

power and responsibilities between the Federal Government and Indian tribes.

Regulatory Flexibility Act

The Administrator, in accordance with the Regulatory Flexibility Act (5 U.S.C. 601–612) (RFA), has reviewed this rule and by approving it certifies that it will not have a significant economic impact on a substantial number of small entities. The purpose of this rule is to remove naldemedine from the list of schedules of the CSA. This action removes regulatory controls and administrative, civil, and criminal sanctions applicable to controlled substances for handlers and proposed handlers of naldemedine. Accordingly, it has the potential for some economic impact in the form of cost savings.

This rule will affect all persons who handle, or propose to handle, naldemedine. Due to the wide variety of unidentifiable and unquantifiable variables that potentially could influence handling of naldemedine, the DEA is unable to determine the number of entities and small entities which might handle naldemedine. However, the DEA estimates that all persons who handle, or propose to handle naldemedine, are currently registered with the DEA to handle controlled substances. Therefore, the 1.7 million (1,683,023 as of April 2017) controlled substance registrations, representing approximately 436,761 entities, would be the maximum number of entities affected by this rule. The DEA estimates that 425,856 (97.5%) of 436,761 affected entities are “small entities” in accordance with the RFA and Small Business Administration size standards.

The DEA estimates all controlled substance registrants handle both controlled and non-controlled substances and these registrants are expected to continue to handle naldemedine. Additionally, since prospective naldemedine handlers are likely to handle other controlled substances, the cost benefits they would receive as a result of the de-control of naldemedine is minimal. As naldemedine handlers continue to handle other controlled substances, they will need to maintain their DEA registration and keep the same security and recordkeeping processes, equipment, and facilities in place and would experience only minimal reduction in security, inventory, recordkeeping, and labeling costs. Physical security control requirements are the same for controlled substances listed in schedules II, III, IV, and V for the vast majority of registrants (practitioners).

While the DEA does not have a basis to estimate the number of affected entities, the DEA estimates that the maximum number of affected entities is 436,761 of which 425,856 are estimated to be small entities. Since the affected entities are expected to handle other controlled substances and maintain security and recordkeeping facilities and processes consistent with controlled substances, the DEA estimates any economic impact will be minimal. Because of these facts, this rule will not have a significant economic impact on a substantial number of small entities.

Unfunded Mandates Reform Act of 1995

In accordance with the Unfunded Mandates Reform Act (UMRA) of 1995, 2 U.S.C. 1501 *et seq.*, the DEA has determined and certifies that this action would not result in any Federal mandate that may result “in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100,000,000 or more (adjusted for inflation) in any one year * * *.” Therefore, neither a Small Government Agency Plan nor any other action is required under UMRA of 1995.

Paperwork Reduction Act

This action does not impose a new collection of information requirement under the Paperwork Reduction Act, 44 U.S.C. 3501–3521. This action would not impose recordkeeping or reporting requirements on State or local governments, individuals, businesses, or organizations. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Congressional Review Act

This rule is not a major rule as defined by section 804 of the Small Business Regulatory Enforcement Fairness Act of 1996 (Congressional Review Act (CRA)). This rule will not result in: An annual effect on the economy of \$100,000,000 or more; a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign based enterprises in domestic and export markets. However, pursuant to the CRA, the DEA has submitted a copy of this final rule to both Houses of Congress and to the Comptroller General.

List of Subjects in 21 CFR Part 1308

Administrative practice and procedure, Drug traffic control, Reporting and recordkeeping requirements.

For the reasons set out above, 21 CFR part 1308 is amended as follows:

PART 1308—SCHEDULES OF CONTROLLED SUBSTANCES

■ 1. The authority citation for 21 CFR part 1308 continues to read as follows:

Authority: 21 U.S.C. 811, 812, 871(b), 956(b), unless otherwise noted.

■ 2. In § 1308.12, revise the introductory text of paragraph (b)(1) to read as follows:

§ 1308.12 Schedule II.

* * * * *

(b) * * *

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate excluding apomorphine, thebaine-derived butorphanol, dextroprhan, nalbuphine, naldemedine, nalmefene, naloxegol, naloxone, and naltrexone, and their respective salts, but including the following:

* * * * *

Dated: September 22, 2017.

Chuck Rosenberg,

Acting Administrator.

[FR Doc. 2017–20919 Filed 9–28–17; 8:45 am]

BILLING CODE 4410-09-P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[Docket ID: DOD–2017–HA–0039]

RIN 0720–AB70

Establishment of TRICARE Select and Other TRICARE Reforms

AGENCY: Office of the Secretary, Department of Defense (DoD).

ACTION: Interim final rule.

SUMMARY: This interim final rule implements the primary features of section 701 and partially implements several other sections of the National Defense Authorization Act for Fiscal Year 2017 (NDAA–17). The law makes significant changes to the TRICARE program, especially to the health maintenance organization (HMO)-like health plan, known as TRICARE Prime; to the preferred provider organization (PPO) health plan, previously called TRICARE Extra which is to be replaced

by TRICARE Select; and to the third health care option, known as TRICARE Standard, which will be terminated as of December 31, 2017, and also replaced by TRICARE Select. The statute also adopts a new health plan enrollment system under TRICARE and new provisions for access to care, high value services, preventive care, and healthy lifestyles. In implementing the statutory changes, this interim final rule makes a number of improvements to TRICARE.

DATES: This interim final rule is effective October 1, 2017. Comments will be received by November 28, 2017.

ADDRESSES: You may submit comments, identified by docket number and title, by any of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.
- *Mail:* Department of Defense, Office of the Deputy Chief Management Officer, Directorate for Oversight and Compliance, Regulatory and Advisory Committee Division, 4800 Mark Center Drive, Mailbox #24, Suite 08D09B, Alexandria, VA 22350-1700.

Instructions: All submissions received must include the agency name, docket number, or title for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at <http://www.regulations.gov> as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: Mr. Mark Ellis, Defense Health Agency, TRICARE Health Plan, (703) 681-0063.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose of the Interim Final Rule

In implementing section 701 and partially implementing several other sections of NDAA-17, this interim final rule advances all four components of the Military Health System's quadruple aim of improved readiness, better care, better health, and lower cost. The aim of improved readiness is served by reinforcing the vital role of the TRICARE Prime health plan to refer patients, particularly those needing specialty care, to military medical treatment facilities (MTFs) in order to ensure that military health care providers maintain clinical currency and proficiency in their professional fields. The objective of better care is enhanced by a number of improvements in beneficiary access to health care services, including increased

geographical coverage for the TRICARE Select provider network, reduced administrative hurdles for TRICARE Prime enrollees to obtain urgent care services and specialty care referrals, and promotion of high value services and medications. The goal of better health is advanced by expanding TRICARE coverage of preventive care services, treatment of obesity, high-value care, and telehealth. And the aim of lower cost is furthered by refining cost-benefit assessments for TRICARE plan specifications that remain under DoD's discretion and adding flexibilities to incentivize high-value health care services.

B. Legal Authority for the Regulatory Action

This interim final rule is required to implement or partially implement several sections of NDAA-17, including 701, 706, 715, 718, and 729. The legal authority for this rule also includes chapter 55 of title 10, United States Code.

C. Summary of Major Provisions of the Interim Final Rule

The major provisions of the interim final rule are:

➤ The establishment of TRICARE Select as a self-managed, PPO option under the TRICARE program. TRICARE Select replaces the TRICARE Extra and Standard programs and adopts a number of improvements, including fixed copayments rather than cost shares for covered benefits provided by a civilian network provider. TRICARE Select beneficiaries can choose any provider for their healthcare; however, they will enjoy lower out-of-pocket costs if they choose preferred providers within the TRICARE civilian network.

➤ The continuation of TRICARE Prime as a managed care, HMO-like option under the TRICARE program. TRICARE Prime adopts a number of changes to conform to specifications in the new law, including categories of health care services applicable to the determination of copayment amounts (such as primary care, specialty care, emergency care).

➤ Improved access to care, including a codified requirement that the TRICARE Select health care plan is available in all locations and at least 85% of the U.S. beneficiary TRICARE Select population is covered by the TRICARE network. Also, for TRICARE Prime enrollees, there are new procedures to ensure timely appointments for health care services and to authorize some or all urgent care visits without the need for referral from a primary care manager.

➤ Promotion of high value services and medications, telehealth services, preventive health care, and healthy lifestyles.

➤ A new design for the health care enrollment system, including mandatory enrollment to maintain TRICARE coverage, an annual open season enrollment period, and hassle-free enrollment procedures.

➤ Other features include preservation of benefits for active duty dependents and TRICARE-for-Life beneficiaries, and changes to the TRICARE Young Adult (TYA), TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), Continued Health Care Benefit Program (CHCBP), and TRICARE Retiree Dental Program (TRDP) to conform with new statutory requirements.

II. Provisions of Interim Final Rule

A. Establishment of TRICARE Select

The rule implements the new law (section 701 of NDAA-17) that establishes TRICARE Select as a self-managed, PPO program. It allows beneficiaries to use the TRICARE civilian provider network, with reduced out-of-pocket costs compared to care from non-network providers, as well as military treatment facilities (when space is available). Similar to the long-operating "TRICARE Extra" and "TRICARE Standard" plans, which TRICARE Select replaces, a major feature is that enrollees will not have restrictions on their freedom of choice with respect to health care providers. TRICARE Select is based primarily on 10 U.S.C. 1075 (as added by section 701 of NDAA-17) and 10 U.S.C. 1097. With respect to beneficiary cost sharing, the statute introduces a new split of beneficiaries into two groups: One group (which the rule refers to as "Group A") consists of sponsors and their family members who first became affiliated with the military through enlistment or appointment before January 1, 2018, and the second group (referred to as "Group B") who first became affiliated on or after January 1, 2018. In general, beneficiary out-of-pocket costs for Group B are higher than for Group A.

In addition to implementing the statutory specifications, the interim final rule also makes improvements for TRICARE Select Group A enrollees, compared to the features of the old TRICARE Extra plan. One such improvement is to convert the current cost-sharing requirement of 15% for active duty family members and 20% for retirees and their family members of the allowable charge for care from a network provider to a fixed dollar

copayment calculated to approximately equal 15% or 20% of the average allowable charge for the category of care involved. Consistent with prevailing private sector health program practices, the fixed dollar copayment is more predictable for the patient and easier for the network health care provider to administer. The breakdown of categories of care (such as outpatient primary care visit, specialty care visit, emergency room visit, etc.) contained in the rule is the same as the categories now specified in the statute for Group B Select enrollees.

A second improvement in TRICARE Select (for both Group A and Group B) is that additional preventive care services that previously were only offered to TRICARE Prime beneficiaries will now (under the authority of 10 U.S.C. 1097 and NDAA–17) also be covered for Select enrollees when furnished by a network health care provider. These are services recommended by the United States Preventive Services Task Force and the Health Resources and Services Administration of the Department of Health and Human Services.

These improvements are based partly on the statutory provision (10 U.S.C. 1075(c)(2)) that Group A Select enrollee cost-sharing requirements are calculated as if TRICARE Extra were still being carried out by DoD. TRICARE Extra specifications are based on the underlying authority of 10 U.S.C. 1097, which allows DoD to adopt special rules for the PPO plan. This statute was the basis for the original set of rules for TRICARE Extra, which were adopted in 1995, and is the authority for these improved rules for TRICARE Select Group A, adopted as if TRICARE Extra were still being carried out by DoD.

Under the interim final rule, the cost sharing rules applicable to TRICARE Select Group B are those specified in 10 U.S.C. 1075. For TRICARE Select Group A, in addition to the copayment rules noted above, consistent with 10 U.S.C. 1075, an enrollment fee of \$150 per person or \$300 per family will begin January 1, 2021, for most retiree families, with annual updates thereafter based on the cost of living adjustment (COLA) applied to retired pay. At the same time, the catastrophic cap will increase from \$3,000 to \$3,500 for these retiree families. These changes, however, will not apply to TRICARE Select Group A active duty families, survivors of members who died while on active duty, or disability retiree families; that is, no enrollment fee will be applicable to this group and the applicable catastrophic cap will continue to be \$1,000 for active duty

families as established under 10 U.S.C. 1079(b) and \$3,000 for survivors of members who died while on active duty or disability retiree families as established under 10 U.S.C. 1086(b).

B. Continuation of TRICARE Prime

A second major feature of this interim final rule, based primarily on 10 U.S.C. 1075a (also added by section 701 of NDAA–17), is the continuation of TRICARE Prime as a managed care, HMO-like program. It generally features use of military treatment facilities (MTFs) and substantially reduced out-of-pocket costs for authorized 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. Like with TRICARE Select, with respect to beneficiary cost sharing, the statute introduces a new split of beneficiaries into two groups (again referred to in the rule as Group A and Group B) based on the military sponsor's initial enlistment or appointment before January 1, 2018 (Group A), or on or after that date (Group B). Beneficiary cost sharing for Group B is slightly higher than for Group A.

As with TRICARE Select, the cost sharing specifications for TRICARE Prime Group B are set forth in the statute, and those for Group A are calculated in accordance with other health care provisions of title 10 (rather than the new section 1075a). The primary original statutory authority for the TRICARE Prime health plan, established by DoD regulation in 1995, was 10 U.S.C. 1097, and this continues to be relied upon for the continued operation of TRICARE Prime for Group A. Also relevant to the original terms of TRICARE Prime was section 731 of the National Defense Authorization Act for Fiscal Year 1994. That law required DoD to include, to the maximum extent practicable, the HMO-like option under TRICARE. That law also required that the HMO-like option “shall be administered so that the costs incurred by the Secretary under the TRICARE program are no greater than the costs that would otherwise be incurred”, to provide health care to beneficiaries. The extent to which this “cost neutrality” requirement has not been maintained was recently highlighted by the Congressional Budget Office: “CBO estimates that under current law, a typical retiree household enrolled in TRICARE Prime as a ‘family’ in 2018, and for whom TRICARE is the primary payer of health benefits, will cost DoD about \$17,400, and a typical family that

uses Standard/Extra will cost DoD about \$12,700.”¹

Based on the TRICARE Prime cost neutrality provision in NDAA–1994, the original 1995 TRICARE Prime regulation included (at 32 CFR 199.18(g)) that cost sharing requirements “may be updated for subsequent years to the extent necessary to maintain compliance with statutory requirements pertaining to government costs.” Since NDAA–1994, Congress took away DoD's discretion for enrollment fee increases, which are now tied by law to the retired pay COLA. However, DoD continues to have discretion to update copayment amounts—which have not changed since 1995—and this discretion is confirmed by the newly enacted 10 U.S.C. 1075a(a)(3).

This discretion to update copayment amounts is continued in the interim final rule, but the framework for setting Prime Group A copayment amounts is being revised. Specifically, DoD is adopting for Group A the same structure of categories of care that Congress adopted for Group B. Thus, for example, while the current TRICARE Prime copayment amount makes no distinction between primary care and specialty care services, the new Group B structure under the statute does have a different copayment for primary care and specialty care. Under the rule, copayment amounts for Group A beneficiaries will be set for each of those categories, as well as the other categories of care the statute now specifies for Group B enrollees. The interim final rule does not specify the amount for each category of care. Rather, consistent with DoD's discretion under current statute and regulation, the actual amount will be set each year prior to open season enrollment. The interim final rule does, however, specify that the amount for each category of care for Group A enrollees may not exceed the amount that Congress set for Group B enrollees. In this way, the Prime copay structure would be in alignment with proposed legislative changes recommended by the Department to Congress for enactment this year to eliminate the “grandfathering” of Group A retiree families and return to a single TRICARE Prime model for all working-age retiree families. Again, it should be noted that this applies only to per-service copayments; enrollment fee increases for Group A enrollees will continue to be based on the retired pay COLA.

¹ Congressional Budget Office Cost Estimate, S. 2943, National Defense Authorization Act for Fiscal Year 2017, June 10, 2016, page 17.

The interim final rule also continues the point-of-service provision of the current TRICARE Prime plan. Any health care services obtained by a Prime enrollee not 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 a network provider is available) will not be paid for under Prime rules, but may be covered by the point-of-service option. This results in higher cost sharing—specifically, a deductible of \$300 per person and \$600 per family, and a copayment of 50 percent of the allowable charges after the deductible. Point-of-service charges do not count against the annual catastrophic cap. These point-of-service rules continue for TRICARE Prime Group A and are also applicable to Group B. For Group B, the rules for point-of-service charges are specified in 10 U.S.C. 1075a(c), which clarifies that point-of-service cost sharing is “notwithstanding” the usual cost sharing rules of Prime Group B enrollees.

One other matter on which the interim final rule preserves DoD discretion, similar to that in the current regulation, is with respect to the locations where TRICARE Prime is offered. This is noted in the current regulation at 32 CFR 199.17(a)(5). Under the interim final rule, the locations where TRICARE Prime will be offered will be determined by the Director, Defense Health Agency (DHA) and announced prior to the annual open season enrollment period. The guiding principle for this decision is that the purpose of TRICARE Prime is to support the medical readiness of the armed forces and the readiness of medical personnel. Codification in regulation of this guiding principle is a corollary to the codification by Congress in statute, specifically sections 703 and 725 of NDAA–17 that MTFs exist to support the medical readiness of the armed forces and the readiness of medical personnel.

TRICARE Prime, especially for working age retirees and family members, provides MTFs clinical workload, including for a range of medical specialty areas that permit military health care providers to maintain currency and proficiency in their respective clinical fields. This important support of a ready medical force is what justifies the higher government cost of Prime (which CBO estimates at \$17,400 per retiree family), notwithstanding the original statutory requirement of cost neutrality between TRICARE Prime and TRICARE Standard. This cost-benefit assessment

supports the conclusion that it is practicable to offer TRICARE Prime in areas where it supports the medical readiness of one or more MTFs. Additionally, where TRICARE Prime is offered, it may be limited to active duty family members if the Director, DHA determines it is not practicable to offer TRICARE Prime to retired beneficiaries as well—a determination that again would take into account the nature of the supported MTF and the range of services it offers.

C. Improved Access to Care

A third significant change in the interim final rule is a set of improvements in standards for access to care. The TRICARE Select plan replaces TRICARE Standard as the generally applicable plan in all areas. Under TRICARE Select, eligible beneficiaries can choose any provider for their healthcare, and they will enjoy lower out-of-pocket costs if they choose providers within the TRICARE civilian network. The vast majority of TRICARE beneficiaries located in the United States will have access to TRICARE network providers (it is DoD’s plan that at least 85% of the U.S. beneficiary population under TRICARE Select will be covered by the network upon implementation), similar to the current TRICARE Extra option, but with the benefit of predictable fixed dollar copayments. In cases in which a network provider is not available to a TRICARE Select enrollee, such as in remote locations where there are very few primary or specialty providers, enrollees will still have access to any TRICARE authorized provider, with cost sharing comparable to the current TRICARE Standard plan (i.e. 25% for retired category beneficiaries).

A second interim final rule enhancement for access to care is that if a TRICARE Prime enrollee seeks to obtain an appointment for care from the managed care support contractor but is not offered an appointment within the applicable access time standards from a network provider, the enrollee will be authorized to receive care from any authorized provider without incurring the additional fees associated with point-of-service care.

A third access to care improvement under the interim final rule is that the TRICARE Prime referral requirement may be waived for urgent care visits for Prime enrollees other than active duty members. This is similar to the current pilot program, which waives the referral requirement (other than for active duty members) for up to two urgent care visits per year. The specific number of urgent care visits without a referral will

be determined annually prior to the beginning of the open season enrollment period.

A fourth access to care improvement is adoption of the new statutory provision that a primary care manager who believes a referral to a specialty care network provider is medically necessary and appropriate need not obtain pre-authorization from the managed care support contractor. Managed care support contractor preauthorization is only required with respect to a primary care manager’s referral for inpatient hospitalization, inpatient care at a skilled nursing facility, inpatient care at a residential treatment center and inpatient care at a rehabilitation facility.

D. Promotion of High Value Services and Medications and Telehealth Services

In addition to the expansion noted above concerning preventive care services, the interim final rule makes a number of other improvements in TRICARE Prime and TRICARE Select based on provisions of sections 701(h), 706, 718, and 729 of NDAA–17. Section 701(h), among other things, provides for a four-year pilot program to encourage use by patients of high value services and medications. Section 706, among other things, authorizes special arrangements with provider groups that will improve population-based health outcomes and focus more on preventive care. Section 729 calls for special actions to incentivize medical intervention programs to address chronic diseases and other conditions and healthy lifestyle interventions. Section 718, among other things, requires actions to promote greater use of telehealth services under TRICARE. While these sections of NDAA–17 also require actions outside the scope of this interim final rule (such as contracting actions) they can be partially implemented, consistent with Congressional intent, in this rule. The interim final rule does this in several ways.

First, the interim final rule authorizes coverage under TRICARE Prime and TRICARE Select for medically necessary treatment of obesity even if it is the sole or major condition treated. Under 10 U.S.C. 1079(a)(10), this is disallowed under the basic program. However, it is DoD’s conclusion that the underlying authority of 10 U.S.C. 1097, together with section 729 of NDAA–17 (which specifically authorizes medical intervention for obesity), allow the Department to cover these services when provided by a network provider

for a TRICARE Prime or TRICARE Select enrollee.

Second, the interim final rule codifies authority of the Director, DHA to waive or reduce copayment requirements for TRICARE Prime and TRICARE Select enrollees for care received from network providers for certain health care services that provide especially high value in terms of better health outcomes for patients. Authority for this includes section 706 and 729 of NDAA-17. This is also consistent with the four-year pilot program authority of section 701(h), but does not necessarily rely on that time-limited authority. Consistent with the intent of these sections, the Department also intends to use the authority of § 199.21(j)(3) of the TRICARE Pharmacy Benefits Program section of the TRICARE regulations to encourage use of high value medications by reducing or eliminating the copayment of selected medicines.

Third, consistent with section 718 of NDAA-17, the interim final rule provides that health care services covered by TRICARE and provided through the use of telehealth modalities are covered services to the same extent as if provided in person at the location of the patient if those services are medically necessary and appropriate for such modalities. The Director, DHA will establish standardized payment methods to reimburse for such services, and shall reduce or eliminate, as appropriate, beneficiary copayments or cost-shares for such services in cases in which a copayment would otherwise apply. This may be done by designating some telehealth services as high value services for which lower copays apply as well as the elimination of any beneficiary cost-sharing related to originating site fees when used to support the provision of telehealth services.

E. Changes to Health Plan Enrollment System

A fourth major change in the interim final rule is its implementation of the new statutory design for the health care enrollment system. Starting in calendar year 2018, beneficiaries other than active duty members and TRICARE-for-Life beneficiaries must elect to enroll in TRICARE Select or TRICARE Prime in order to be covered by the private sector care portion of TRICARE. While TRICARE-for-Life beneficiaries under the age of 65 are permitted to enroll in TRICARE Prime under limited circumstances, their failure to enroll will not affect their coverage by the private sector care portion of TRICARE. Enrollment will be done during an open season period prior to the beginning of

each plan year, which operates with the calendar year. An enrollment choice will be effective for the plan year. As an exception to the open season enrollment rule, enrollment changes can be made during the plan year for certain qualifying events, such as a change in eligibility status, marriage, divorce, birth of a new family member, relocation, loss of other health insurance, or other events.

Eligible Prime or Select beneficiaries who do not enroll will no longer have private sector care coverage under the TRICARE program (including the TRICARE retail pharmacy and mail order pharmacy programs) until the next open enrollment season 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 NDAA-17, to give beneficiaries another chance to adjust to this new requirement for annual enrollment. For the administrative convenience of beneficiaries, there are also procedures for automatic enrollment in Prime and Select for most active duty family members, and automatic renewal of enrollments of covered beneficiaries, subject to the opportunity to decline or cancel.

Due to a compressed implementation schedule that precludes an annual open season enrollment period in calendar year 2017 for existing TRICARE beneficiaries to elect or change their TRICARE coverage, the Department will convert existing TRICARE Standard coverage to TRICARE Select coverage effective January 1, 2018. All other existing TRICARE coverages will be renewed effective January 1, 2018. As noted previously, beneficiaries may elect to change their TRICARE coverage anytime during the limited grace period in calendar year 2018.

F. Additional Provisions of Interim Final Rule

The interim final rule has several other noteworthy provisions. First, there are no changes in benefits for TRICARE-for-Life beneficiaries, or generally in cost sharing levels for active duty family members. Second, although “TRICARE Standard” is terminated as a distinct TRICARE plan as of December 31, 2017, basic program benefits (as established under 32 CFR 199.4) continue under both TRICARE Prime and TRICARE Select. In addition, when a TRICARE Select beneficiary receives services covered by the basic program benefits from an authorized health care provider

who is not part of the TRICARE provider network, that care is covered by TRICARE as “out-of-network” care under terms that match the old TRICARE Standard plan. Third, in order to transition enrollment fees, deductibles, and catastrophic caps from a fiscal year basis to a calendar year basis, special rules apply for the last quarter of calendar year 2017, including that a Prime enrollee’s enrollment fee for the quarter is one-fourth of the enrollment fee for fiscal year 2017, and 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. A similar transition rule will apply to TRICARE for Life, TYA, TRR and TRS to align remaining program deductibles and/or catastrophic caps from a fiscal year to calendar year basis for consistency and ease of administration.

Additionally, the interim final rule adopts several changes to regulatory provisions applicable to the TYA, TRS, TRR, and TRDP programs to conform with new statutory requirements. In implementing section 701(a) of NDAA-17, together with section 701(j)(1)(F), the rule conforms the TYA regulation to the statutory language which established the eligibility of TYA under 10 U.S.C. 1110b to enroll in TRICARE Select and provided that the TYA premium shall apply instead of the otherwise applicable TRICARE Prime or Select enrollment fee. In implementing section 701(j)(1)(B), the rule conforms the TRICARE Reserve Select plan regulation to the statutory language which defines “TRICARE Reserve Select” as the TRICARE Select self-managed, preferred-provider network option under 10 U.S.C. 1075 made available to beneficiaries under 10 U.S.C. 1076d and requires payment of a premium for coverage instead of the TRICARE Select enrollment fee. In implementing section 701(j)(1)(C), the rule conforms the TRICARE Retired Reserve plan regulation to the statutory language which defines “TRICARE Retired Reserve” as the TRICARE Select self-managed, preferred-provider network option under 10 U.S.C. 1075 made available to beneficiaries under 10 U.S.C. 1076e and requires payment of a premium for coverage instead of the TRICARE Select enrollment fee. In implementing section 701(a) and 701(e), the rule conforms the CHCBP regulation to replace TRICARE Standard with TRICARE Select as the continuation health care benefit for Department of Defense and the other uniformed services beneficiaries losing eligibility.

In implementing section 715, the rule conforms the TRDP regulation to the statutory language which authorizes an interagency agreement between the Department of Defense and the Office of Personnel Management to allow beneficiaries otherwise eligible for the TRDP to enroll in a dental insurance plan offered under the Federal Employees Dental and Vision Insurance Program. Under the statute, TRDP beneficiaries will have the opportunity to access a dental plan with significantly higher annual maximum benefit and a lower premium cost than available under the current TRDP, while giving the Department an opportunity to eliminate costs associated with procuring and administering a separate TRDP contract.

Also, the interim final rule adopts several changes to regulatory provisions applicable to benefit coverage of medically necessary food and vitamins. Section 714 of NDAA-17 confirms long-standing TRICARE policy authorizing benefit coverage of medically necessary vitamins when prescribed for management of a covered disease or condition. In addition, while section 714 confirms long-standing TRICARE policy authorizing medical nutritional therapy coverage of medically necessary food and medical equipment/supplies necessary to administer such food when prescribed for dietary management of a covered disease or condition, the law also allows the medically necessary food benefit to include coverage of low protein modified foods. Consistent with this we also recognize the role of Nutritionists and Registered Dieticians in the appropriate planning for the use of medically necessary foods.

Additionally, the interim final rule adopts several conforming changes to regulatory provisions applicable to general TRICARE administration, the TRICARE Pharmacy Benefits Program and the Extended Health Care Option to reflect transition of deductibles, catastrophic caps, and program reimbursement limitations, as applicable, from a fiscal year basis to a calendar year basis for consistency and ease of administration. Simultaneously, technical corrections are being made to the TRICARE Pharmacy Benefits Program to conform regulation provisions to statutory provisions enacted by section 702 of the National

Defense Authorization Act for Fiscal Year 2016.

Finally, the interim final rule includes authority for the Director, DHA to establish preferred provider networks in areas outside the United States where it is determined to be economically in the best interests of the Department of Defense. As a result of the TRICARE Philippines Demonstration Project, which commenced in January 1, 2013, the Department has determined that the TRICARE contracted preferred provider network established in designated locations in the Philippines provided adequate access to beneficiaries with 97 percent of care delivered by network providers. It also successfully achieved the demonstration goals of reducing aberrant billing activities, reduced out-of-pocket expenses for beneficiaries, and increased overall beneficiary satisfaction while leading to a net savings to the government. Although the demonstration was projected to continue through December 31, 2018, the Philippines preferred provider network is determined to be economically in the interests of the Department of Defense and the demonstration shall terminate effective December 31, 2017, with transition of the demonstration's approved preferred provider network to a TRICARE Select preferred provider network effective January 1, 2018.

G. Recap: Cost Sharing Tables

The following two tables summarize beneficiary fees (including enrollment fees, deductibles, cost sharing amounts, and catastrophic loss protection limits) under TRICARE Select and TRICARE Prime for calendar year 2018. For future calendar years, all fees are subject to review and annual updating in accordance with sections 1075, 1075a, and 1097 of title 10, United States Code. Table 1 is for active duty family members (ADFM's); Table 2 is for retiree families. As a guide for understanding the tables:

> For services listed as "to be determined (TBD)", the Director, DHA will ensure the applicable fee for calendar year 2018 will be available at www.health.mil/rates before December 1, 2017.

> For services not specifically addressed in these tables, applicable cost-sharing requirements shall be

established by the Director, DHA and published annually.

> For services designated as "IN", the listed fee is for covered services or supplies obtained "in-network," meaning received from TRICARE authorized network providers.

> For TRICARE Prime beneficiaries, if covered services or supplies are not obtained in accordance with the rules and procedures of Prime (e.g., failure to obtain a required referral or unauthorized use of a non-network provider), the services or supplies will be reimbursed under a point-of-service option for which there is a deductible of \$300 per person or \$600 per family and a cost share of 50 percent of the allowable charges after the deductible.

> For services designated as "OON", the listed fee for TRICARE Select beneficiaries is for covered services or supplies obtained "out-of-network", meaning received from non-network TRICARE authorized providers.

> Certain preventive services have no cost sharing whether received from network or non-network providers. However, certain preventive services are not covered services for TRICARE Prime or Select beneficiaries unless obtained from network providers. Additionally, TRICARE Prime beneficiaries are required to obtain services in accordance with the rules and procedures of Prime to avoid point-of-service charges.

> Enrollment fees and deductibles are listed in the tables as individual/family, indicating the dollar amounts applicable per individual or per family.

> The criteria for fees associated with High Value Primary Care Outpatient Care and High Value Specialty Outpatient Care are under development but will be designed to encourage beneficiaries to receive health care services from high-value providers as highlighted in the contractor's network provider directory. When finalized, the fees will be made available at www.health.mil/rates.

> Inpatient subsistence refers to the rate charged for inpatient care obtained in a military treatment facility.

> "COLA" is the cost-of-living adjustment for retired pay under 10 U.S.C. 1401a by which certain fees are required to be annually indexed.

> "<" means less than; ≤ means less than or equal to.

TABLE 1—TRICARE SELECT AND TRICARE PRIME COST SHARING FOR ACTIVE DUTY FAMILY MEMBERS FOR CALENDAR YEAR 2018

	Select Group A ADFMs	Select Group B ADFMs	Prime Group A ADFMs	Prime Group B ADFMs
Annual Enrollment	\$0	\$0	\$0	\$0
Annual Deductible	E1–E4: \$50/\$100; E5 & above: \$150/\$300.	E1–E4: \$50/\$100; E5 & above: \$150/\$300.	0	0
Annual Catastrophic Cap	\$1,000	\$1,000	1,000	1,000
Preventive Care Outpatient Visit.	\$0	\$0	0	0
Primary Care Outpatient Visit ..	Fixed fee to = 15% of average allowable amount IN; 20% OON.	\$15 primary care IN; 20% OON.	0	0
Specialty Care Outpatient Visit	Fixed fee to = 15% of average allowable amount IN; 20% OON.	\$25 specialty care IN; 20% OON.	0	0
High-Value Primary Care Outpatient Visit.	Under Development; Less than normal primary care amount.	Under Development; Less than normal primary care amount.	0	0
High-Value Specialty Care Outpatient Visit.	Under Development; Less than normal primary care amount.	Under Development; Less than normal primary care amount.	0	0
Emergency Room Visit	Fixed fee to = 15% of average allowable amount IN; 20% OON.	\$40 IN; 20% OON	0	0
Urgent Care Center	Same as primary care outpatient amount IN; 20% OON.	\$20 IN; 20% OON	0	0
Ambulatory Surgery	\$25	\$25 IN; 20% OON	0	0
Ambulance Service (not including air).	Fixed fee to = 15% of average allowable amount IN; 20% OON.	\$15 IN; 20% OON	0	0
Durable Medical Equipment	15% IN; 20% OON	10% IN; 20% OON	0	0
Inpatient Hospital Admission ...	Subsistence charge/day, minimum \$25/admission.	\$60/admission IN; 20% OON ..	0	0
Inpatient Skilled Nursing/Rehab Facility.	Subsistence charge/day, minimum \$25/admission.	\$25/day IN; \$50/day OON	0	0

TABLE 2—TRICARE SELECT AND TRICARE PRIME COST SHARING FOR RETIREE FAMILIES FOR CALENDAR YEAR 2018

	Select Group A Retirees	Select Group B Retirees	Prime Group A Retirees	Prime Group B Retirees
Annual Enrollment	\$0 until 2021; \$150/\$300 in 2021 +COLA?	\$450/\$900	FY17 amount (\$282.60/\$565.20) +COLA.	\$350/\$700.
Annual Deductible	\$150/\$300	\$150/\$300 IN; \$300/\$600 OON	\$0	\$0.
Annual Catastrophic Cap	\$3,000 until 2021; \$3,500 in 2021.	\$3,500	\$3,000	\$3,500.
Preventive Care Visit	\$0	\$0	\$0	\$0.
Primary Care Outpatient Visit ..	Fixed fee that = 20% of average allowable amount IN; 25% OON.	\$25 primary IN; 25% OON	TBD, ≤\$20 primary	\$20 primary.
Specialty Care Outpatient Visit	Fixed fee that = 20% of average allowable amount IN; 25% OON.	\$40 specialty IN; 25% OON	TBD, ≤\$30 specialty	\$30 specialty.
High Value Primary Care OP Visit.	Under Development; <normal primary care amount.	Under Development; <normal primary care amount.	Under Development; <normal primary care amount.	Under Development; <normal primary care amount.
High Value Specialty Care OP Visit.	Under Development; <normal specialty care amount.	Under Development; <normal specialty care amount.	Under Development; <normal specialty care amount.	Under Development; <normal specialty care amount.
Emergency Room Visit	Fixed fee that = 20% of average allowable amount IN; 25% OON.	\$80 IN; 25% OON	TBD, ≤\$60	\$60.
Urgent Care Center	Same as primary care outpatient amount IN; 25% OON.	\$40 IN; 25% OON	TBD, ≤\$30	\$30.
Ambulatory Surgery	20% IN; 25% OON	\$95 IN; 25% OON	TBD, ≤\$60	\$60.
Ambulance Service (not including air).	Fixed fee that = 20% of average allowable amount IN; 25% OON.	\$60 IN; 25% OON	TBD, ≤\$40	\$40.
Durable Med. Equip	20% IN; 25% OON	20% IN; 25% OON	20%	20%.
Inpatient Admission	\$250/day up to 25% hosp. charge + 20% separately billed services IN; 25% OON.	\$175/admission IN; 25% OON	TBD, ≤\$150/admission	\$150/admission.
Inpatient Skilled Nursing/Rehab Admission.	\$250/day up to 25% hospital charge + 20% separately billed services IN; 25% OON.	\$50/day IN; Lesser of \$300/day or 20% OON.	TBD, ≤\$30/day	\$30/day.

III. Regulatory Procedures

Public Comments Invited

This is being issued as an interim final rule in order to comply with

statutory specifications regarding effective dates of changes to TRICARE as a health care entitlement program. For example, the change from a fiscal year-based TRICARE plan year for

purposes of enrollment fees, deductibles, and catastrophic caps to a calendar year-based TRICARE plan year requires that this regulation be in place by October 1, 2017. Many other changes

must be in place by January 1, 2018, including the operation of TRICARE Select to replace TRICARE Extra and TRICARE Standard, which DoD no longer has authority to operate as of that date. In view of the statutory effective dates of the substantial changes in TRICARE, the Department finds that obtaining public comment in advance of issuing this rule is impracticable, unnecessary, and contrary to the public interest. Nonetheless, DoD invites public comments on this rule and is committed to considering all comments and issuing a final rule as soon as practicable.

Executive Order (E.O.) 13771, "Reducing Regulation and Controlling Regulatory Costs"

E.O. 13771 seeks to control costs associated with the government imposition of private expenditures required to comply with Federal regulations and to reduce regulations that impose such costs. Consistent with the analysis of transfer payments under OMB Circular A-4, this interim final rule does not involve regulatory costs subject to E.O. 13771.

Executive Order 12866, "Regulatory Planning and Review" and Executive Order 13563, "Improving Regulation and Regulatory Review"

Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distribute impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This interim final rule has been designated "significant regulatory action," although not economically significant, under section 3(f) of Executive Order 12866. Accordingly, this rule has been reviewed by the Office of Management and Budget (OMB).

Congressional Review Act, 5 U.S.C. 804(2)

Under the Congressional Review Act, a major rule may not take effect until at least 60 days after submission to Congress of a report regarding the rule. A major rule is one that would have an annual effect on the economy of \$100 million or more or have certain other impacts. This interim final rule is not a major rule under the Congressional Review Act.

Public Law 96-354, "Regulatory Flexibility Act" (RFA), (5 U.S.C. 601)

The Regulatory Flexibility Act requires that each Federal agency analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. This interim final rule is not an economically significant regulatory action, and it will not have a significant impact on a substantial number of small entities. Therefore, this rule is not subject to the requirements of the RFA.

Public Law 104-4, Sec. 202, "Unfunded Mandates Reform Act"

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$140 million. This interim final rule will not mandate any requirements for state, local, or tribal governments or the private sector.

Public Law 96-511, "Paperwork Reduction Act" (44 U.S.C. Chapter 35)

This rulemaking does not contain a "collection of information" requirement, and will not impose additional information collection requirements on the public under Public Law 96-511, "Paperwork Reduction Act" (44 U.S.C. Chapter 35).

Executive Order 13132, "Federalism"

This interim final rule has been examined for its impact under E.O. 13132, and it does not contain policies that have federalism implications that would have substantial direct effects on the States, on the relationship between the national Government and the States, or on the distribution of powers and responsibilities among the various levels of Government. Therefore, consultation with State and local officials is not required.

List of Subjects in 32 CFR Part 199

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, Mental health, Mental health parity, Military personnel.

For the reasons stated in the preamble, the Department of Defense amends 32 CFR part 199 as set forth below:

PART 199—CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

■ 1. The authority citation for part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55.

■ 2. In § 199.2, paragraph (b) is amended by:

■ a. Revising the definitions of "Basic program," "Deductible," "Deductible certificate," "Former member," and "Member."

■ b. Adding the definitions of "Program year" and "Retired category" in alphabetical order.

■ c. Revising the definition of "Retiree."

■ d. Adding the definition of "TRICARE Extra" in alphabetical order.

■ e. Removing the definition of "TRICARE extra plan."

■ f. Adding the definition of "TRICARE for Life" and "TRICARE Prime" in alphabetical order.

■ g. Removing the definition of "TRICARE prime plan."

■ h. Revising the definitions of "TRICARE program" and "TRICARE Retired Reserve."

■ i. Adding the definitions of "TRICARE Select" and "TRICARE Standard" in alphabetical order.

■ j. Removing the definition of "TRICARE standard plan."

The revisions and additions read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

Basic program. The primary medical benefits set forth in § 199.4, generally referred to as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as authorized under chapter 55 of title 10 United States Code, were made available to eligible beneficiaries under this part.

* * * * *

Deductible. Payment by an individual beneficiary or family of a specific first dollar amount of the TRICARE allowable amount for otherwise covered outpatient services or supplies obtained in any program year. The dollar amount of deductible per individual or family is calculated as specified by law.

Deductible certificate. A statement issued to the beneficiary (or sponsor) by a TRICARE contractor certifying to deductible amounts satisfied by a beneficiary for any applicable program year.

* * * * *

Former member. An individual who is eligible for, or entitled to, retired pay, at age 60, for non-Regular service in

accordance with chapter 1223, title 10, United States Code but who has been discharged and who maintains no military affiliation. These former members, at age 60, and their eligible dependents are entitled to medical care, commissary, exchange, and MWR privileges. Under age 60, they and their eligible dependents are entitled to commissary, exchange, and MWR privileges only.

* * * * *

Member. An individual who is affiliated with a Service, either an active duty member, Reserve member, active duty retired member, or Retired Reserve member. Members in a retired status are not former members. Also referred to as the sponsor.

* * * * *

Program year. The appropriate year (e.g., calendar year, fiscal year, rolling 12-month period, etc.) specified in the administration of TRICARE programs for application of unique requirements or limitations (e.g., enrollment fees, deductibles, catastrophic loss protection, etc.) on covered health care services obtained or provided during the designated time period.

* * * * *

Retired category. Retirees and their family members who are beneficiaries covered by 10 U.S.C. 1086(c), other than Medicare-eligible beneficiaries as described in 10 U.S.C. 1086(d).

Retiree. For ease of reference in this part only, and except as otherwise specified in this part, the term means a member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

* * * * *

TRICARE Extra. The preferred-provider option of the TRICARE program made available prior to January 1, 2018, under which TRICARE Standard beneficiaries may obtain discounts on cost sharing as a result of using TRICARE network providers.

TRICARE for Life. The Medicare wraparound coverage option of the TRICARE program made available to an eligible beneficiary by reason of 10 U.S.C. 1086(d).

* * * * *

TRICARE Prime. The managed care option of the TRICARE program established under § 199.17.

TRICARE program. The program established under § 199.17.

* * * * *

TRICARE Retired Reserve. The program established under 10 U.S.C. 1076e and § 199.25.

* * * * *

TRICARE Select. The self-managed, preferred-provider network option under the TRICARE Program established by 10 U.S.C. 1075 and § 199.17 to replace TRICARE Extra and Standard after December 31, 2017.

TRICARE Standard. The TRICARE program made available prior to January 1, 2018, under which the basic program of health care benefits generally referred to as CHAMPUS was made available to eligible beneficiaries under this part.

* * * * *

- 3. Section 199.4 is amended by:
 - a. Adding paragraph (c)(1)(iii);
 - b. Revising paragraph (d)(3)(iii);
 - c. Adding paragraph (d)(3)(vi)(D);
 - d. Revising paragraph (e)(28)(iv);
 - e. Adding paragraph (e)(28)(v);
 - f. Removing the words “fiscal year” everywhere they appear and adding in their place the words “calendar year” in paragraphs (f)(2) through (4) and (10);
 - g. Adding paragraph (f)(13);
 - h. Revising paragraph (g)(39) introductory text and adding paragraph (g)(39)(v).
 - i. Revising paragraph (g)(57).

The revisions and additions read as follows:

§ 199.4 Basic program benefits.

* * * * *

- (c) * * *
- (1) * * *

(iii) **Telehealth services.** Health care services covered by TRICARE and provided through the use of telehealth modalities are covered services to the same extent as if provided in person at the location of the patient if those services are medically necessary and appropriate for such modalities. The Director will establish special procedures for payment for such services. Additionally, where appropriate, in order to incentive the use of telehealth services, the Director may modify the otherwise applicable beneficiary cost-sharing requirements in paragraph (f) of this section which otherwise apply.

* * * * *

- (d) * * *
- (3) * * *

(iii) **Medical supplies and dressings (consumables)**—(A) *In general.* In general, medical supplies and dressings (consumables) are those that do not withstand prolonged, repeated use. Such items must be related directly to an appropriate and verified covered medical condition of the specific beneficiary for whom the item was purchased and obtained from a medical supply company, a pharmacy, or authorized institutional provider. Examples of covered medical supplies

and dressings are disposable syringes for a known diabetic, colostomy sets, irrigation sets, and elastic bandages. An external surgical garment specifically designed for use follow a mastectomy is considered a medical supply item.

Note 1 to paragraph (d)(3)(iii)(A): Generally, the allowable charge of a medical supply item will be under \$100. Any item over this amount must be reviewed to determine whether it would qualify as a DME item. If it is, in fact, a medical supply item and does not represent an excessive charge, it can be considered for benefits under paragraph (d)(3)(iii) of this section.

(B) **Medically necessary food and medical equipment and supplies necessary to administer such food (other than durable medical equipment and supplies) when prescribed for dietary management of a covered disease or condition.** (1) Medically necessary food, including a low protein modified food product or an amino acid preparation product, may be covered when:

(i) Furnished pursuant to the prescription, order, or recommendation of a TRICARE authorized provider acting within the provider’s scope of license/certificate of practice, for the dietary management of a covered disease or condition;

(ii) Is a specifically formulated and processed product (as opposed to a naturally occurring foodstuff used in its natural state) for the partial or exclusive feeding of an individual by means of oral intake or enteral feeding by tube;

(iii) Is intended for the dietary management of an individual who, because of therapeutic or chronic medical needs, has limited or impaired capacity to ingest, digest, absorb, or metabolize ordinary foodstuffs or certain nutrients, or who has other special medically determined nutrient requirements, the dietary management of which cannot be achieved by the modification of the normal diet alone;

(iv) Is intended to be used under medical supervision, which may include in a home setting; and

(v) Is intended only for an individual receiving active and ongoing medical supervision under which the individual requires medical care on a recurring basis for, among other things, instructions on the use of the food.

(2) Medically necessary food does not include:

(i) Food taken as part of an overall diet designed to reduce the risk of a disease or medical condition or as weight-loss products, even if the food is recommended by a physician or other health care professional;

(ii) Food marketed as gluten-free for the management of celiac disease or non-celiac gluten sensitivity;

(iii) Food marketed for the management of diabetes; or

(iv) Such other products as the Director, Defense Health Agency determines appropriate.

(3) Covered disease or condition under paragraph (d)(3)(iii)(B) of this section means:

(i) Inborn errors of metabolism;

(ii) Medical conditions of malabsorption;

(iii) Pathologies of the alimentary tract or the gastrointestinal tract;

(iv) A neurological or physiological condition; and

(v) Such other diseases or conditions the Director, Defense Health Agency determines appropriate.

* * * * *

(vi) * * *

(D) Medically necessary vitamins used for the management of a covered disease or condition pursuant to a prescription, order, or recommendation of a TRICARE authorized provider acting within the provider's scope of license/certificate of practice. For purposes of this paragraph (d)(3)(vi)(D), the term "covered disease or condition" means:

(1) Inborn errors of metabolism;

(2) Medical conditions of malabsorption;

(3) Pathologies of the alimentary tract or the gastrointestinal tract;

(4) A neurological or physiological condition;

(5) Pregnancy in relation to prenatal vitamins, with the limitation the prenatal vitamins that require a prescription in the United States may be covered for prenatal care only;

(6) Such other disease or conditions the Director, Defense Health Agency determines appropriate.

* * * * *

(e) * * *

(28) * * *

(iv) Health promotion and disease prevention visits (which may include all of the services provided pursuant to § 199.17(f)(2)) for beneficiaries 6 years of age or older may be provided in connection with immunizations and cancer screening examinations authorized by paragraphs (e)(28)(i) and (ii) of this section).

(v) Breastfeeding support, supplies (including breast pumps and associated equipment), and counseling.

* * * * *

(f) * * *

(13) *Special transition rule for the last quarter of calendar year 2017.* In order to transition deductibles and catastrophic caps from a fiscal year basis to a calendar year basis, the deductible amount and the catastrophic cap

amount specified in paragraph (f) of this section will be applicable to the 15-month period of October 1, 2016 through December 31, 2017.

(g) * * *

(39) *Counseling.* Educational, vocational, non-medical nutritional counseling, counseling for socioeconomic purposes, stress management, and/or lifestyle modification purposes, except the following are not excluded:

* * * * *

(v) Medical nutritional therapy (also referred to as medical nutritional counseling) required in the administration of the medically necessary foods, services and supplies authorized in paragraph (d)(3)(iii)(B) of this section, medically necessary vitamins authorized in paragraph (d)(3)(vi)(D) of this section, or when medically necessary for other authorized covered services.

* * * * *

(57) *Food, food substitutes.* Food, food substitutes, vitamins, or other nutritional supplements, including those related to prenatal care, except as authorized in paragraphs (d)(3)(iii)(B) and (d)(3)(vi)(D) of this section.

* * * * *

■ 4. Section 199.5 is amended by:

■ a. Removing the words "fiscal year" everywhere they appear and adding in their place the words "program year" in paragraphs (c)(7)(iii), (f)(3), (g)(2)(i), and (h)(3)(v)(A); and

■ b. Adding paragraph (a)(3).

The addition reads as follows:

§ 199.5 TRICARE Extended Health Care Option (ECHO).

(a) * * *

(3) The Government's cost-share for ECHO or ECHO home health benefits during any program year is limited as stated in this section. In order to transition the program year from a fiscal year to a calendar year basis, the Government's annual cost-share limitation specified in paragraph (f) of this section shall be prorated for the last quarter of calendar year 2018 as authorized by 10 U.S.C. 1079(f)(2)(A).

* * * * *

■ 5. Section 199.6 is amended by revising paragraphs (c)(3)(iii)(L) and (M) to read as follows:

§ 199.6 TRICARE-authorized providers.

* * * * *

(c) * * *

(3) * * *

(iii) * * *

(L) *Nutritionist.* The nutritionist must be licensed by the State in which the care is provided and must be under the

supervision of a physician who is overseeing the episode of treatment or the covered program of services.

(M) *Registered dietician.* The dietician must be licensed by the State in which the care is provided and must be under the supervision of a physician who is overseeing the episode of treatment or the covered program of services.

* * * * *

§ 199.7 [Amended]

■ 6. Section 199.7(a)(6) is amended by removing the words "fiscal year" everywhere they appear and adding in their place the words "calendar year".

§ 199.8 [Amended]

■ 7. Section 199.8(d)(1)(v) is amended by removing "Sec. 199.4(f)(10)" and adding in its place "§ 199.4(f)(10)" and removing the words "fiscal year" and adding in their place the words "calendar year".

■ 8. Section 199.11 is amended by revising paragraph (a) to read as follows:

§ 199.11 Overpayments recovery.

(a) *General.* Actions to recover overpayments arise when the government has a right to recover money, funds, or property from any person, partnership, association, corporation, governmental body or other legal entity, foreign or domestic, except another Federal agency, because of an erroneous payment of benefits under both CHAMPUS and the TRICARE program under this part. The term "Civilian Health and Medical Program of the Uniformed Services" (CHAMPUS) is defined in 10 U.S.C. 1072(2), referred to as the CHAMPUS basic program. Prior to January 1, 2018, the term "TRICARE program" referred to the triple-option of health benefits known as TRICARE Prime, TRICARE Extra, and TRICARE Standard. Specifically, TRICARE Standard was the TRICARE program under which the basic program of health care benefits generally referred to as CHAMPUS was made available to eligible beneficiaries under this Part 199. Effective January 1, 2018, the term "TRICARE program" is defined in 10 U.S.C. 1072(2) and includes TRICARE Prime, TRICARE Select and TRICARE for Life. It is the purpose of this section to prescribe procedures for investigation, determination, assertion, collection, compromise, waiver and termination of claims in favor of the United States for erroneous benefit payments arising out of the administration CHAMPUS and the TRICARE program. For the purpose of this section, references herein to TRICARE beneficiaries, claims, benefits,

payments, or appeals shall include CHAMPUS beneficiaries, claims, benefits, payments, or appeals. A claim against several joint debtors arising from a single incident or transaction is considered one claim. The Director, or a designee, may pursue collection against all joint debtors and is not required to allocate the burden of payment between debtors.

* * * * *

■ 9. Section 199.17 is revised to read as follows.

§ 199.17 TRICARE program.

(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 pre-authorizations 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 § 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 §§ 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 § 199.4. While the law required termination of TRICARE Standard as a distinct TRICARE plan December 31, 2017, the CHAMPUS basic program benefits under § 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 beneficiaries 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 § 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 § 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 one-half of such dependent's support.

(4) *Retirees, 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. Additionally, 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 § 199.16.

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

(e) *Health benefits under the TRICARE Select plan*—(1) *Civilian sector care.* The health benefits under TRICARE Select for enrolled beneficiaries received from civilian providers are those under § 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 § 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 National Defense Authorization Act for Fiscal Year 2017, 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 paragraph (f)(5) of this section may be associated with actions taken for high value medications under § 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 § 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 § 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 § 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 § 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 § 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 §§ 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 § 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 §§ 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 § 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 § 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 enrollees, the enrollment fee, catastrophic cap and cost sharing amounts are as set forth in 10 U.S.C. 1075a.

(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 § 199.4.

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

(ii) For Group B 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.

(3) *Special cost-sharing rules.* (A) 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.

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

(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.

(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 pre-authorization 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 § 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)(iv) 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.

(iv) When Prime is operating in non-catchment 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 § 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 issued 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 re-enrollment 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 disenrolls 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 disenrolled 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 who 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 § 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 § 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 § 199.4, subject to the applicable catastrophic cap, deductibles and cost-shares under § 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.

§ 199.18 [Removed and Reserved]

- 10. Section 199.18 is removed and reserved.
- 11. Section 199.20 is amended by:
 - a. Revising paragraph (a);
 - b. Removing the words "TRICARE Standard program" and adding in their place the words "TRICARE Select program" in paragraph (c);
 - c. Revising paragraphs (d)(7)(i)(D) introductory text, (d)(7)(i)(D)(1) and (2), and (e)(1) and (3);
 - d. Removing the words "TRICARE Standard" and adding in their place the words "TRICARE Select program" in paragraphs (f) through (n);
 - e. Removing and reserving paragraph (o);
 - f. Revising paragraph (p)(1);

- g. Removing the semicolon at the end of paragraph (p)(2)(iii) and adding ";" and " in its place;
- h. Revising paragraph (p)(2)(iv); and
- i. Removing paragraph (p)(2)(v).

The revisions and additions read as follows:

§ 199.20 Continued Health Care Benefit Program (CHCBP).

(a) *Purpose*. The CHCBP is a premium-based temporary health care coverage program, authorized by 10 U.S.C. 1078a, and available to individuals who meet the eligibility and enrollment criteria as set forth in paragraph (d)(1) of this section. The CHCBP is not part of the TRICARE program. However, as set forth in this section, it functions under similar rules and procedures to the TRICARE Select program. Because the purpose of the CHCBP is to provide a continuation health care benefit for Department of Defense and the other uniformed services beneficiaries losing eligibility, it will be administered so that it appears, to the maximum extent practicable, to be part of the TRICARE Select program. Medical coverage under this program will be the same as the benefits payable under the TRICARE Select program. There is a cost for enrollment to the CHCBP and these premium costs must be paid by CHCBP enrollees before any care may be cost shared.

* * * * *

(d) * * *

(7) * * *

(i) * * *

(D) In the case of a former spouse of a member or former member (other than the former spouse whose marriage was dissolved after the separation of the member from the service unless such separation was by retirement), the period of coverage under the CHCBP is unlimited, if former spouse:

(1) Has not remarried before age of 55 after the marriage to the member or former member was dissolved; and

(2) Was eligible for TRICARE as a dependent or enrolled in CHCBP at any time during the 18 month period before the date of the divorce, dissolution, or annulment; and

* * * * *

(e) * * *

(1) *In general*. Except as provided in paragraph (e)(2) of this section, the provisions of § 199.4 shall apply to the CHCBP as they do to TRICARE Select under § 199.17.

* * * * *

(3) *Beneficiary liability*. For purposes of CHCBP coverage, the beneficiary deductible, catastrophic cap and cost

share provisions of the TRICARE Select plan applicable to Group B beneficiaries under § 199.17(l)(2)(ii) shall apply based on the category of beneficiary (e.g., Active Duty Family Member or Retiree Family) to which the CHCBP enrollee last belonged, except that for separating active duty members, amounts applicable to TRICARE Select Active Duty Family Members shall apply. The premium under paragraph (q) of this section applies instead of any TRICARE Select plan enrollment fee under § 199.17.

* * * * *

(p) * * * (1) *In general.* Special programs established under this part that are not part of the TRICARE Select program are not, unless specifically provided in this section, available to participants in the CHCBP.

(2) * * *

(iv) The TRICARE Prime Program under § 199.17.

* * * * *

■ 12. Section 199.21 is amended by:

■ a. Revising paragraphs (i)(2) introductory text and (i)(2)(i) through (iv);

■ b. Removing and reserving paragraph (i)(2)(v); and

■ c. Revising paragraphs (i)(2)(vi) through (viii) and (i)(2)(x)(A).

The revisions read as follows:

§ 199.21 TRICARE Pharmacy Benefits Program.

* * * * *

(i) * * * (2) *Cost-sharing amounts.* Active duty members of the uniformed services do not pay cost-shares or annual deductibles. For other categories of beneficiaries, after applicable annual deductibles are met, cost-sharing amounts prior to October 1, 2016, are set forth in this paragraph (i)(2).

(i) For pharmaceutical agents obtained from a military treatment facility, there is no cost-sharing or annual deductible.

(ii) For pharmaceutical agents obtained from a retail network pharmacy there is a:

(A) \$24.00 cost-share per prescription required for up to a 30-day supply of a formulary pharmaceutical agent.

(B) \$10.00 cost-share per prescription for up to a 30-day supply of a generic pharmaceutical agent.

(C) \$0.00 cost-share for vaccines/immunizations authorized as preventive care for eligible beneficiaries.

(iii) For formulary and generic pharmaceutical agents obtained from a retail non-network pharmacy, except as provided in paragraph (i)(2)(vi) of this section, there is a 20 percent or \$20.00

cost-share (whichever is greater) per prescription for up to a 30-day supply of the pharmaceutical agent.

(iv) For pharmaceutical agents obtained under the TRICARE mail-order program there is a:

(A) \$20 cost-share per prescription for up to a 90-day supply of a formulary pharmaceutical agent.

(B) \$0.00 cost-share for up to a 90-day supply of a generic pharmaceutical agent.

(C) \$49.00 cost-share for up to a 90-day supply of a non-formulary pharmaceutical agent.

(D) \$0.00 cost-share for smoking cessation pharmaceutical agents covered under the smoking cessation program.

(vi) For TRICARE Prime beneficiaries there is no annual deductible applicable for pharmaceutical agents obtained from retail network pharmacies or the TRICARE mail-order program. However, for TRICARE Prime beneficiaries who obtain formulary or generic pharmaceutical agents from retail non-network pharmacies, an enrollment year deductible of \$300 per person and \$600 per family must be met after which there is a beneficiary cost-share of 50 percent per prescription for up to a 30-day supply of the pharmaceutical agent.

(vii) For TRICARE Select beneficiaries the annual deductible which must be met before the cost-sharing amounts for pharmaceutical agents in paragraph (i)(2) of this section are applicable is as provided for each category of TRICARE Select enrollee in § 199.17(l)(2).

(viii) For TRICARE beneficiaries not otherwise qualified to enroll in TRICARE Prime or Select, the annual deductible which must be met before the cost-sharing amounts for pharmaceutical agents in paragraph (i)(2) of this section are applicable is as provided in § 199.4(f).

* * * * *

(x) * * *

(A) Beginning October 1, 2016, the amounts specified in this paragraph (i)(2) shall be increased annually by the percentage increase in the cost-of-living adjustment by which retired pay is increased under 10 U.S.C. 1401a for the year. If the amount of the increase is equal to or greater than 50 cents, the amount of the increase shall be rounded to the nearest multiple of \$1. If the amount of the increase is less than 50 cents, the increase shall not be made for that year, but shall be carried over to, and accumulated with, the amount of the increase for the subsequent year or years and made when the aggregate amount of increases for a year is equal to or greater than 50 cents.

* * * * *

■ 13. In § 199.22, paragraph (a) is revised to read as follows:

§ 199.22 TRICARE Retiree Dental Program (TRDP).

(a) *Establishment.* The TRDP is a premium based indemnity dental insurance coverage program that will be available to certain retirees and their surviving spouses, their dependents, and certain other beneficiaries, as specified in paragraph (d) of this section. The TRDP is authorized by 10 U.S.C. 1076c.

(1) The Director will, except as authorized in paragraph (a)(2) of this section, make available a premium based indemnity dental insurance plan for eligible TRDP beneficiaries specified in paragraph (d) of this section consistent with the provisions of this section.

(2) The TRDP premium based indemnity dental insurance program under paragraph (a) of this section may be provided by allowing eligible beneficiaries specified in paragraph (d) of this section to enroll in an insurance plan under chapter 89A of title 5, United States Code that provides benefits similar to those benefits provided under paragraph (f) of this section. Such enrollment shall be authorized pursuant to an agreement entered into between the Department of Defense and the Office of Personnel Management which agreement, in the event of any inconsistency, shall take precedence over provisions in this section.

* * * * *

■ 14. Section 199.24 is amended by revising paragraphs (a) introductory text, (a)(4)(i) heading, (a)(4)(i)(A), (a)(4)(iv), (c) introductory text, (d) introductory text, (d)(1)(ii) and (iii), (d)(2) and (3), (f), and (g)(1) to read as follows:

§ 199.24 TRICARE Reserve Select.

(a) *Establishment.* TRICARE Reserve Select offers the TRICARE Select self-managed, preferred-provider network option under § 199.17 to qualified members of the Selected Reserve, their immediate family members, and qualified survivors under this section.

* * * * *

(4) * * *

(i) *TRICARE Select rules applicable.* (A) Unless specified in this section or otherwise prescribed by the Director, provisions of TRICARE Select under § 199.17 apply to TRICARE Reserve Select.

* * * * *

(iv) *Benefits.* When their coverage becomes effective, TRICARE Reserve

Select beneficiaries receive the TRICARE Select benefit including access to military treatment facility services and pharmacies, as described in §§ 199.17 and 199.21. TRICARE Reserve Select coverage features the deductible, catastrophic cap and cost share provisions of the TRICARE Select plan applicable to Group B active duty family members under § 199.17(l)(2)(ii) for both the member and the member's covered family members; however, the TRICARE Reserve Select premium under paragraph (c) of this section applies instead of any TRICARE Select plan enrollment fee under § 199.17. Both the member and the member's covered family members are provided access priority for care in military treatment facilities on the same basis as active duty service members' dependents who are not enrolled in TRICARE Prime as described in § 199.17(d)(1)(i)(D).

* * * * *

(c) *TRICARE Reserve Select premiums.* Members are charge premiums for coverage under TRICARE Reserve Select that represent 28 percent of the total annual premium amount that the Director determines on an appropriate actuarial basis as being appropriate for coverage under the TRICARE Select benefit for the TRICARE Reserve Select eligible population. Premiums are to be paid monthly, except as otherwise provided through administrative implementation, pursuant to procedures established by the Director. The monthly rate for each month of a calendar year is one-twelfth of the annual rate for that calendar year.

* * * * *

(d) *Procedures.* The Director may establish procedures for the following.

(1) * * *

(ii) *Qualifying event.* Procedures for qualifying events in TRICARE Select plans under § 199.17(o) shall apply to TRICARE Reserve Select coverage. Additionally, the Director may identify other events unique to needs of the Reserve Components as qualifying events.

(iii) *Enrollment.* Procedures for enrollment in TRICARE Select plans under § 199.17(o) shall apply to TRICARE Reserve Select enrollment. Generally, the effective date of coverage will coincide with the first day of a month unless enrollment is due to a qualifying event and a different date on or after the qualifying event is required to prevent a lapse in health care coverage.

* * * * *

(2) *Termination.* Termination of coverage for the TRS member/survivor will result in termination of coverage for

the member's/survivor's family members in TRICARE Reserve Select. Procedures may be established for coverage to be terminated as follows.

(i) Coverage shall terminate when members or survivors no longer qualify for TRICARE Reserve Select as specified in paragraph (b) of this section, with one exception. If a member is involuntarily separated from the Selected Reserve under other than adverse conditions, as characterized by the Secretary concerned, and is covered by TRICARE Reserve Select on the last day of his or her membership in the Selected Reserve, then TRICARE Reserve Select coverage may terminate up to 180 days after the date on which the member was separated from the Selected Reserve. This applies regardless of type of coverage. This exception expires December 31, 2018.

(ii) Coverage may terminate for members, former members, and survivors who gain coverage under another TRICARE program.

(iii) In accordance with the provisions of § 199.17(o)(2) coverage terminates for members/survivors who fail to make premium payments in accordance with established procedures.

(iv) Coverage may be terminated for members/survivors upon request at any time by submitting a completed request in the appropriate format in accordance with established procedures.

(3) *Re-enrollment following termination.* Absent a new qualifying event, members/survivors (subject to paragraph (d)(1)(iv) of this section) are not eligible to re-enroll in TRICARE Reserve Select until the next annual open season.

* * * * *

(f) *Administration.* The Director may establish other rules and procedures for the effective administration of TRICARE Reserve Select, and may authorize exceptions to requirements of this section, if permitted by law.

(g) * * *

(1) *Coverage.* This term means the medical benefits covered under the TRICARE Select program as further outlined in § 199.17 whether delivered in military treatment facilities or purchased from civilian sources.

* * * * *

■ 15. Section 199.25 is amended by revising paragraphs (a) introductory text, (a)(4)(i) heading, (a)(4)(i)(A), (a)(4)(iv), (c) introductory text, (d) introductory text, (d)(1)(ii) and (iii), (d)(2) and (3), (f), and (g)(1) to read as follows:

§ 199.25 TRICARE Retired Reserve.

(a) *Establishment.* TRICARE Retired Reserve offers the TRICARE Select self-

managed, preferred-provider network option under § 199.17 to qualified members of the Retired Reserve, their immediate family members, and qualified survivors under this section.

* * * * *

(4) * * *

(i) *TRICARE Select rules applicable.*

(A) Unless specified in this section or otherwise prescribed by the ASD (HA), provisions of TRICARE Select under § 199.17 apply to TRICARE Retired Reserve.

* * * * *

(iv) *Benefits.* When their coverage becomes effective, TRICARE Retired Reserve beneficiaries receive the TRICARE Select benefit including access to military treatment facilities on a space available basis and pharmacies, as described in § 199.17. TRICARE Retired Reserve coverage features the deductible, cost sharing, and catastrophic cap provisions of the TRICARE Select plan applicable to Group B retired members and dependents of retired members under § 199.17(l)(2)(ii); however, the TRICARE Reserve Select premium under paragraph (c) of this section applies instead of any TRICARE Select plan enrollment fee under § 199.17. Both the member and the member's covered family members are provided access priority for care in military treatment facilities on the same basis as retired members and their dependents who are not enrolled in TRICARE Prime as described in § 199.17(d)(1)(i)(E).

* * * * *

(c) *TRICARE Retired Reserve premiums.* Members are charged for coverage under TRICARE Retired Reserve that represent the full cost of the program as determined by the Director utilizing an appropriate actuarial basis for the provision of the benefits provided under the TRICARE Select program for the TRICARE Retired Reserve eligible beneficiary population. Premiums are to be paid monthly, except as otherwise provided through administrative implementation, pursuant to procedures established by the Director. The monthly rate for each month of a calendar year is one-twelfth of the annual rate for that calendar year.

* * * * *

(d) *Procedures.* The Director may establish procedures for the following.

(1) * * *

(ii) *Qualifying event.* Procedures for qualifying events in TRICARE Select plans under § 199.17(o) shall apply to TRICARE Retired Reserve coverage.

(iii) *Enrollment.* Procedures for enrollment in TRICARE Select plans under § 199.17(o) shall apply to

TRICARE Retired Reserve enrollment. Generally, the effective date of coverage will coincide with the first day of a month unless enrollment is due to a qualifying event and a different date on or after the qualifying event is required to prevent a lapse in health care coverage.

* * * * *

(2) *Termination.* Termination of coverage for the TRR member/survivor will result in termination of coverage for the member's/survivor's family members in TRICARE Retired Reserve. Procedures may be established for coverage to be terminated as follows.

(i) Coverage shall terminate when members or survivors no longer qualify for TRICARE Retired Reserve as specified in paragraph (c) of this section. For purposes of this section, the member or their survivor no longer qualifies for TRICARE Retired Reserve when the member has been eligible for coverage in a health benefits plan under Chapter 89 of Title 5, U.S.C. for more than 60 days. Further, coverage shall terminate when the Retired Reserve member attains the age of 60 or, if survivor coverage is in effect, when the deceased Retired Reserve member would have attained the age of 60.

(ii) Coverage may terminate for members, former members, and survivors who gain coverage under another TRICARE program.

(iii) In accordance with the provisions of § 199.17(o)(2) coverage terminates for members/survivors who fail to make premium payments in accordance with established procedures.

(iv) Coverage may be terminated for members/survivors upon request at any time by submitting a completed request in the appropriate format in accordance with established procedures.

(3) *Re-enrollment following termination.* Absent a new qualifying event, members/survivors are not eligible to re-enroll in TRICARE Retired Reserve until the next annual open season.

* * * * *

(f) *Administration.* The Director may establish other rules and procedures for the effective administration of TRICARE Retired Reserve, and may authorize exceptions to requirements of this section, if permitted by law.

(g) * * *

(1) *Coverage.* This term means the medical benefits covered under the TRICARE Select program as further outlined in § 199.17 whether delivered in military treatment facilities or purchased from civilian sources.

* * * * *

■ 16. Section 199.26 is amended by:

- a. Revising paragraphs (a) introductory text, (a)(4)(i)(C), (a)(4)(i)(D) introductory text, and (a)(4)(ii) and (iv);
- b. Removing paragraph (a)(4)(v);
- c. Revising paragraphs (c) introductory text, (d) introductory text, and (d)(1)(ii);
- d. Removing paragraph (d)(1)(iii);
- e. Revising paragraphs (d)(2) introductory text, (d)(2)(v), (vi), and (vii), and (f); and
- f. Removing paragraph (g).

The revisions read as follows:

§ 199.26 TRICARE Young Adult.

(a) *Establishment.* The TRICARE Young Adult (TYA) program offers options of medical benefits provided under the TRICARE program to qualified unmarried adult children of TRICARE-eligible uniformed service sponsors who do not otherwise have eligibility for medical coverage under a TRICARE program at age 21 (23 if enrolled in a full-time course of study at an approved institution of higher learning, and the sponsor provides over 50 percent of the student's financial support), and are under age 26.

* * * * *

(4) * * *

(i) * * *

(C) TRICARE Select is available to all TYA-eligible young adult dependents.

(D) TRICARE Prime is available to TYA-eligible young adult dependents, provided that TRICARE Prime (including the Uniformed Services Family Health Plan) is available in the geographic location where the TYA enrollee resides. TYA-eligible young adults are:

* * * * *

(ii) *Premiums.* TYA coverage is a premium based program that an eligible young adult dependent may purchase. There is only individual coverage, and a premium shall be charged for each dependent even if there is more than one qualified dependent in the uniformed service sponsor's family that qualifies for TYA coverage. Dependents qualifying for TYA status can purchase individual TRICARE Select or TRICARE Prime coverage (as applicable) according to the rules governing the TRICARE option for which they are qualified on the basis of their uniformed service sponsor's TRICARE-eligible status (active duty, retired, Selected Reserve, or Retired Reserve) and the availability of a desired option in their geographic location. Premiums shall be determined in accordance with paragraph (c) of this section.

* * * * *

(iv) *Benefits.* When their TYA coverage becomes effective, qualified

beneficiaries receive the benefit of the TRICARE option that they selected, including, if applicable, access to military treatment facilities and pharmacies. TYA coverage features the cost share, deductible and catastrophic cap provisions applicable to Group B beneficiaries based on the program selected, *i.e.*, the TRICARE Select program under § 199.17(l)(2)(ii) or the TRICARE Prime program under § 199.17(l)(ii), as well as the status of their military sponsor. Access to military treatment facilities under the system of access priorities in § 199.17(d)(1) is also based on the program selected as well as the status of the military sponsor. Premiums are not credited to deductibles or catastrophic caps; however, TYA premiums shall apply instead of any applicable TRICARE Prime or Select enrollment fee.

* * * * *

(c) *TRICARE Young Adult premiums.* Qualified young adult dependents are charged premiums for coverage under TYA that represent the full cost of the program, including reasonable administrative costs, as determined by the Director utilizing an appropriate actuarial basis for the provision of TRICARE benefits for the TYA-eligible beneficiary population. Separate premiums shall be established for TRICARE Select and Prime plans. There may also be separate premiums based on the uniformed services sponsor's status. Premiums are to be paid monthly, except as otherwise provided through administrative implementation, pursuant to procedures established by the Director. The monthly rate for each month of a calendar year is one-twelfth of the annual rate for that calendar year.

* * * * *

(d) *Procedures.* The Director may establish procedures for the following.

(1) * * *

(ii) *Enrollment.* Procedures for enrollment in TRICARE plans under § 199.17(o) shall apply to a qualified dependent purchasing TYA coverage. Generally, the effective date of coverage will coincide with the first day of a month unless enrollment is due to a qualifying event and a different date on or after the qualifying event is required to prevent a lapse in health care coverage.

(2) *Termination.* Procedures may be established for TYA coverage to be terminated as follows.

* * * * *

(v) Coverage may be terminated for young adult dependents upon request at any time by submitting a completed

request in the appropriate format in accordance with established procedures.

(vi) In accordance with the provisions of § 199.17(o)(2), coverage terminates for young adult dependents who fail to make premium payments in accordance with established procedures.

(vii) Absent a new qualifying event, young adults are not eligible to re-enroll in TYA until the next annual open season.

* * * * *

(f) *Administration.* The Director may establish other processes, policies and procedures for the effective administration of the TYA Program and may authorize exceptions to requirements of this section, if permitted.

Dated: September 20, 2017.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2017-20392 Filed 9-28-17; 8:45 am]

BILLING CODE 5001-06-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG-2017-0172]

RIN 1625-AA00

Safety Zone; Pacific Ocean, Kilauea Lava Flow Ocean Entry on Southeast Side of Island of Hawaii, HI

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is extending, for an additional six months, the existing temporary safety zone surrounding the entry of lava from the Kilauea volcano into the navigable waters of the Pacific Ocean on the southeast side of the Island of Hawaii, HI. The extension of this safety zone is necessary to protect persons and vessels from hazards associated with molten lava entering the ocean while the proposed rule is reviewed.

DATES: This rule is effective from September 28, 2017 through March 28, 2018.

ADDRESSES: To view documents mentioned in this preamble as being available in the docket, go to <https://www.regulations.gov>, type USCG-2017-0172 in the "SEARCH" box and click "SEARCH." Click on Open Docket Folder on the line associated with this rule.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or

email Lieutenant Commander John Bannon, Waterways Management Division, Coast Guard; telephone: 808-541-4359, email: John.E.Bannon@uscg.mil.

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

BLS Bureau of Labor Statistics
COTP Captain of the Port
DHS Department of Homeland Security
FR Federal Register
NPRM Notice of proposed rulemaking
§ Section symbol
OMB Office of Management and Budget
RFA Regulatory Flexibility Act
SNPRM Supplemental notice of proposed rulemaking
TFR Temporary final rule
U.S.C. United States Code

II. Background Information and Regulatory History

The Coast Guard is extending, for an additional six months, an existing temporary safety zone for the navigable waters surrounding the entry of lava from the Kilauea Volcano into the Pacific Ocean on the southeast side of the Island of Hawaii, HI. Extending this safety zone ensures mariners remain safe from the potential hazards associated with molten lava entering the ocean while the proposed rule is being reviewed. This safety zone will continue to encompass all waters within 300 meters (984 feet) of all entry points of lava flow into the ocean. Because the entry points of the lava vary, the safety zone location will also vary. Entry of persons or vessels into this safety zone remains prohibited, unless specifically authorized by the Captain of the Port (COTP) Honolulu, or his designated representative.

Lava flow that enters the ocean can be potentially hazardous to anyone near it, particularly when lava deltas collapse. A lava delta is new land that forms when lava accumulates above sea level, and extends from the existing base of a sea cliff. Persons near active lava flow entry sites incur potential hazards, particularly when lava deltas collapse. These hazards include, but are not limited to, plumes of hot, corrosive seawater laden with hydrochloric acid, and fine volcanic particles that can irritate the skin, eyes, and lungs; explosions of debris and eruptions of scalding water from hot rock entering the ocean; sudden lava delta collapses; and waves associated with these explosions and collapses.

Lava has been entering the ocean at the Kamokuna lava delta on Kilauea Volcano's south coast since July 2016. On December 31, 2016, a large portion of lava delta collapsed into the ocean at the Kamokuna entry point. Following

this collapse, portions of the adjacent sea cliff fell into the ocean, producing localized waves, and showers of debris. As of March 2017, a new delta has begun to form at the Kamokuna ocean entry point. This lava delta continues to grow and collapse, and cracks parallel to the sea cliff surrounding it persist, indicating further collapses may occur with little or no warning.

On March 28, 2017, the Coast Guard established a temporary final rule (TFR) and put into place a safety zone for mariners near lava entry points to address the hazards of the lava entering the ocean. The TFR discussed Sector Honolulu's review of nearly 30 years of delta collapse and ejecta distance observations from the Hawaii Volcano Observatory records. The TFR was published in the April 3, 2017 **Federal Register** (82 FR 16109).

On April 3, 2017, the Coast Guard also published a notice of proposed rulemaking (NPRM) to establish a permanent safety zone that would encompass all waters extending 300 meters (984 feet) in every direction around all entry points of lava flow into the navigable waters surrounding the entry of lava from the Kilauea Volcano into the Pacific Ocean on the southeast side of the Island of Hawaii, HI (82 FR 16142). We determined that a radius of 300 meters was a reasonable, minimum high-hazard zone around a point of active lava flow entering the ocean. The safety zone allows the Coast Guard to impose and enforce restrictions on vessels operating closely to the lava entry area, which protects persons and vessels from the potential hazards associated with molten lava entering the ocean. The NPRM addressed this concern and invited the public to comment on the safety zone. The comment period, which ended on June 2, 2017, received 67 comments. On May 8, 2017, at a public meeting held in Hilo, HI, meeting participants discussed the proposed rule and NPRM's public comments.

During the period of the TFR, four tour operators and one photographer with economic ties to lava tourism petitioned the COTP Honolulu for entry within 300 meters of the high-hazard zone. They also requested and petitioned for various levels of entry distances—ranging from a close, safe distance to 50 meters—based on sea conditions resulting from the lava entry. The COTP Honolulu granted express authorization for entry within 300 meters to the five operators. The authorization included operational restrictions and other vessel safety criteria requirements considered by the