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§ 199.18 Uniform HMO Benefit.

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

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

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

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

sistant Secretary of Defense (Health Affairs).

(3) In addition to preventive care services provided pursuant to paragraph (b)(2) of this section, other benefit enhancements may be added and other benefit restrictions may be waived or relaxed in connection with health care services provided to include the Uniform HMO Benefit. Any such other enhancements or changes must be approved by the Assistant Secretary of Defense (Health Affairs) based on uniform standards.

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

(2) *Amount of enrollment fees.* In fiscal year 2001, the annual enrollment fee for retirees and their dependents is \$230 individual, \$460 family.

(3) *Waiver of enrollment fee for certain beneficiaries.* The Assistant Secretary of Defense (Health Affairs) may waive the enrollment fee requirements of this section for Medicare-eligible beneficiaries.

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

(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements (see § 199.4(f)), special reduced cost sharing percentages or per service specific dollar amounts are required. The specific requirements shall be uniform and shall be published periodically by the Assistant Secretary of Defense (Health Affairs). For care provided on or after April 1, 2001, no copayment shall be charged for care provided under TRICARE Prime to a dependent of an active duty member, except for the copayments charged under the Pharmacy Benefits Program (see § 199.21) and under the point of service

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option of TRICARE Prime (see § 199.17(n)(4)).

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

(i) For most physician office visits and other routine services, there is a per visit fee for retirees and their dependents. This fee applies to primary care and specialty care visits, except as provided elsewhere in this paragraph (d)(2) of this section. It also applies to family health services, home health care visits, eye examinations, and immunizations. It does not apply to ancillary health services or to preventive health services described in paragraph (b)(2) of this section, or to maternity services under § 199.4(e)(16).

(ii) There is a copayment for outpatient mental health visits. It is a per visit fee for retirees and their dependents for individual visits. For group visits, there is a lower per visit fee for retirees and their dependents.

(iii) There is a cost share of durable medical equipment, prosthetic devices, and other authorized supplies for retirees and their dependents.

(iv) For emergency room services, there is a per visit fee for retirees and their dependents.

(v) For ambulatory surgery services, there is a per service fee for retirees and their dependents.

(vi) There is a copayment for prescription drugs per prescription, including medical supplies necessary for administration, for dependents of active duty members and for retirees and their dependents under the Pharmacy Benefits Program (see § 199.17(m)(5)).

(vii) There is a copayment for ambulance services for retirees and their dependents.

(3) *Amount of outpatient cost sharing requirements.* In fiscal year 2001, the outpatient cost sharing requirements are as follows:

(i) For most physician office visits and other routine services, as described in paragraph (d)(2)(i) of this section, the per visit fee for retirees and their dependents is \$12.

(ii) For outpatient mental health visits, the per visit fee for retirees and their dependents is \$25. For group outpatient mental health visits, there is a

lower per visit fee for retirees and their dependents of \$17.

(iii) The cost share for durable medical equipment, prosthetic devices, and other authorized supplies for retirees and their dependents is 20 percent of the negotiated fee.

(iv) For emergency room services, the per visit fee for retirees and their dependents is \$30.

(v) For primary surgeon services in ambulatory surgery, the per service fee for retirees and their dependents is \$25.

(vi) The copayments for prescription drugs are established under the Pharmacy Benefits Program (see § 199.21).

(vii) The copayment for ambulance services for retirees and their dependents is \$20.

(e) *Inpatient cost sharing requirements under the uniform HMO benefit*—(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements (see § 199.4(f)), special cost sharing amounts are required. The specific requirements shall be uniform and shall be published periodically by the Assistant Secretary of Defense (Health Affairs). For services provided on or after April 1, 2001, no copayment shall be charged for inpatient care provided under TRICARE Prime to a dependent of an active duty member except under the point of service option of TRICARE Prime (see § 199.17(n)(4)). In addition, for services provided on or after April 1, 2001, no copayment shall be charged for inpatient care provided under TRICARE Prime to a dependent of an active duty member in military medical treatment facilities.

(2) *Structure of cost sharing.* For services other than mental illness or substance use treatment, there is a nominal copayment for retired members, dependents of retired members, and survivors. For inpatient mental health and substance use treatment, a separate per day charge is established. For services provided on or after April 1, 2001, no inpatient copayment shall be charged an active duty dependent enrolled in TRICARE Prime. This elimination of inpatient copayments applies to active duty dependents enrolled in TRICARE Prime who are admitted to a civilian or military inpatient facility.

(3) *Amount of inpatient cost sharing requirements.* In fiscal year 2001, the inpatient cost sharing requirements for retirees and their dependents for acute care admissions and other non-mental health/substance use treatment admissions is a per diem charge of \$11, with a minimum charge of \$25 per admission. For mental health/substance use treatment admissions, and for partial hospitalization services, the per diem charge for retirees and their dependents is \$40.

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

(2) The limits established by paragraph (f)(1) of this section do not apply to out-of-pocket costs incurred pursuant to paragraph (m)(1)(i) or (m)(2)(i) of § 199.17 under the point-of-service option of TRICARE Prime.

(g) *Updates.* The enrollment fees for fiscal year 2001 set under paragraph (c) of this section and the per service specific dollar amounts for fiscal year 2001 set under paragraphs (d) and (e) of this section may be updated for subsequent years to the extent necessary to maintain compliance with statutory requirements pertaining to government costs. This updating does not apply to cost sharing that is expressed as a percentage of allowable charges; these percentages will remain unchanged.

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§ 199.20 Continued Health Care Benefit Program (CHCBP).

(a) *Purpose.* The CHCBP is a premium-based temporary health care coverage program that will be available to beneficiaries 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 of the TRICARE Standard program. Because the purpose of the CHCBP is to provide a continuation health care benefit for the Department of Defense and the other uniformed services (National Oceanic and Atmospheric Administration (NOAA), Public Health Service (PHS), and Coast Guard) beneficiaries losing eligibility, it will be administered so that it appears, to the maximum extent possible, to be part of the TRICARE Standard program. Medical coverage under this program will be the same as the benefits payable under the TRICARE Standard program. However, unlike the Standard program there is a cost for enrollment to the CHCBP and these premium costs are payable by enrollees before any care may be provided.

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

(c) *Definitions.* Except as may be specifically provided in this section, to the extent terms defined in § 199.2 are relevant to the administration of the CHCBP, the definitions contained in that section shall apply to the CHCBP as they do to the TRICARE Standard program.

(d) *Eligibility and enrollment.* (1) *Eligibility.* Enrollment in the CHCBP is open to any individual, except as noted in this section, who:

(i) Ceases to meet the requirements for eligibility under 10 U.S.C. chapter 55 or 10 U.S.C. 1145, and

(ii) Who on the day before they cease to meet the eligibility requirements for such care they were covered under a health benefit plan under 10 U.S.C. chapter 55 or transitional healthcare under 10 U.S.C. 1145, and