4(e)(28)(i) through (iv) and 199.17(f)(2). Beneficiaries shall not be required to pay any portion of the cost of these preventive services even if the beneficiary has not satisfied any applicable deductible for that year.

(ii) *Primary care outpatient visits.* These are outpatient visits, not occurring in an ER or urgent care center, with the following provider specialties:

(A) General Practice.

(B) Family Practice.

(C) Internal Medicine.

(D) OB/GYN.

(E) Pediatrics.

(F) Physician's Assistant.

(G) Nurse Practitioner.

(H) Nurse Midwife.

(iii) *Specialty care outpatient visits.* This category applies to outpatient care provided by provider specialties other than those listed under primary care outpatient visits under paragraph (k)(2)(ii) of this section and not specifically included in one of the other categories of care (e.g., emergency room visits etc.) under paragraph (k)(2) of this section. This category also includes partial hospitalization services, intensive outpatient treatment, and opioid treatment program services. The per visit fee shall be applied on a per day basis on days services are received, with the exception of opioid treatment program services reimbursed in accordance with Sec. 199.14(a)(2)(ix)(A)(3)(i) which per visit fee will apply on a weekly basis.

(iv) *Emergency room visits.*

(v) *Urgent care center visits.*

(vi) *Ambulance services.* This is for ground ambulance services.

(vii) *Ambulatory surgery.* This is for facility-based outpatient ambulatory surgery services.

(viii) *Inpatient hospital admissions.*

(ix) *Skilled nursing facility or rehabilitation facility admissions.* This category includes a residential treatment center, or substance use disorder rehabilitation facility residential treatment program.

(x) *Durable medical equipment, prosthetic devices, and other authorized supplies.*

(xi) *Outpatient prescription pharmaceuticals.* These are addressed in Sec. 199.21.

(3) *Beneficiary categories further subdivided.* For purposes of both TRICARE Prime and TRICARE Select, enrollment fees and cost sharing by beneficiary category (e.g., active duty family member category or retired category) are further differentiated between two groups.

(i) Group A consists of Prime or Select enrollees whose sponsor originally enlisted or was appointed in a uniformed service before January 1, 2018.

(ii) Group B consists of Prime or Select enrollees whose sponsor originally enlisted or was appointed in a uniformed service on or after January 1, 2018.

(l) Enrollment fees and cost sharing (including deductibles and catastrophic cap) amounts. This paragraph (l) provides enrollment fees and cost sharing requirements applicable to TRICARE Prime and TRICARE Select enrollees.

(1) *Enrollment fee and cost sharing under TRICARE Prime.* (i) For Group A enrollees:

(A) There is no enrollment fee for the active duty family member category.

(B) The retired category enrollment fee in calendar year 2018 is equal to the Prime enrollment fee for fiscal year 2017, indexed to calendar year 2018 and thereafter in accordance with 10 U.S.C. 1097. The Assistant Secretary of Defense (Health Affairs) may exempt survivors of active duty deceased sponsors and medically retired Uniformed Services members and their dependents from future increases in enrollment fees. The Assistant Secretary of Defense (Health Affairs) may also waive the enrollment fee requirements for Medicare-eligible beneficiaries.

(C) The cost sharing amounts are established annually in connection with the open season enrollment period. An amount is established for each category of care identified in paragraph (k)(2) of this section, taking into account all applicable statutory provisions, including 10 U.S.C. chapter 55. The amount for each category of care may not exceed the amount for Group B as set forth in 10 U.S.C. 1075a.

(D) The catastrophic cap is $1,000 for active duty families and $3,000 for retired category families.

(ii) For Group B TRICARE Prime enrollees, the enrollment fee, catastrophic cap, and cost sharing amounts are as set forth in 10 U.S.C. 1075a. The cost sharing requirements applicable to services not specifically addressed in the table set forth in 10 U.S.C. 1075a(b)(1) shall be determined by the Director, DHA.

(iii) For both Group A and Group B, for health care services obtained by a Prime enrollee but not obtained in accordance with the rules and procedures of Prime (e.g. failure to obtain a primary care manager referral when such a referral is required or seeing a non-network provider when Prime rules require use of a network provider and one is available) will not be paid under Prime rules but may be covered by the point-of-service option. For services obtained under the point-of-service option, the deductible is $300 per person and $600 per family. The beneficiary cost share is 50 percent of the allowable charges for inpatient and outpatient care, after the deductible. Point-of-service charges do not count against the annual catastrophic cap.

(2) *Enrollment fee and cost sharing under TRICARE Select.* (i) For Group A enrollees:

(A) The enrollment fee in calendar years 2018 through 2020 is zero and the catastrophic cap is as provided in 10 U.S.C. 1079 or 1086. The enrollment fee and catastrophic cap in 2021 and thereafter for certain beneficiaries in the retired category is as provided in 10 U.S.C. 1075(e), except the enrollment fee and catastrophic cap adjustment shall not apply to survivors of active duty deceased sponsors and medically retired Uniformed Services members and their dependents.

(B) The cost sharing amounts for network care for Group A enrollees are calculated for each category of care described in paragraph (k)(2) of this section by taking into account all applicable statutory provisions, including 10 U.S.C. chapter 55, as if TRICARE Extra and Standard programs were still being implemented. When determined practicable, including efficiency and effectiveness in administration, the amounts established are converted to fixed dollar amounts for each category of care for which a fixed dollar amount is established by 10 U.S.C. 1075. When determined not to be practicable, as in the categories of care including ambulatory surgery, inpatient admissions, and inpatient skilled nursing/ rehabilitation admissions, the calculated cost-sharing amounts are not converted to fixed dollar amounts. The fixed dollar amount for each category is set prospectively for each calendar year as the amount (rounded down to the nearest dollar amount) equal to 15% for enrollees in the active duty family beneficiary category or 20% for enrollees in the retired beneficiary category of the projected average allowable payment amount for each category of care during the year, as estimated by the Director. The projected average allowable payment amount for primary care (including urgent care) and specialty care outpatient appointments include payments for ancillary services (e.g., laboratory and radiology services) that are provided in connection with the respective outpatient visit. As such, there is no separate cost sharing for these ancillary services.

(C) The cost share for care received from non-network providers is as provided in Sec. 199.4.

(D) The annual deductible amount is as provided in 10 U.S.C. 1079 or 1086.

(ii) For Group B TRICARE Select enrollees, the enrollment fee, annual deductible for services received while in an outpatient status, catastrophic cap., and cost sharing amounts are as provided in 10 U.S.C. 1075 and as consistent with this section. The cost sharing requirements applicable to services not specifically addressed in 10 U.S.C. 1075 shall be determined by the Director, DHA.

(3) *Special cost-sharing rules.* (i) There is no separate cost-sharing applicable to ancillary health care services obtained in conjunction with an outpatient primary or specialty care visit under TRICARE Prime or from network providers under TRICARE Select.

(ii) Cost-sharing for maternity care services shall be determined in accordance with Sec. 199.4(e)(16).

(iii) Cost-sharing and copayments (including deductibles) shall be waived for in-network telehealth services during the national emergency for the global coronavirus 2019 (COVID-19) pandemic.

(4) *Special transition rule for the last quarter of calendar year 2017.* In order to transition enrollment fees, deductibles, and catastrophic caps from a fiscal year basis to a calendar year basis, the following special rules apply for the last quarter of calendar year 2017:

(A) A Prime enrollee's enrollment fee for the quarter is one-fourth of the enrollment fee for fiscal year 2017.

(B) The deductible amount and the catastrophic cap amount for fiscal year 2017 will be applicable to the 15-month period of October 1, 2016 through December 31, 2017.

(m) Limit on out-of-pocket costs under TRICARE Prime and TRICARE Select. For the purpose of this paragraph (m), out-of-pocket costs means all payments required of beneficiaries under paragraph (l) of this section, including enrollment fees, deductibles, and cost sharing amounts, with the exception of point-of-service charges. In any case in which a family reaches their applicable catastrophic cap, all remaining payments that would have been required of the beneficiary under paragraph (l) of this section for authorized care, with the exception of applicable point-of-service charges pursuant to paragraph (l)(1)(iii) of this section, will be paid by the program for the remainder of that calendar year.

(n) Additional health care management requirements under TRICARE Prime. Prime has additional, special health care management requirements not applicable under TRICARE Select.

(1) *Primary care manager.* (i) All active duty members and Prime enrollees will be assigned a primary care manager pursuant to a system established by the Director, and consistent with the access standards in paragraph (p)(5)(i) of this section. The primary care manager may be an individual, physician, a group practice, a clinic, a treatment site, or other designation. The primary care manager may be part of the MTF or the Prime civilian provider network. The enrollee will be given the opportunity to register a preference for primary care manager from a list of choices provided by the Director. This preference will be entered on a TRICARE Prime enrollment form or similar document. Preference requests will be considered, but primary care manager assignments will be subject to availability under the MTF beneficiary category priority system under paragraph (d) of this section and subject to other operational requirements.

(ii) Prime enrollees who are dependents of active duty members in pay grades E–1 through E–4 shall have priority over other active duty dependents for enrollment with MTF PCMs, subject to MTF capacity.

(2) *Referral and preauthorization requirements.*(i) Under TRICARE Prime there are certain procedures for referral and preauthorization.

(A) For the purpose of this paragraph (n)(2), referral addresses the issue of who will provide authorized health care services. In many cases, Prime beneficiaries will be referred by a primary care manager to a medical department of an MTF if the type of care needed is available at the MTF. In such a case, failure to adhere to that referral will result in the care being subject to point-of-service charges. In other cases, a referral may be to the civilian provider network, and again, point-of-service charges would apply to a failure to follow the referral.

(B) In contrast to referral, preauthorization addresses the issue of whether particular services may be covered by TRICARE, including whether they appear necessary and appropriate in the context of the patient's diagnosis and circumstances. A major purpose of preauthorization is to prevent surprises about coverage determinations, which are sometimes dependent on particular details regarding the patient's condition and circumstances. While TRICARE Prime has referral requirements that do not exist for TRICARE Select, TRICARE Select has some preauthorization requirements that do not exist for TRICARE Prime.

(C) In any other special circumstances identified by the Director, generally with notice provided in connection with the open season enrollment period for the plan year.

(ii) Except as otherwise provided in this paragraph (n)(2), a beneficiary enrolled in TRICARE Prime is required to obtain a referral for care through a designated primary care manager (or other authorized care coordinator) prior to obtaining care under the TRICARE program.

(iii) There is no referral requirement under paragraph (n)(2)(i) of this section in the following circumstances.

(A) In emergencies;

(B) For urgent care services for a certain number of visits per year (zero to unlimited), with the number specified by the Director and notice provided in connection with the open season enrollment period preceding the plan year; and

(C) In any other special circumstances identified by the Director, generally with notice provided in connection with the open season enrollment period for the plan year.

(iv) A primary care manager who believes a referral to a specialty care provider is medically necessary and appropriate need not obtain preauthorization from the managed care support contractor before referring a patient to a network specialty care provider. Such preauthorization is only required with respect to a primary care manager's referral for:

(A) Inpatient hospitalization;

(B) Inpatient care at a skilled nursing facility;

(C) Inpatient care at a rehabilitation facility; and

(D) Inpatient care at a residential treatment facility.

(v) The restrictions in paragraph (n)(2)(iv) of this section on preauthorization requirements do not apply to any preauthorization requirements that are generally applicable under TRICARE, independent of TRICARE Prime referrals, such as:

(A) Under the Pharmacy Benefits Program under 10 U.S.C. 1074g and Sec. 199.21.

(B) For laboratory and other ancillary services.

(C) Durable medical equipment.

(vi) The cost-sharing requirement for a beneficiary enrolled in TRICARE Prime who does not obtain a referral for care when it is required, including care from a non-network provider, is as provided in paragraph (l)(1)(iii) of this section concerning point of service care.

(vii) In the case of care for which preauthorization is not required under paragraph (n)(2)(iv) of this section, the Director may authorize a managed care support contractor to offer a voluntary pre-authorization program to enable beneficiaries and providers to confirm covered benefit status and/or medical necessity or to understand the criteria that will be used by the managed care support contractor to adjudicate the claim associated with the proposed care. A network provider may not be required to use such a program with respect to a referral.

(3) *Restrictions on the use of providers.* The requirements of this paragraph (n)(3) shall be applicable to health care utilization under TRICARE Prime, except in cases of emergency care and under point-of-service option (see paragraph (n)(4) of this section).

(i) Prime enrollees must obtain all primary health care from the primary care manager or from another provider to which the enrollee is referred by the primary care manager or otherwise authorized.

(ii) For any necessary specialty care and non-emergent inpatient care, the primary care manager or other authorized individual will assist in making an appropriate referral.

(iii) Though referrals for specialty care are generally the responsibility of the primary care managers, subject to discretion exercised by the TRICARE Regional Directors, and established in regional policy or memoranda of understanding, specialist providers may be permitted to refer patients for additional specialty consultation appointment services within the TRICARE contractor's network without prior authorization by primary care managers.

(iv) The following procedures will apply to health care referrals under TRICARE Prime:

(A) The first priority for referral for specialty care or inpatient care will be to the local MTF (or to any other MTF in which catchment area the enrollee resides).

(B) If the local MTF(s) are unavailable for the services needed, but there is another MTF at which the needed services can be provided, the enrollee may be required to obtain the services at that MTF. However, this requirement will only apply to the extent that the enrollee was informed at the time of (or prior to) enrollment that mandatory referrals might be made to the MTF involved for the service involved.

(C) If the needed services are available within civilian preferred provider network serving the area,

the enrollee may be required to obtain the services from a provider within the network. Subject to availability, the enrollee will have the freedom to choose a provider from among those in the network.

(D) If the needed services are not available within the civilian preferred provider network serving the area, the enrollee may be required to obtain the services from a designated civilian provider outside the area. However, this requirement will only apply to the extent that the enrollee was informed at the time of (or prior to) enrollment that mandatory referrals might be made to the provider involved for the service involved (with the provider and service either identified specifically or in connection with some appropriate classification).

(E) In cases in which the needed health care services cannot be provided pursuant to the procedures identified in paragraphs (n)(3)(iv)(A) through (D) of this section, the enrollee will receive authorization to obtain services from a TRICARE-authorized civilian provider(s) of the enrollee's choice not affiliated with the civilian preferred provider network.

(v) When Prime is operating in noncatchment areas, the requirements in paragraphs (n)(3)(iv)(B) through (E) of this section shall apply.

(4) *Point-of-service option.* TRICARE Prime enrollees retain the freedom to obtain services from civilian providers on a point-of service basis. Any health care services obtained by a Prime enrollee, but not obtained in accordance with the rules and procedures of Prime, will be covered by the point-of-service option. In such cases, all requirements applicable to health benefits under Sec. 199.4 shall apply, except that there shall be higher deductible and cost sharing requirements (as set forth in paragraph (l)(1)(iii)) of this section). However, Prime rules may cover such services if the enrollee did not know and could not reasonably have been expected to know that the services were not obtained in accordance with the utilization management rules and procedures of Prime.

(5) *Prime travel benefit.* In accordance with guidelines issues by the Assistant Secretary of Defense (Health Affairs), certain travel expenses may be reimbursed when a TRICARE Prime enrollee is referred by the primary care manager for medically necessary specialty care more than 100 miles away from the primary care manager's office. Such guidelines shall be consistent with appropriate provisions of generally applicable Department of Defense rules and procedures governing travel expenses.

(o) TRICARE program enrollment procedures. There are certain requirements pertaining to procedures for enrollment in TRICARE Prime, TRICARE Select, and TRICARE Prime Remote for Active Duty Family Members. (These procedures do not apply to active duty members, whose enrollment is mandatory and automatic.)

(1) *Annual open season enrollment.*(i) As a general rule, enrollment (or a modification to a previous enrollment) must occur during the open season period prior to the plan year, which is on a calendar year basis. The open season enrollment period will be of at least 30 calendar days duration. An enrollment choice will be applicable for the plan year.

(ii) Open season enrollment procedures may include automatic reenrollment in the same plan for the next plan year for enrollees or sponsors that will occur in the event the enrollee does not take other action during the open season period.

(2) *Exceptions to the calendar year enrollment process.* The Director will identify certain qualifying events that may be the basis for a change in enrollment status during a plan year, such as a change in eligibility status, marriage, divorce, birth of a new family member, relocation, loss of other health

insurance, or other events. In the case of such an event, a beneficiary eligible to enroll in a plan may newly enroll, disenroll, or modify a previous enrollment during the plan year. Initial payment of the applicable enrollment fee shall be collected for new enrollments in accordance with established procedures. Any applicable enrollment fee will be pro-rated. A beneficiary who dis-enrolls without enrolling at the same time in another plan is not eligible to enroll in a plan later in the same plan year unless

there is another qualifying event. A beneficiary who is dis-enrolled for failure to pay a required enrollment fee installment is not eligible to re-enroll in a plan later in the same plan year unless there is another qualifying event. Generally, the effective date of coverage will coincide with the date of the qualifying event.

(3) *Installment payments of enrollment fee.* The Director will establish procedures for installment payments of enrollment fees.

(4) *Effect of failure to enroll.* Beneficiaries eligible to enroll in Prime or Select and who do not enroll will no longer have coverage under the TRICARE program until the next annual open season enrollment or they have a qualifying event, except that they do not lose any statutory eligibility for space-available care in military medical treatment facilities. There is a limited grace period exception to this enrollment requirement for calendar year 2018, as provided in section 701(d)(3) of the National Defense Authorization Act for Fiscal Year 2017.

(5) *Automatic enrollment for certain dependents.* Under 10 U.S.C. 1097a, in the case of dependents of active duty members in the grade of E–1 to E–4, such dependents who reside in a catchment area of a military treatment facility shall be enrolled in TRICARE Prime. The Director may provide for the automatic enrollment in TRICARE Prime for such dependents of active duty members in the grade of E–5 and higher. In any case of automatic enrollment under this paragraph (o)(5), the member will be provided written notice and the automatic enrollment may be cancelled at the election of the member.

(6) *Grace periods.* The Director may make provisions for grace periods for enrollment-related actions to facilitate effective operation of the enrollment program.

(p) Civilian preferred provider networks. A major feature of the TRICARE program is the civilian preferred provider network.

(1) *Status of network providers.* Providers in the preferred provider network are not employees or agents of the Department of Defense or the United States Government. Although network providers must follow numerous rules and procedures of the TRICARE program, on matters of professional judgment and professional practice, the network provider is independent and not operating under the direction and control of the Department of Defense.

(2) *Utilization management policies.* Preferred providers are required to follow the utilization management policies and procedures of the TRICARE program. These policies and procedures are part of discretionary judgments by the Department of Defense regarding the methods of delivering and financing health care services that will best achieve health and economic policy objectives.

(3) *Quality assurance requirements.* A number of quality assurance requirements and procedures are applicable to preferred network providers. These are for the purpose of assuring that the health care services paid for with government funds meet the standards called for in the contract and provider agreement.

(4) *Provider qualifications.* All preferred providers must meet the following qualifications:

(i) They must be TRICARE-authorized providers and TRICARE-participating providers. In addition, a network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) except as follows:

(A) If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.

(B) If the beneficiary was informed in writing that the specific services were excluded or excludable from TRICARE coverage and the beneficiary agreed in writing, in advance of the services being provided, to pay for the services, the provider may bill the beneficiary.

(ii) All physicians in the preferred provider network must have staff privileges in a hospital accredited by The Joint Commission (TJC) or other accrediting body determined by the Director. This requirement may be waived in any case in which a physician's practice does not include the need for admitting privileges in such a hospital, or in locations where no accredited facility exists. However, in any case in which the requirement is waived, the physician must comply with alternative qualification standards as are established by the Director.

(iii) All preferred providers must agree to follow all quality assurance, utilization management, and patient referral procedures established pursuant to this section, to make available to designated DoD utilization management or quality monitoring contractors medical records and other pertinent records, and to authorize the release of information to MTF Commanders regarding such quality assurance and utilization management activities.

(iv) All preferred network providers must be Medicare participating providers, unless this requirement is waived based on extraordinary circumstances. This requirement that a provider be a Medicare participating provider does not apply to providers not eligible to be participating providers under Medicare.

(v) The network provider must be available to all TRICARE beneficiaries.

(vi) The provider must agree to accept the same payment rates negotiated for Prime enrollees for any person whose care is reimbursable by the Department of Defense, including, for example, Select participants, supplemental care cases, and beneficiaries from outside the area.

(vii) All preferred providers must meet all other qualification requirements, and agree to comply with all other rules and procedures established for the preferred provider network.

(viii) In locations where TRICARE Prime is not available, a TRICARE provider network will, to the extent practicable, be available for TRICARE Select enrollees. In these locations, the minimal requirements for network participation are those set forth in paragraph (p)(4)(i) of this section. Other requirements of this paragraph (p) will apply unless waived by the Director.

(5) *Access standards.* Preferred provider networks will have attributes of size, composition, mix of providers and geographical distribution so that the networks, coupled with the MTF capabilities (when applicable), can adequately address the health care needs of the enrollees. In the event that a Prime enrollee seeks to obtain from the managed care support contractor an appointment for care but is not

offered an appointment within the access time standards from a network provider, the enrollee will be authorized to receive care from a non-network provider without incurring the additional fees associated with point-of-service care. The following are the access standards:

(i) Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.

(ii) The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.

(iii) Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers pursuant to paragraph (p)(5)(ii) of this section), within the service area 24 hours a day, seven days a week.

(iv) The network shall include a sufficient number and mix of board certified specialists to meet reasonably the anticipated needs of enrollees. Travel time for specialty care shall not exceed one hour under normal circumstances, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the Specialized Treatment Services Program.

(v) Office waiting times in nonemergency circumstances shall not exceed 30 minutes, except when emergency care is being provided to patients, and the normal schedule is disrupted.

(6) *Special reimbursement methods for network providers.* The Director, may establish, for preferred provider networks, reimbursement rates and methods different from those established pursuant to Sec. 199.14. Such provisions may be expressed in terms of percentage discounts off CHAMPUS allowable amounts, or in other terms. In circumstances in which payments are based on hospital-specific rates (or other rates specific to particular institutional providers), special reimbursement methods may permit payments based on discounts off national or regional prevailing payment levels, even if higher than particular institution specific payment rates.

(q) Preferred provider network establishment. (1) The any qualified provider method may be used to establish a civilian preferred provider network. Under this method, any TRICARE-authorized provider that meets the qualification standards established by the Director, or designee, may become a part of the preferred provider network. Such standards must be publicly announced and uniformly applied. Also under this method, any provider who meets all applicable qualification standards may not be excluded from the preferred provider network. Qualifications include:

(i) The provider must meet all applicable requirements in paragraph (p)(4) of this section.

(ii) The provider must agree to follow all quality assurance and utilization management procedures established pursuant to this section.

(iii) The provider must be a participating provider under TRICARE for all claims.

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

(v) 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 Director (or other authorized official) upon appropriate notice to the other party. The Director shall establish an agreement model or other guidelines to promote uniformity in the agreements.

(2) In addition to the above requirements, the Director, or designee, may establish additional categories of preferred providers of high quality/high value that require additional qualifications.

(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 (see especially applicable provisions of Sec. 199.9) are applicable to the TRICARE program.

(s) [Reserved]

(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, or designated TRICARE contractor.

(u) Care provided outside the United States. The TRICARE program is not automatically implemented in all respects outside the United States. This paragraph (u) sets forth the provisions of this section applicable to care received outside the United States under the following TRICARE health plans.

(1) *TRICARE Prime.* The Director may, in conjunction with implementation of the TRICARE program, authorize a special Prime program for command sponsored dependents of active duty members who accompany the members in their assignments in foreign countries. Under this special program, a preferred provider network may be established through contracts or agreements with selected health care providers. Under the network, Prime covered services will be provided to the enrolled covered dependents subject to applicable Prime deductibles, copayments, and point-of-service charges. To the extent practicable, rules and procedures applicable to TRICARE Prime under this section shall apply unless specific exemptions are granted in writing by the Director. The use of this authority by the Director for any particular geographical area will be published on the primary publicly available Internet Web site of the Department and on the publicly available Internet Web site of the managed care support contractor that has established the provider network under the TRICARE program. Published information will include a description of the preferred provider network program and other pertinent information. The Director shall also issue policies, instructions, and guidelines necessary to implement this special program.

(2) *TRICARE Select.* The TRICARE Select option shall be available outside the United States except that a preferred provider network of providers shall only be established in areas where the Director determines that it is economically in the best interest of the Department of Defense. In such a case, the Director shall establish a preferred provider network through contracts or agreements with selected health care providers for eligible beneficiaries to receive covered benefits subject to the enrollment and cost-sharing amounts applicable to the specific category of beneficiary. When an eligible beneficiary, other than a TRICARE for Life beneficiary, receives covered services from an authorized TRICARE non-network provider, including in areas where a preferred provider network has not been established by the Director, the beneficiary shall be subject to cost-sharing amounts applicable to out-of-network care. To the extent practicable, rules and procedures applicable to TRICARE Select under this section

shall apply unless specific exemptions are granted in writing by the Director. The use of this authority by the Director to establish a TRICARE preferred provider network for any particular geographical area will be published on the primary publicly available Internet Web site of the Department and on the publicly available Internet Web site of the managed care support contractor that has established the provider network under the TRICARE program. Published information will include a description of the preferred provider network program and other pertinent information. The Director shall also issue policies, instructions, and guidelines necessary to implement this special program.

(3) *TRICARE for Life.* The TRICARE for Life (TFL) option shall be available outside the United States. Eligible TFL beneficiaries may receive covered services and supplies authorized under Sec. 199.4, subject to the applicable catastrophic cap, deductibles and costshares under Sec. 199.4, whether received from a network provider or any authorized TRICARE provider not in a preferred provider network. However, if a TFL beneficiary receives covered services from a PPN provider, the beneficiary's out-of-pocket costs will generally be lower.

(v) Administration of the TRICARE program in the state of Alaska. In view of the unique geographical and environmental characteristics impacting the delivery of health care in the state of Alaska, administration of the TRICARE program in the state of Alaska will not include financial underwriting of the delivery of health care by a TRICARE contractor. All other provisions of this section shall apply to administration of the TRICARE program in the state of Alaska as they apply to the other 49 states and the District of Columbia.

(w) Administrative procedures. The Assistant Secretary of Defense (Health Affairs), the Director, 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.

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