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FINAL RULE

The Department of Defense, Office of the Secretary, has authorized the following addition(s)/revision(s) to 32 CFR Part 199, reissued April 2005.

CHANGE TITLE: **CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS); TRICARE RESERVE SELECT; TRICARE DENTAL PROGRAM; EARLY ELIGIBILITY FOR TRICARE FOR CERTAIN RESERVE COMPONENT MEMBERS**

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training, or on inactive duty training; or

(ii) Traveling to or from the place at which the member was to perform or had performed such active duty, active duty for training, or inactive duty training.

Note to paragraph (b)(3)(ii)(B): Dependent under Section 711 of the National Defense Authorization Act for Fiscal Year 2001 includes spouse, unremarried widow/widower, child, parent/parent-in-law, unremarried former spouse, and unmarried person in the legal custody of a member or former member, as those terms of dependency are defined and periods of eligibility are set forth in 10 U.S.C. 1072(2).

(4) Medal of Honor recipients. (i) A former member of the armed forces who is a Medal of Honor recipient and who is not otherwise entitled to medical and dental benefits has the same CHAMPUS eligibility as does a retiree.

(ii) Immediate dependents. CHAMPUS eligible dependents of a Medal of Honor Recipient are those identified in paragraphs (b)(2)(i) of this section (except for former spouses) and (b)(2)(ii) of this section (except for a child placed in legal custody of a Medal of Honor recipient under (b)(2)(ii)(H)(4) of this section).

(iii) Effective date. The CHAMPUS eligibility established by paragraphs (b)(4)(i) and (ii) of this section is applicable to health care services provided on or after October 30, 2000.

(5) Reserve Component Members Issued Delayed-Effective-Date Orders.

(i) Member. A member of a reserve component of the armed forces who is ordered to active duty for a period of more than 30 consecutive days in support of a contingency operation under a provision of law referred to in section 101(a)(13)(B) of Title 10, United States Code, that provides for active-duty service to begin on a date after the date of the issuance of the order.

(ii) Dependents. CHAMPUS eligible dependents under this paragraph (b)(5) are those identified in paragraphs (b)(2)(i) (except former spouses) and (b)(2)(ii) of this section.

(iii) Effective date. The eligibility established by paragraphs (b)(5)(i) and (ii) of this section shall begin on or after November 6, 2003, and shall be effective on the later of the date that is:

(A) The date of issuance of the order referred to in paragraph (b)(5)(i) of this section; or

(B) 180 days before the date on which the period of active duty is to begin.

(iv) Termination date. The eligibility established by paragraphs (b)(5)(i) and (ii) of this section ends upon entry of the member onto active duty (at which time CHAMPUS eligibility for the dependents of the member is established under paragraph (b)(2) of this section) or upon cancellation or amendment of the orders referred to in paragraph (b)(5)(i) of this section such that they no longer meet the requirements of that paragraph (b)(5)(i).

(c) Beginning dates of eligibility. (1) Beginning dates of eligibility depend on the class to which the individual belongs and the date the individual became a member of the class.

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Those who join after the class became eligible attain individual eligibility on the date they join.

(2) Beginning dates of eligibility for each class of spouse (*excluding spouses who are victims of abuse and eligible spouses of certain deceased reservists*) are as follows:

(i) A spouse of a member for:

(A) Medical benefits authorized by the Dependents' Medical Care Act of 1956, December 7, 1956;

(B) Outpatient medical benefits under the Basic Program, October 1, 1966;

(C) Inpatient medical benefits under the Basic Program *and* benefits under the Extended Care Health Option, January 1, 1967;

(ii) A spouse of a former member:

(A) For medical benefits under the Basic Program, January 1, 1967.

(B) Ineligible for benefits under the Extended Care Health Option.

(iii) A former spouse:

(A) For medical benefits under the Basic Program, dates of beginning eligibility are as indicated for each category of eligible former spouse identified within paragraph (b)(2)(i) of this section.

(B) Ineligible for benefits under the Extended Care Health Option.

(3) Beginning dates of eligibility for spouses who are victims of abuse (*excluding spouses who are victims of abuse of certain deceased reservists*) are as follows:

(i) An abused spouse meeting the requirements of paragraph (b)(2)(iii)(A)(1) of this section, including an eligible former spouse:

(A) For medical and dental care for problems associated with the physical or emotional abuse under the Basic Program for a period of up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(B) For all medical and dental benefits under the Basic Program for the period that the spouse is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October 17, 1998.

(C) For medical and dental care for problems associated with the physical or emotional abuse under the Extended Care Health Option for a period up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(D) For all medical and dental benefits described in section 199.5 for the period that the spouse is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October

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- (A) The individual is under 65 years old;
- (B) The individual became eligible for Medicare under the provisions of 42 U.S.C. 426-1(a);
- (C) The individual is enrolled in Part B of Medicare; and
- (D) The individual has applied and qualified for continued CHAMPUS eligibility through the Defense Enrollment Eligibility Reporting System (DEERS).

(ix) Individuals with certain disabilities. Each case relating to Medicare eligibility resulting from being disabled requires individual investigation. All beneficiaries except dependents of active duty members lose their CHAMPUS eligibility when Medicare coverage becomes available to a disabled person unless the following conditions have been met. CHAMPUS eligibility will continue if:

- (A) The individual is under 65 years old;
- (B) The individual became eligible for Medicare under the provisions of 42 U.S.C. 426(b)(2);
- (C) **The individual is enrolled in Part B of Medicare except that in the case of a retroactive determination of entitlement to Medicare Part A hospital insurance benefits for a person under 65 years of age there is no requirement to enroll in Medicare Part B from the Medicare Part A entitlement date until the issuance of such retroactive determination; and**
- (D) The individual has applied and qualified for continued CHAMPUS eligibility through the Defense Enrollment Eligibility Reporting System (DEERS).

(x) Disabled students, that is children age 21 or 22, who are pursuing a full-time course of higher education and who, either during the school year or between semesters, suffer a disabling illness or injury with resultant inability to resume attendance at the institution remain eligible for CHAMPUS medical benefits for 6 months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, CHAMPUS benefits can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child 21 or 22 years old in a full time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child 21 or 22 years old in student status does not have eligibility and *may not* qualify for eligibility under the requirements related to mental or physical incapacity as described in paragraph (b)(2)(ii)(H)(2) of this section.

(g) Reinstatement of CHAMPUS eligibility. Circumstances which result in reinstatement of CHAMPUS eligibility are as follows:

(1) End Stage renal disease. Unless CHAMPUS eligibility has been continued under paragraph (f)(3)(viii) of the section, when Medicare eligibility ceases for end-stage renal disease patients, CHAMPUS eligibility resumes if the person is otherwise still eligible. He or she is required to take action to be reinstated as a CHAMPUS beneficiary and to obtain a new identification card.

(2) Disability. Some disabilities are permanent, others temporary. Each case must be reviewed individually. Unless CHAMPUS eligibility has been continued under paragraph (f)(3)(ix) of this section, when disability ends and Medicare eligibility ceases, CHAMPUS eligibility resumes if the person is otherwise still eligible. Again, he or she is required to take action to obtain a new CHAMPUS identification card.

(3) Enrollment in Medicare Part B. For individuals whose CHAMPUS eligibility has terminated pursuant to paragraph (f)(2)(iii) or (f)(3)(vi) of this section due to beneficiary action to decline Part B of Medicare, CHAMPUS eligibility resumes, effective on the date Medicare Part B coverage begins, if the person subsequently enrolls in Medicare Part B and the person is otherwise still eligible.

(h) Determination of eligibility status. Determination of an individual's eligibility as a CHAMPUS beneficiary is the primary responsibility of the Uniformed Service in which the member or former member is, or was, a member, or in the case of dependents of a NATO military member, the Service that sponsors the NATO member. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, OCHAMPUS, review the eligibility of a specific person when there is reason to question the eligibility status. In such cases, a report on the results of the review and any action taken will be submitted to the Director, OCHAMPUS, or a designee.

(i) Procedures for determination of eligibility. Procedures for the determination of eligibility are prescribed within the Department of Defense Instruction 1000.13 available at local military facilities personnel offices.

(j) CHAMPUS procedures for verification of eligibility. (1) Eligibility for CHAMPUS benefits will be verified through the Defense Enrollment Eligibility Reporting System (DEERS) maintained by the Uniformed Services, except for abused dependents as set forth in paragraph (b)(2)(iii) of this section. It is the responsibility of the CHAMPUS beneficiary, or parent, or legal representative, when appropriate, to provide the necessary evidence required for entry into the DEERS file to establish CHAMPUS eligibility and to ensure that all changes in status that may affect eligibility be reported immediately to the appropriate Uniformed Service for action.

(2) Ineligibility for CHAMPUS benefits may be presumed in the absence of prescribed eligibility evidence in the DEERS file.

(3) The Director, OCHAMPUS, shall issue guidelines as necessary to implement the provisions of this section.

[64 FR 46135, Aug 24, 1999, as amended at 66 FR 9654, Feb 9, 2001; 66 FR 16400, Mar 26, 2001; 66 FR 40606, Aug 3, 2001; 67 FR 15725, Apr 3, 2002; 68 FR 23032, Apr 30, 2003; 68 FR 32361, May 30, 2003; 69 FR 44947, Jul 28, 2004; 69 FR 51564, Aug 20, 2004; 69 FR 60554, Oct 12, 2004; 70 FR 12802, Mar 16, 2005; 71 FR 31944, Jun 2, 2006; 72 FR 2447, Jan 19, 2007; 73 FR 30478, May 28, 2008; 75 FR 50883, Aug 18, 2010; 76 FR 81367, Dec 28, 2011; 77 FR 38176, Jun 27, 2012; **80 FR 55254, Sep 15, 2015**]

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by 10 U.S.C., for a period of thirty-one (31) days or more. An affected Reserve component member must elect to enroll in the TDP and complete the enrollment application within thirty (30) days following entry on active duty or within sixty (60) days following implementation of the TDP. Following enrollment, beneficiaries must remain enrolled, with the member paying premiums, until the end of the member's active duty period in support of the contingency operation or twelve (12) months, whichever occurs first unless one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met.

(3) Continuation of enrollment from Expanded Active Duty Dependents Dental Benefit Plan. Beneficiaries enrolled in the Expanded Active Duty Dependents Dental Benefit Plan at the time when TDP coverage begins must complete their two (2) year enrollment period established under this former plan except if one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met. Once this original two (2) year enrollment period is met, the active duty member may continue TDP enrollment on a month-to-month basis. A new one (1) year enrollment period will only be incurred if the active duty member disenrolls and attempts to reenroll in the TDP at a later date.

(4) Continuation of enrollment from TRICARE Selected Reserve Dental Program. Beneficiaries enrolled in the TRICARE Selected Reserve Dental Program at the time when TDP coverage begins must complete their one (1) year enrollment period established under this former program except if one of the conditions for disenrollment specified in paragraph (c)(3)(ii)(E) of this section is met. Once this original one (1) year enrollment period is met, the Selected Reserve member may continue TDP enrollment on a month-to-month basis. A new one (1) year enrollment period will only be incurred if the Selected Reserve member disenrolls and attempts to reenroll in the TDP at a later date.

(D) Beginning dates of eligibility. The beginning date of eligibility for TDP benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and the enrollment and premium is received by the dental plan contractor, subject to a predetermined and publicized dental plan contractor monthly cut-off date, except that the date of eligibility shall not be earlier than the first day of the month in which the TDP is implemented. This includes any changes between single and family member premium coverage and coverage of newly eligible or enrolled dependents or members.

(E) Changes in and termination of enrollment. (1) *Changes in status of active duty, Selected Reserve or Individual Ready Reserve member. When the active duty, Selected Reserve or Individual Ready Reserve member is separated, discharged, retired, transferred to the Standby or Retired Reserve, his or her enrolled dependents and/or the enrolled Selected Reserve or Individual Ready Reserve member loses eligibility and enrollment as of 11:59 p.m. on the last day of the month in which the change in status takes place. When the Selected Reserve or Individual Ready Reserve member is ordered to active duty for a period of more than 30 days without a break in service, the member loses eligibility and is disenrolled, if previously enrolled; however, their enrolled dependents maintain their eligibility and previous enrollment subject to eligibility, enrollment and disenrollment provisions described in this section and in the TDP contract.*

(i) *Reserve component members separated from active duty in support of a contingency operation. When a member of a reserve component who is separated from active duty to which called or ordered in support of a contingency operation if the active duty is for more than 30 days, the member becomes eligible for Transitional Health Care pursuant to 10 U.S.C.*

1145(a) and the member is entitled to dental care to which a member of the uniformed services on active duty for more than 30 days is entitled. Thus the member has no requirement for the TDP and is not eligible to purchase the TDP. Upon the termination of Transitional Health Care eligibility, the member regains TDP eligibility and is reenrolled, if previously enrolled.

(ii) Dependents of members separated from active duty in support of a contingency operation. Dependents of a member of a reserve component who is separated from active duty to which called or ordered in support of a contingency operation if the active duty is active for more than 30 days maintain their eligibility and previous enrollment, subject to eligibility, enrollment and disenrollment provisions described in this section and in the TDP contract. During the member's Transitional Health Care eligibility, the dependents are considered family members of Reserve Component members.

(iii) Members separated from active duty and not covered by 10 U.S.C. 1145(a)(2)(B). When the previously enrolled active duty member is transferred back to the Selected Reserve or Individual Ready Reserve, and is not covered by 10 U.S.C. 1145(a)(2)(B), without a break in service, the member regains TDP eligibility and is reenrolled; however, enrolled dependents maintain their eligibility and previous enrollment subject to eligibility, enrollment and disenrollment provisions described in this section and in the TDP contract.

(iv) Eligible dependents of an active duty, Selected Reserve or Individual Ready Reserve member serving a sentence of confinement in conjunction with a sentence of punitive discharge are still eligible for the TDP until such time as the active duty, Selected Reserve or Individual Ready Reserve member's discharge is executed.

(2) Survivor eligibility. Eligible dependents of active duty members who die while on active duty for a period of more than 30 days and eligible dependents of members of the Ready Reserve (i.e., Selected Reserve or Individual Ready Reserve, as specified in 10 U.S.C. 10143 and 10144(b) respectively) who die, shall be eligible for survivor enrollment in the TDP. During the period of survivor enrollment, the government will pay both the government and the eligible dependent's portion of the premium share. This survivor enrollment shall be up to (3) three years from the date of the member's death, except that, in the case of a dependent of the deceased who is described in 10 U.S.C. 1072(2)(D) or (I), the period of survivor enrollment shall be the longer of the following periods beginning on the date of the member's death:

- (i) Three years.
- (ii) The period ending on the date on which such dependent attains 21 years of age.
- (iii) In the case of such dependent who, at 21 years of age, 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 administering Secretary and was, at the time of the member's death, in fact dependent on the member for over one-half of such dependent's support, the period ending on the earlier of the following dates: The date on which such dependent ceases to pursue such a course of study, as determined by the administering Secretary; or the date on which such dependent attains 23 years of age.

(3) Changes in status of dependent.--(i) Divorce. A spouse separated from an active duty, Selected Reserve or Individual Ready Reserve member by a final divorce decree loses all eligibility based on his or her former marital relationship as of 11:59 p.m. of the last day of the month in which the divorce becomes final. The eligibility of the active duty, Selected Reserve or Individual Ready Reserve member's own children (including adopted and eligible illegitimate children) is unaffected by the divorce. An unadopted stepchild, however, loses eligibility with the termination of the marriage, also as of 11:59 p.m. of the last day of the month in which the divorce becomes final.

(ii) Annulment. A spouse whose marriage to an active duty, Selected Reserve or Individual Ready Reserve member is dissolved by annulment loses eligibility as of 11:59 p.m. of the last day of the month in which the court grants the annulment order. The fact that the annulment legally declares the entire marriage void from its inception does not affect the termination date of eligibility. When there are children, the eligibility of the active duty, Selected Reserve or Individual Ready Reserve member's own children (including adopted and eligible illegitimate children) is unaffected by the annulment. An unadopted stepchild, however, loses eligibility with the annulment of the marriage, also as of 11:59 p.m. of the last day of the month in which the court grants the annulment order.

(iii) Adoption. A child of an active duty, Selected Reserve or Individual Ready Reserve member who is adopted by a person, other than a person whose dependents are eligible for TDP benefits while the active duty, Selected Reserve or Individual Ready Reserve member is living, thereby severing the legal relationship between the child and the active duty, Selected Reserve or Individual Ready Reserve member, loses eligibility as of 11:59 p.m. of the last day of the month in which the adoption becomes final.

(iv) Marriage of child. A child of an active duty, Selected Reserve or Individual Ready Reserve member who marries a person whose dependents are not eligible for the TDP, loses eligibility as of 11:59 p.m. on the last day of the month in which the marriage takes place. However, should the marriage be terminated by death, divorce, or annulment before the child is twenty-one (21) years old, the child again become eligible for enrollment as a dependent as of 12:00 a.m. of the first day of the month following the month in which the occurrence takes place that terminates the marriage and continues up to age twenty-one (21) if the child does not remarry before that time. If the marriage terminates after the child's 21st birthday, there is no reinstatement of eligibility.

(v) Disabling illness or injury of child age 21 or 22 who has eligibility based on his or her student status. A child twenty-one (21) or twenty-two (22) years old who is pursuing a full-time course of higher education and who, either during the school year or between semesters, suffers a disabling illness or injury with resultant inability to resume attendance at the institution remains eligible for the TDP for six (6) months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, the TDP can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child twenty-one (21) or twenty-two (22) years old in full-time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child twenty-one (21) or twenty-two (22) years old in student status does not have eligibility related to mental or physical incapacity as described in Sec. 199.3(b)(2)(iv)(C)(2).

(4) Other.--(i) Disenrollment because of no eligible beneficiaries. When an active duty, Selected Reserve or Individual Ready Reserve member ceases to have any eligible beneficiaries, enrollment is terminated for those enrolled dependents.

(ii) Option to disenroll as a result of a change in active duty station. When an active duty member transfers with enrolled dependents to a duty station where space-available dental care for the enrolled dependents is readily available at the local Uniformed Service dental treatment facility, the active duty member may elect, within ninety (90) calendar days of the transfer, to disenroll their dependents from the TDP. If the active duty member is later transferred to a duty station where dental care for the dependents is not available in the local Uniformed Service dental treatment facility, the active duty member may reenroll their eligible dependents in the TDP provided the member, as of the date of reenrollment, otherwise meets the requirements for enrollment, including the intent to remain on active duty for a period of not less than one (1) year. This disenrollment provision does not apply to enrolled dependents of members of the Selected Reserve or Individual Ready Reserve or to enrolled members of the Selected Reserve or Individual Ready Reserve.

(iii) Option to disenroll due to transfer to OCONUS service area. When an enrolled dependent of an active duty, Selected Reserve or Individual Ready Reserve member or an enrolled Selected Reserve or Individual Ready Reserve member relocates to locations within the OCONUS service area, the active duty, Selected Reserve or Individual Ready Reserve member may elect, within ninety (90) calendar days of the relocation, to disenroll their dependents from the TDP, or in the case of enrolled members of the Selected Reserve or Individual Ready Reserve, to disenroll themselves from the TDP. The active duty, Selected Reserve or Individual Ready Reserve member may reenroll their eligible dependents, or in the case of members of the Selected Reserve or Individual Ready Reserve, may reenroll themselves in the TDP provided the member, as of the date of reenrollment, otherwise meets the requirements for enrollment, including the intent to remain on active duty or as a member of the Selected Reserve or Individual Ready Reserve (or any combination thereof without a break in service or transfer to a non-eligible status) for a period of not less than one (1) year.

(iv) Option to disenroll after an initial one (1) year enrollment. When a dependent's enrollment under an active duty, Selected Reserve or Individual Ready Reserve member or a Selected Reserve or Individual Ready Reserve member's own enrollment has been in effect for a continuous period of one (1) year, the active duty, Selected Reserve or Individual Ready Reserve member may disenroll their dependents, or in the case of enrolled members of the Selected Reserve or Individual Ready Reserve may disenroll themselves at any time following procedures as set up by the dental plan contractor. Subsequent to the disenrollment, the active duty, Selected Reserve or Individual Ready Reserve member may reenroll their eligible dependents, or in the case of members of the Selected Reserve or Individual Ready Reserve may reenroll themselves, for another minimum period of one (1) year. If, during any one (1) year enrollment period, the active duty, Selected Reserve or Individual Ready Reserve member disenrolls their dependents, or in the case of members of the Selected Reserve or Individual Ready Reserve disenrolls themselves, for reasons other than those listed in this paragraph (c)(3)(ii)(E) or fails to make premium payments, dependents enrolled under the active duty, Selected Reserve or Individual Ready Reserve member, or enrolled members of the Selected Reserve and Individual Ready Reserve, will be subject to a lock-out period of twelve (12) months. Following this period of time, active duty, Selected Reserve or Individual Ready Reserve members will be able to reenroll their eligible

dependents, or members of the Selected Reserve or Individual Ready Reserve will be able to reenroll themselves, if they so choose. The twelve (12) month lock-out period applies to enrolled dependents of a Reserve component member who disenrolls for reasons other than those listed in this paragraph (c)(3)(ii)(E) or fails to make premium payments after the member has enrolled pursuant to paragraph (c)(3)(ii)(C) of this section.

(5) TRICARE Dental Program coverage shall terminate for members who no longer qualify for the TRICARE Dental Program as specified in paragraph (c)(2) 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 TRICARE Dental Program coverage is in effect for the member and/or the family on the last day of his or her membership in the Selected Reserve; then the TRICARE Dental Program coverage that was actually in effect may terminate no earlier than 180 days after the date on which the member is separated from the Selected Reserve. This exception expires December 31, 2018.

(d) **Premium sharing--**(1) General. Active duty, Selected Reserve or Individual Ready Reserve members enrolling their eligible dependents, or members of the Selected Reserve or Individual Ready Reserve enrolling themselves, in the TDP shall be required to pay all or a portion of the premium cost depending on their status.

(i) Members required to pay a portion of the premium cost. This premium category includes active duty members (under a call or order to active duty that does not specify a period of thirty (30) days or less) on behalf of their enrolled dependents. It also includes members of the Selected Reserve (as specified in 10 U.S.C. 10143) and the Individual Ready Reserve (as specified in 10 U.S.C. 10144(b)) enrolled on their own behalf.

(ii) Members required to pay the full premium cost. This premium category includes members of the Selected Reserve (as specified in 10 U.S.C. 10143), and the Individual Ready Reserve (as specified in 10 U.S.C. 10144), on behalf of their enrolled dependents. It also includes members of the Individual Ready Reserve (as specified in 10 U.S.C. 10144(a)) enrolled on their own behalf.

(2) Proportion of premium share. The proportion of premium share to be paid by the active duty, Selected Reserve and Individual Reserve member pursuant to paragraph (d)(1)(i) of this section is established by the ASD(HA), or designee, at not more than forty (40) percent of the total premium. The proportion of premium share to be paid by the Selected Reserve and Individual Reserve member pursuant to paragraph (d)(1)(ii) of this section is established by the ASD(HA), or designee, at one hundred (100) percent of the total premium.

(3) Provision for increases in active duty, Selected Reserve and Individual Ready Reserve member's premium share. (i) Although previously capped at \$20 per month, the law has been amended to authorize the cap on active duty, Selected Reserve and Individual Ready Reserve member's premiums pursuant to paragraph (d)(1)(i) of this section to rise, effective as of January 1 of each year, by the percent equal to the lesser of:

(A) The percent by which the rates of basic pay of members of the Uniformed Services are increased on such date; or

(B) The sum of one-half percent and the percent computed under 5 U.S.C. 5303(a) for the increase in rates of basic pay for statutory pay systems for pay periods beginning on or after

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such date.

(ii) Under the legislation authorizing an increase in the monthly premium cap, the methodology for determining the active duty, Selected Reserve and Individual Ready Reserve member's TDP premium pursuant to paragraph (d)(1)(i) of this section will be applied as if the methodology had been in continuous use since December 31, 1993.

(4) Reduction of premium share for enlisted members. For enlisted members in pay grades E-1 through E-4, the ASD(HA) or designee, may reduce the monthly premium these active duty, Selected Reserve and Individual Ready Reserve members pay pursuant to paragraph (d)(1)(i) of this section.

(5) Reduction of cost-shares for enlisted members. For enlisted members in pay grades E-1 through E-4, the ASD(HA) or designee, may reduce the cost-shares that active duty, Selected Reserve and Individual Ready Reserve members pay on behalf of their enrolled dependents and that members of the Selected Reserve and Individual Ready Reserve pay on their own behalf for selected benefits as specified in paragraph (e)(3)(i) of this section.

(6) Premium payment method. The active duty, Selected Reserve and Individual Ready Reserve member's premium share may be deducted from the active duty, Selected Reserve or Individual Ready Reserve member's basic pay or compensation paid under 37 U.S.C. 206, if sufficient pay is available. For members who are otherwise eligible for TDP benefits and who do not receive such pay and dependents who are otherwise eligible for TDP benefits and whose sponsors do not receive such pay, or if insufficient pay is available, the premium payment may be collected pursuant to procedures established by the Director, OCHAMPUS, or designee.

(7) Annual notification of premium rates. TDP premium rates will be determined as part of the competitive contracting process. Information on the premium rates will be widely distributed by the dental plan contractor and the Government.

(e) Plan benefits--(1) General.--(i) Scope of benefits. The TDP provides coverage for diagnostic and preventive services, sealants, restorative services, endodontics, periodontics, prosthodontics, orthodontics and oral and maxillofacial surgery.

(ii) Authority to act for the plan. The authority to make benefit determinations and authorize plan payments under the TDP rests primarily with the insurance, service plan, or prepayment dental plan contractor, subject to compliance with Federal law and regulation and Government contract provisions. The Director, OCHAMPUS, or designee, provides required benefit policy decisions resulting from changes in Federal law and regulation and appeal decisions. No other persons or agents (such as dentists or Uniformed Services HBAs) have such authority.

(iii) Dental benefits brochure.--(A) Content. The Director, OCHAMPUS, or designee, shall establish a comprehensive dental benefits brochure explaining the benefits of the plan in common lay terminology. The brochure shall include the limitations and exclusions and other benefit determination rules for administering the benefits in accordance with the law and this part. The brochure shall include the rules for adjudication and payment of claims, appealable issues, and appeal procedures in sufficient detail to serve as a common basis for

interpretation and understanding of the rules by providers, beneficiaries, claims examiners, correspondence specialists, employees and representatives of other Government bodies, HBAs, and other interested parties. Any conflict, which may occur between the dental benefits brochure and law or regulation, shall be resolved in favor of law and regulation.

(B) Distribution. The dental benefits brochure will be available through the dental plan contractor and will be distributed with the assistance of the Uniformed Services HBAs and major personnel centers at Uniformed Service installations and headquarters to all members enrolling themselves or their eligible dependents.

(iv) Alternative course of treatment policy. The Director, OCHAMPUS, or designee, may establish, in accordance with generally accepted dental benefit practices, an alternative course of treatment policy which provides reimbursement in instances where the dentist and beneficiary select a more expensive service, procedure, or course of treatment than is customarily provided. The alternative course of treatment policy must meet following conditions:

(A) The service, procedure, or course of treatment must be consistent with sound professional standards of dental practice for the dental condition concerned.

(B) The service, procedure, or course of treatment must be a generally accepted alternative for a service or procedure covered by the TDP for the dental condition.

(C) Payment for the alternative service or procedure may not exceed the lower of the prevailing limits for the alternative procedure, the prevailing limits or dental plan contractor's scheduled allowance for the otherwise authorized benefit procedure for which the alternative is substituted, or the actual charge for the alternative procedure.

(2) Benefits. The following benefits are defined (subject to the TDP's exclusions, limitations, and benefit determination rules approved by OCHAMPUS) using the American Dental Association's Council on Dental Care Program's Code on Dental Procedures and Nomenclature. The Director, OCHAMPUS, or designee, may modify these services, to the extent determined appropriate based on developments in common dental care practices and standard dental insurance programs.

(i) Diagnostic and preventive services. Benefits may be extended for those dental services described as oral examination, diagnostic, and preventive services defined as traditional prophylaxis (i.e., scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth) when performed directly by dentists and dental hygienists as authorized under paragraph (f) of this section. These include the following categories of service:

(A) Diagnostic services. (1) Clinical oral examinations.

(2) Radiographs and diagnostic imaging.

(3) Tests and laboratory examinations.

(B) Preventive services. (1) Dental prophylaxis.

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- (2) Topical fluoride treatment (office procedure).
- (3) Other preventive services.
- (4) Space maintenance (passive appliances).

(ii) General services and services "by report". The following categories of services are authorized when performed directly by dentists or dental hygienists, as authorized under paragraph (f) of this section, only in unusual circumstances requiring justification of exceptional conditions directly related to otherwise authorized procedures. Use of the procedures may not result in the fragmentation of services normally included in a single procedure. The dental plan contractor may recognize a "by report" condition by providing additional allowance to the primary covered procedure instead of recognizing or permitting a distinct billing for the "by report" service. These include the following categories of general services:

- (A) Unclassified treatment.
- (B) Anesthesia.
- (C) Professional consultation.
- (D) Professional visits.
- (E) Drugs.
- (F) Miscellaneous services.

(iii) Restorative services. Benefits may be extended for restorative services when performed directly by dentists or dental hygienists, or under orders and supervision by dentists, as authorized under paragraph (f) of this section. These include the following categories of restorative services:

- (A) Amalgam restorations.
- (B) Resin restorations.
- (C) Inlay and onlay restorations.
- (D) Crowns.
- (E) Other restorative services.

(iv) Endodontic services. Benefits may be extended for those dental services involved in treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of endodontic services:

- (A) Pulp capping.

- (B) Pulpotomy and pulpectomy.
- (C) Endodontic therapy.
- (D) Apexification and recalcification procedures.
- (E) Apicoectomy and periradicular services.
- (F) Other endodontic procedures.
- (v) Periodontic services. Benefits may be extended for those dental services involved in prevention and treatment of diseases affecting the supporting structures of the teeth to include periodontal prophylaxis, gingivectomy or gingivoplasty, gingival curettage, etc., when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of periodontic services:
 - (A) Surgical services.
 - (B) Periodontal services.
 - (C) Other periodontal services.
- (vi) Prosthodontic services. Benefits may be extended for those dental services involved in fabrication, insertion adjustment, relinement, and repair of artificial teeth and associated tissues to include removable complete and partial dentures, fixed crowns and bridges when performed directly by dentists as authorized under paragraph (f)(4) of this section. These include the following categories of prosthodontic services:
 - (A) Prosthodontics (removable).
 - (1) Complete and partial dentures.
 - (2) Adjustments to dentures.
 - (3) Repairs to complete and partial dentures.
 - (4) Denture rebase procedures.
 - (5) Denture reline procedures.
 - (6) Other removable prosthetic services.
 - (B) Prosthodontics (fixed).
 - (1) Fixed partial denture pontics.
 - (2) Fixed partial denture retainers.
 - (3) Other partial denture services.

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(vii) Orthodontic services. Benefits may be extended for the supervision, guidance, and correction of growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations through the use of orthodontic procedures and devices when performed directly by dentists as authorized under paragraph (f) of this section to include in-process orthodontics. These include the following categories of orthodontic services:

- (A) Limited orthodontic treatment.
- (B) Minor treatment to control harmful habits.
- (C) Interceptive orthodontic treatment.
- (D) Comprehensive orthodontic treatment.
- (E) Other orthodontic services.

(viii) Oral and maxillofacial surgery services. Benefits may be extended for basic surgical procedure of the extraction, reimplantation, stabilization and repositioning of teeth, alveoloplasties, incision and drainage of abscesses, suturing of wounds, biopsies, etc., when performed directly by dentists as authorized under paragraph (f) of this section. These include the following categories of oral and maxillofacial surgery services:

- (A) Extractions.
- (B) Surgical extractions.
- (C) Other surgical procedures.
- (D) Alveoloplasty--surgical preparation of ridge for denture.
- (E) Surgical incision.
- (F) Repair of traumatic wounds.
- (G) Complicated suturing.
- (H) Other repair procedures.

(ix) Exclusion of adjunctive dental care. Adjunctive dental care benefits are excluded under the TDP. For further information on adjunctive dental care benefits under TRICARE/CHAMPUS, see Sec. 199.4(e)(10).

(x) Benefit limitations and exclusions. The Director, OCHAMPUS, or designee, may establish such exclusions and limitations as are consistent with those established by dental insurance and prepayment plans to control utilization and quality of care for the services and items covered by the TDP.

(xi) Limitation on reduction of benefits. If a reduction in benefits is planned, the Secretary of Defense, or designee, may not reduce TDP benefits without notifying the

appropriate Congressional committees. If a reduction is approved, the Secretary of Defense, or designee, must wait one (1) year from the date of notice before a benefit reduction can be implemented.

(3) Cost-shares, liability and maximum coverage.--(i) Cost-shares. The following table lists maximum active duty, Selected Reserve and Individual Ready Reserve member and dependent cost-shares for covered services for participating and nonparticipating providers of care (see paragraph (f)(6) of this section for additional active duty, Selected Reserve and Individual Ready Reserve costs). These are percentages of the dental plan contractor's determined allowable amount that the active duty, Selected Reserve and Individual Ready Reserve member or beneficiary must pay to these providers. For care received in the OCONUS service area, the ASD(HA), or designee, may pay certain cost-shares and other portions of a provider's billed charge for enrolled dependents of active duty members (under a call or order that does not specify a period of thirty (30) days or less), and for members of the Selected Reserve (as specified in 10 U.S.C. 10143) and Individual Ready Reserve (as specified in 10 U.S.C. 10144(b)) enrolled on their own behalf.

[In percent]

COVERED SERVICES	COST-SHARE	
	FOR PAY GRADES E-1, E-2, E-3 AND E-4	COST-SHARE FOR ALL OTHER PAY GRADES
Diagnostic	0	0
Preventive, except Sealants	0	0
Emergency Services.....	0	0
Sealants	20	20
Professional Consultations.....	20	20
Professional Visits.....	20	20
Post Surgical Services	20	20
Basic Restorative (example: amalgams, resins, stainless steel crowns)	20	20
Endodontic	30	40
Periodontic	30	40
Oral and Maxillofacial Surgery	30	40
General Anesthesia	40	40
Intravenous Sedation	50	50
Other Restorative (example: crowns, onlays, casts)	50	50
Prosthodontics	50	50
Medications	50	50
Orthodontic	50	50
Miscellaneous.....	50	50

(ii) Dental plan contractor liability. When more than twenty-five (25) percent or more than two hundred (200) enrollees in a specific five (5) digit zip code area are unable to obtain a periodic or initial (non-emergency) dentistry appointment with a network provider within twenty-one (21) calendar days and within thirty-five (35) miles of the enrollee's place of residence, then the TRICARE Management Activity (TMA) will designate that area as "non-compliant with the access standard." Once so designated, the dental program contractor will

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reimburse the beneficiary, or active duty, Selected Reserve or Individual Ready Reserve member, or the nonparticipating provider selected by enrollees in that area (or a subset of the area or nearby zip codes in other five (5) digit zip code areas as determined by TMA) at the level of the provider's usual fees less the applicable enrollee cost-share, if any. TMA shall determine when such area becomes compliant with the access standards. This access standard and associated liability does not apply to care received in the OCONUS service area.

(iii) Maximum coverage amounts. Beneficiaries are subject to an annual maximum coverage amount for non-orthodontic dental benefits and a lifetime maximum coverage amount for orthodontics as established by the ASD (HA) or designee.

(f) Authorized providers--(1) General. Beneficiaries may seek covered services from any provider who is fully licensed and approved to provide dental care or covered anesthesia benefits in the state where the provider is located. This includes licensed dental hygienists, practicing within the scope of their licensure, subject to any restrictions a state licensure or legislative body imposes regarding their status as independent providers of care.

(2) Authorized provider status does not guarantee payment of benefits. The fact that a provider is "authorized" is not to be construed to mean that the TDP will automatically pay a claim for services or supplies provided by such a provider. The Director, OCHAMPUS, or designee, also must determine if the patient is an eligible beneficiary, whether the services or supplies billed are authorized and medically necessary, and whether any of the authorized exclusions of otherwise qualified providers presented in this section apply.

(3) Utilization review and quality assurance. Services and supplies furnished by providers of care shall be subject to utilization review and quality assurance standards, norms, and criteria established under the TDP. Utilization review and quality assurance assessments shall be performed under the TDP consistent with the nature and level of benefits of the plan, and shall include analysis of the data and findings by the dental plan contractor from other dental accounts.

(4) Provider required. In order to be considered benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of a TDP authorized provider practicing within the scope of his or her license.

(5) Participating provider. An authorized provider may elect to participate for all TDP beneficiaries and accept the fee or charge determinations as established and made known to the provider by the dental plan contractor. The fee or charge determinations are binding upon the provider in accordance with the dental plan contractor's procedures for participation. The authorized provider may not participate on a claim-by-claim basis. The participating provider must agree to accept, within one (1) day of a request for appointment, beneficiaries in need of emergency palliative treatment. Payment to the participating provider is based on the lower of the actual charge or the dental plan contractor's determination of the allowable charge; however, payments to participating providers shall be in accordance with the methodology specified in paragraph (g)(2)(ii) of this section. Payment is made directly to the participating provider, and the participating provider may only charge the beneficiary the percent cost-share of the dental plan contractor's allowable charge for those benefit categories as specified in paragraph (e) of this section, in addition to the full charges for any services not authorized as benefits.

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(6) Nonparticipating provider. An authorized provider may elect to not participate for all TDP beneficiaries and request the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member to pay any amount of the provider's billed charge in excess of the dental plan contractor's determination of allowable charges (to include the appropriate cost-share). Neither the Government nor the dental plan contractor shall have any responsibility for any amounts over the allowable charges as determined by the dental plan contractor, except where the dental plan contractor is unable to identify a participating provider of care within thirty-five (35) miles of the beneficiary's place of residence with appointment availability within twenty-one (21) calendar days. In such instances of the nonavailability of a participating provider and in accordance with the provisions of the dental contract, the nonparticipating provider located within thirty-five (35) miles of the beneficiary's place of residence shall be paid his or her usual fees (either by the beneficiary or the dental plan contractor if the beneficiary elected assignment of benefits), less the percent cost-share as specified in paragraph (e)(3)(i) of this section.

(i) Assignment of benefits. A nonparticipating provider may accept assignment of benefits for claims (for beneficiaries certifying their willingness to make such assignment of benefits) by filing the claims completed with the assistance of the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member for direct payment by the dental plan contractor to the provider.

(ii) No assignment of benefits. A nonparticipating provider for all beneficiaries may request that the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member file the claim directly with the dental plan contractor, making arrangements with the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member for direct payment by the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member.

(7) Alternative delivery system--(i) General. Alternative delivery systems may be established by the Director, OCHAMPUS, or designee, as authorized providers. Only dentists, dental hygienists and licensed anesthetists shall be authorized to provide or direct the provision of authorized services and supplies in an approved alternative delivery system.

(ii) Defined. An alternative delivery system may be any approved arrangement for a preferred provider organization, capitation plan, dental health maintenance or clinic organization, or other contracted arrangement which is approved by OCHAMPUS in accordance with requirements and guidelines.

(iii) Elective or exclusive arrangement. Alternative delivery systems may be established by contract or other arrangement on either an elective or exclusive basis for beneficiary selection of participating and authorized providers in accordance with contractual requirements and guidelines.

(iv) Provider election of participation. Otherwise authorized providers must be provided with the opportunity of applying for participation in an alternative delivery system and of achieving participation status based on reasonable criteria for timeliness of application, quality of care, cost containment, geographic location, patient availability, and acceptance of reimbursement allowance.

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(v) Limitation on authorized providers. Where exclusive alternative delivery systems are established, only providers participating in the alternative delivery system are authorized providers of care. In such instances, the TDP shall continue to pay beneficiary claims for services rendered by otherwise authorized providers in accordance with established rules for reimbursement of nonparticipating providers where the beneficiary has established a patient relationship with the nonparticipating provider prior to the TDP's proposal to subcontract with the alternative delivery system.

(vi) Charge agreements. Where the alternative delivery system employs a discounted fee-for-service reimbursement methodology or schedule of charges or rates which includes all or most dental services and procedures recognized by the American Dental Association's Council on Dental Care Program's Code on Dental Procedures and Nomenclature, the discounts or schedule of charges or rates for all dental services and procedures shall be extended by its participating providers to beneficiaries of the TDP as an incentive for beneficiary participation in the alternative delivery system.

(g) Benefit payment--(1) General. TDP benefits payments are made either directly to the provider or to the beneficiary or active duty, Selected Reserve or Individual Ready Reserve member, depending on the manner in which the claim is submitted or the terms of the subcontract of an alternative delivery system with the dental plan contractor.

(2) Benefit payment. Beneficiaries are not required to utilize participating providers. For beneficiaries who do use these participating providers, however, these providers shall not balance bill any amount in excess of the maximum payment allowed by the dental plan contractor for covered services. Beneficiaries using nonparticipating providers may be balance-billed amounts in excess of the dental plan contractor's determination of allowable charges. The following general requirements for the TDP benefit payment methodology shall be met, subject to modifications and exceptions approved by the Director, OCHAMPUS, or designee:

(i) Nonparticipating providers (or the Beneficiaries or active duty, Selected Reserve or Individual Ready Reserve members for unassigned claims) shall be reimbursed at the equivalent of not less than the 50th percentile of prevailing charges made for similar services in the same locality (region) or state, or the provider's actual charge, whichever is lower, subject to the exception listed in paragraph (e)(3)(ii) of this section, less any cost-share amount due for authorized services.

(ii) Participating providers shall be reimbursed in accordance with the contractor's network agreements, less any cost-share amount due for authorized services.

(3) Fraud, abuse, and conflict of interest. The provisions of Sec. 199.9 shall apply except for Sec. 199.9(e). All references to "CHAMPUS contractors", "CHAMPUS beneficiaries" and "CHAMPUS providers" in Sec. 199.9 shall be construed to mean the "dental plan contractor", "TDP beneficiaries" and "TPD providers" respectively for the purposes of this section. Examples of fraud include situations in which ineligible persons not enrolled in the TDP obtain care and file claims for benefits under the name and identification of a beneficiary; or when providers submit claims for services and supplies not rendered to Beneficiaries; or when a participating provider bills the beneficiary for amounts over the dental plan contractor's determination of allowable charges; or when a provider fails to collect the specified patient cost-share amount.

(h) Appeal and hearing procedures. The provisions of Sec. 199.10 shall apply except where noted in this section. All references to “CHAMPUS contractors”, “CHAMPUS beneficiaries”, “CHAMPUS participating providers” and “CHAMPUS Explanation of Benefits” in Sec. 199.10 shall be construed to mean the “dental plan contractor”, “TDP beneficiaries”, “TDP participating providers” and “Dental Explanation of Benefits or DEOB” respectively for the purposes of this section. References to “OCHAMPUSEUR” in Sec. 199.10 are not applicable to the TDP or this section.

(1) General. See Sec. 199.10(a).

(i) Initial determination--(A) Notice of initial determination and right to appeal. See Sec. 199.10(a)(1)(i).

(B) Effect of initial determination. See Sec. 199.10(a)(1)(ii).

(ii) Participation in an appeal. Participation in an appeal is limited to any party to the initial determination, including OCHAMPUS, the dental plan contractor, and authorized representatives of the parties. Any party to the initial determination, except OCHAMPUS and the dental plan contractor, may appeal an adverse determination. The appealing party is the party who actually files the appeal.

(A) Parties to the initial determination. See Secs. 199.10(a)(2)(i) and 199.10(a)(2)(i)(A), (B), (C) and (E). In addition, a third party other than the dental plan contractor, such as an insurance company, is not a party to the initial determination and is not entitled to appeal, even though it may have an indirect interest in the initial determination.

(B) Representative. See Sec. 199.10(a)(2)(ii).

(iii) Burden of proof. See Sec. 199.10(a)(3).

(iv) Evidence in appeal and hearing cases. See Sec. 199.10(a)(4).

(v) Late filing. If a request for reconsideration, formal review, or hearing is filed after the time permitted in this section, written notice shall be issued denying the request. Late filing may be permitted only if the appealing party reasonably can demonstrate to the satisfaction of the dental plan contractor, or the Director, OCHAMPUS, or designee, that timely filing of the request was not feasible due to extraordinary circumstances over which the appealing party had no practical control. Each request for an exception to the filing requirement will be considered on its own merits. The decision of the Director, OCHAMPUS, or a designee, on the request for an exception to the filing requirement shall be final.

(vi) Appealable issue. See Secs. 199.10(a)(6), 199.10(a)(6)(i), 199.10(a)(6)(iv), including Secs. 199.10(a)(6)(iv) (A) and (C), and 199.10(a)(6)(v) for an explanation and examples of non-appealable issues. Other examples of issues that are not appealable under this section include:

(A) The amount of the dental plan contractor-determined allowable charge since the methodology constitutes a limitation on benefits under the provisions of this section.

(B) Certain other issues on the basis that the authority for the initial determination is not vested in OCHAMPUS. Such issues include but are not limited to the following examples:

(1) A determination of a person's enrollment in the TDP is the responsibility of the dental plan contractor and ultimate responsibility for resolving a beneficiary's enrollment rests with the dental plan contractor. Accordingly, a disputed question of fact concerning a beneficiary's enrollment will not be considered an appealable issue under the provisions of this section, but shall be resolved in accordance with paragraph (c) of this section and the dental plan contractor's enrollment policies and procedures.

(2) Decisions relating to the issuance of a nonavailability statement (NAS) in each case are made by the Uniformed Services. Disputes over the need for an NAS or a refusal to issue an NAS are not appealable under this section. The one exception is when a dispute arises over whether the facts of the case demonstrate a dental emergency for which an NAS is not required. Denial of payment in this one situation is an appealable issue.

(3) Any decision or action on the part of the dental plan contractor to include a provider in their network or to designate a provider as participating is not appealable under this section. Similarly, any decision or action on the part of the dental plan contractor to exclude a provider from their network or to deny participating provider status is not appealable under this section.

(vii) Amount in dispute--(A) General. An amount in dispute is required for an adverse determination to be appealed under the provisions of this section, except as set forth or further explained in Sec. 199.10(a)(7)(ii), (iii) and (iv).

(B) Calculated amount. The amount in dispute is calculated as the amount of money the dental plan contractor would pay if the services involved in the dispute were determined to be authorized benefits of the TDP. Examples of amounts of money that are excluded by this section from payments for authorized benefits include, but are not limited to:

(1) Amounts in excess of the dental plan contractor's--determined allowable charge.

(2) The beneficiary's cost-share amounts.

(3) Amounts that the beneficiary, or parent, guardian, or other responsible person has no legal obligation to pay.

(4) Amounts excluded under the provisions of Sec. 199.8 of this part.

(viii) Levels of appeal. See Sec. 199.10(a)(8)(i). Initial determinations involving the sanctioning (exclusion, suspension, or termination) of TDP providers shall be appealed directly to the hearing level.

(ix) Appeal decision. See Sec. 199.10(a)(9).

(2) Reconsideration. See Sec. 199.10(b).

(3) Formal review. See Sec. 199.10(c).

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(4) Hearing--(i) General. See Secs. 199.10(d) and 199.10(d)(1) through (d)(5) and (d)(7) through (d)(12) for information on the hearing process.

(ii) Authority of the hearing officer. The hearing officer, in exercising the authority to conduct a hearing under this part, will be bound by 10 U.S.C., chapter 55, and this part. The hearing officer in addressing substantive, appealable issues shall be bound by the dental benefits brochure applicable for the date(s) of service, policies, procedures, instructions and other guidelines issued by the ASD(HA), or a designee, or by the Director, OCHAMPUS, or a designee, in effect for the period in which the matter in dispute arose. A hearing officer may not establish or amend the dental benefits brochure, policy, procedures, instructions, or guidelines. However, the hearing officer may recommend reconsideration of the policy, procedures, instructions or guidelines by the ASD (HA), or a designee, when the final decisions is issued in the case.

(5) Final decision. See Secs. 199.10(e)(1) and 199.10(e)(1)(i) for information on final decisions in the appeal and hearing process, with the exception that no recommended decision shall be referred for review by ASD(HA).

(i) Implementing Instructions. The Director, TRICARE Management Activity or designee may issue TRICARE Dental Program policies, standards, and criteria as may be necessary to implement the intent of this section.

[66 FR 12860, Mar 1, 2001; 66 FR 16400, Mar 26, 2001, as amended at 68 FR 65174, Nov 19, 2003; 69 FR 55359, Sep 14, 2004; 70 FR 55252, Sep 21, 2005; 71 FR 1696, Jan 11, 2006; 71 FR 31943, Jun 2, 2006; 71 FR 66872, Nov 17, 2006; 72 FR 53685, Sep 20, 2007; 76 FR 57643, Sep 16, 2011; 76 FR 81367, Dec 28, 2011; **80 FR 55254, Sep 15, 2015**]

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PART 199.24 - TRICARE RESERVE SELECT

(a) Establishment. TRICARE Reserve Select is established for the purpose of offering TRICARE Standard and Extra health coverage to qualified members of the Selected Reserve and their immediate family members.

(1) Purpose. TRICARE Reserve Select is a premium-based health plan that is available for purchase by members of the Selected Reserve and certain survivors of Selected Reserve members as specified in paragraph (c) of this section.

(2) Statutory Authority. TRICARE Reserve Select is authorized by 10 U.S.C. 1076d.

(3) Scope of the Program. TRICARE Reserve Select is applicable in the 50 United States, the District of Columbia, Puerto Rico, and, to the extent practicable, other areas where members of the Selected Reserve serve. In locations other than the 50 states of the United States and the District of Columbia, the Assistant Secretary of Defense (Health Affairs) may authorize modifications to the program rules and procedures as may be appropriate to the area involved.

(4) Major Features of TRICARE Reserve Select. The major features of the program include the following:

(i) TRICARE rules applicable. (A) Unless specified in this section or otherwise prescribed by the ASD(HA), provisions of 32 CFR Part 199 apply to TRICARE Reserve Select.

(B) Certain special programs established in 32 CFR part 199 are not available to members covered under TRICARE Reserve Select. These include the Extended Care Health Option (Sec. 199.5), the Special Supplemental Food Program (see Sec. 199.23), and the Supplemental Health Care Program (Sec. 199.16), except when referred by a Military Treatment Facility (MTF) provider for incidental consults and the MTF provider maintains clinical control over the episode of care. The TRICARE Dental Program (Sec. 199.13) is independent of this program and is otherwise available to all members of the Selected Reserve and their eligible family members whether or not they purchase TRICARE Reserve Select coverage. The Continued Health Care Benefits Program (Sec. 199.20) is also independent of this program and is otherwise available to all members who qualify.

(ii) Premiums. TRICARE Reserve Select coverage is available for purchase by any Selected Reserve member if the member fulfills all of the statutory qualifications. A member of the Selected Reserve covered under TRICARE Reserve Select shall pay 28 percent of the total amount that the ASD(HA) determines on an appropriate actuarial basis as being appropriate for that coverage. There is one premium rate for member-only coverage and one premium rate for member and family coverage.

(iii) Procedures. Under TRICARE Reserve Select, Reserve Component members who fulfilled all of the statutory qualifications may purchase either the member-only type of coverage or the member-and-family type of coverage by submitting a completed request in the appropriate format along with an initial payment of the applicable premium. Rules and

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procedures for purchasing coverage and paying applicable premiums are prescribed in this section.

(iv) Benefits. When their coverage becomes effective, TRICARE Reserve Select beneficiaries receive the TRICARE Standard (and Extra) benefit including access to military treatment facility services and pharmacies, as described in Sec. Sec. 199.17 and 199.21. TRICARE Reserve Select coverage features the deductible and cost share provisions of the TRICARE Standard (and Extra) plan applicable to active duty family members for both the member and the member's covered family members (paragraph (a)(4)(iv) of this section). 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 Sec. 199.17(d)(1)(i)(D).

(b) Qualifications for TRICARE Reserve Select coverage--(1) Ready Reserve member. A Ready Reserve member qualifies to purchase TRICARE Reserve Select coverage if the Service member meets both the following criteria:

(i) Is a member of the Selected Reserve of the Ready Reserve of the Armed Forces, or a member of the Individual Ready Reserve of the Armed Forces who has volunteered to be ordered to active duty pursuant to the provisions of 10 U.S.C. 12304 in accordance with section 10 U.S.C. 10144(b); and

(ii) Is not enrolled in, or eligible to enroll in, a health benefits plan under 5 U.S.C. chapter 89. That statute has been implemented under 5 CFR part 890 as the Federal Employees Health Benefits (FEHB) program. For purposes of the FEHB program, the terms "enrolled," "enroll" and "enrollee" are defined in 5 CFR 890.101. Further, the member (or certain former member involuntarily separated) no longer qualifies for TRICARE Reserve Select when the member (or former member) has been eligible for coverage to be effective in a health benefits plan under the FEHB program for more than 60 days.

(2) TRICARE Reserve Select survivor. If a qualified Service member dies while in a period of TRICARE Reserve Select coverage, the immediate family member(s) of such member is qualified to purchase new or continue existing TRICARE Reserve Select coverage for up to six months beyond the date of the member's death as long as they meet the definition of immediate family members as specified in paragraph (g)(2) of this section. This applies regardless of type of coverage in effect on the day of the TRICARE Reserve Select member's death.

(c) TRICARE Reserve Select premiums. Members are charged premiums for coverage under TRICARE Reserve Select that represent 28 percent of the total annual premium amount that the Director, Defense Health Agency determines on an appropriate actuarial basis as being appropriate for coverage under the TRICARE Standard (and Extra) 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, Healthcare Operations in the Defense Health Agency. The monthly rate for each month of a calendar year is one-twelfth of the annual rate for that calendar year.

(1) Annual establishment of rates. TRICARE Reserve Select monthly premium rates shall be established and updated annually on a calendar year basis for each of the two types

of coverage, member-only and member- and-family as described in paragraph (d)(1) of this section. Starting with calendar year 2009, the appropriate actuarial basis for purposes of this paragraph (c) shall be determined for each calendar year by utilizing the actual reported cost of providing benefits under this section to members and their dependents during the calendar years preceding such calendar year. Reported actual TRS cost data from calendar years 2006 and 2007 was used to determine premium rates for calendar year 2009. This established pattern will be followed to determine premium rates for all calendar years subsequent to 2009.

(2) Premium adjustments. In addition to the determinations described in paragraph (c)(1) of this section, premium adjustments may be made prospectively for any calendar year to reflect any significant program changes or any actual experience in the costs of administering TRICARE Reserve Select.

(3) Survivor premiums. A surviving family member of a Reserve Component service member who qualified for TRICARE Reserve Select coverage as described in paragraph (b)(2) of this section will pay premium rates as follows. The premium amount shall be at the member-only rate if there is only one surviving family member to be covered by TRICARE Reserve Select and at the member and family rate if there are two or more survivors to be covered.

(d) Procedures. The Director, Healthcare Operations in the Defense Health Agency, may establish procedures for the following.

(1) Purchasing coverage. Procedures may be established for a qualified member to purchase one of two types of coverage: Member-only coverage or member and family coverage. Immediate family members of a qualified member as specified in paragraph (g)(2) of this section may be included in such family coverage. To purchase either type of TRICARE Reserve Select coverage for effective dates of coverage described below, members and survivors qualified under either paragraph (b)(1) or (2) of this section must submit a request in the appropriate format, along with an initial payment of the applicable premium required by paragraph (c) of this section in accordance with established procedures.

(i) Continuation coverage. Procedures may be established for a qualified member or qualified survivor to purchase TRICARE Reserve Select coverage with an effective date immediately following the date of termination of coverage under another TRICARE program.

(ii) Qualifying life event. Procedures may be established for a qualified member or qualified survivor to purchase TRICARE Reserve Select coverage on the occasion of a qualifying life event that changes the immediate family composition (e.g., birth, adoption, divorce, etc.) that is eligible for coverage under TRICARE Reserve Select. The effective date for TRICARE Reserve Select coverage will coincide with the date of the qualifying life event. It is the responsibility of the member to provide personnel officials with the necessary evidence required to substantiate the change in immediate family composition. Personnel officials will update DEERS in the usual manner. Appropriate action will be taken upon receipt of the completed request in the appropriate format along with an initial payment of the applicable premium in accordance with established procedures.

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(iii) Open enrollment. Procedures may be established for a qualified member to purchase TRICARE Reserve Select coverage at any time. The effective date of coverage will coincide with the first day of a month.

(iv) Survivor coverage under TRICARE Reserve Select. Procedures may be established for a surviving family member of a Reserve Component service member who qualified for TRICARE Reserve Select coverage as described in paragraph (b)(2) of this section to purchase new TRICARE Reserve Select coverage or continue existing TRICARE Reserve Select coverage for up to six months beyond the date of the member's death. The effective date of coverage will be the day following the date of the member's death.

(2) Changing type of coverage. Procedures may be established for TRICARE Reserve Select members to request to change type of coverage during open enrollment as described in paragraph (d)(1)(iii) of this section or on the occasion of a qualifying life event that changes immediate family composition as described in paragraph (d)(1)(ii) of this section by submitting a completed request in the appropriate format.

(3) Suspension and termination. Suspension/termination of coverage for the TRS member/survivor will result in suspension/termination of coverage for the member's/survivor's family members in TRICARE Reserve Select, except as described in paragraph (d)(1)(iv) of this section. Procedures may be established for coverage to be suspended or 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) Coverage may be suspended and finally terminated for members/survivors who fail to make premium payments in accordance with established procedures.

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

(v) Under paragraph (d)(3)(iii) or (iv) of this section, TRICARE Reserve Select coverage may first be suspended for a period of up to one year followed by final termination. Procedures may be established for the suspension to be lifted upon request before final termination is applied.

(4) Processing. Upon receipt of a completed request in the appropriate format, enrollment actions will be processed into DEERS in accordance with established procedures.

(5) Periodic revision. Periodically, certain features, rules or procedures of TRICARE Reserve Select may be revised. If such revisions will have a significant effect on members' or survivors' costs or access to care, members or survivors may be given the opportunity to change their type of coverage or terminate coverage coincident with the revisions.

(e) Preemption of State laws. (1) Pursuant to 10 U.S.C. 1103, the Department of Defense has determined that in the administration of chapter 55 of title 10, U.S. Code, 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. This determination is applicable to contracts that implement this section.

(2) Based on the determination set forth in paragraph (f)(1) of this section, any State or local law or regulation pertaining to health insurance, prepaid health plans, or other health care delivery, administration, and financing methods is preempted and does not apply in connection with TRICARE Reserve Select. 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 TRICARE Reserve Select. (However, the Department of Defense may, by contract, establish legal obligations on the part of DoD contractors to conform with requirements similar to or identical to requirements of State or local laws or regulations with respect to TRICARE Reserve Select.)

(3) The preemption of State and local laws set forth in paragraph (f)(2) of this section includes State and local laws imposing premium taxes on health 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 10 U.S.C. 1103. 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 the purposes of assessing the effect of Federal preemption of State and local taxes and fees in connection with DoD health services contracts, interpretations shall be consistent with those applicable to the Federal Employees Health Benefits Program under 5 U.S.C. 8909(f).

(f) Administration. The Director, Healthcare Operations in the Defense Health Agency 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) Terminology. The following terms are applicable to the TRICARE Reserve Select program.

(1) Coverage. This term means the medical benefits covered under the TRICARE Standard or Extra programs as further outlined in other sections of 32 CFR part 199 whether delivered in military treatment facilities or purchased from civilian sources.

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- (2) Immediate family member. This term means spouse (except former spouses) as defined in Sec. 199.3(b)(2)(i), or child as defined in Sec. 199.3(b)(2)(ii).
- (3) Qualified member. This term means a member who has satisfied all the criteria that must be met before the member is authorized for TRS coverage.
- (4) Qualified survivor. This term means an immediate family member who has satisfied all the criteria that must be met before the survivor is authorized for TRS coverage.

[70 FR 12802, Mar. 16, 2005; 71 FR 31944; Jun. 2, 2006; 71 FR 35532, Jun 21, 2006; 72 FR 46383, Aug. 20, 2007; 76 FR 57641, Sep. 16, 2011; 80 FR 55254; Sep 15, 2015]

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