provide for the verification of drafts prior to payment.

(i) Verification may utilize sampling techniques.

(ii) Payment of drafts shall be made out of Defense Health Program funds.

(f) *Rebate agreements.* (1) DoD is authorized to enter into an agreement with a manufacturer of a particular brand of a food item that provides for the exclusive supply to the program of the same or similar types of food items by that manufacturer.

(i) The agreement shall identify a contract brand of food item.

(ii) Under the agreement, the manufacturer shall rebate to the Department an agreed portion of the amounts paid by DoD for the procurement of the contract brand.

(2) The DoD shall use competitive procedures under title 10, chapter 137 to select the contract brand.

(3) Amounts rebated shall be credited to the appropriation available for carrying out the program and shall be applied against expenditures for the program in the same period as the other sums in the appropriation.

(g) *Administrative appeals and civil rights.* (1) Applicants who are denied certification or participants that are denied recertification shall be provided with a notice of ineligibility. The notice shall include information on the applicant's right to appeal the determination and instructions on doing so.

(2) Benefits shall not be provided while an appeal is pending when an applicant is denied benefits, a participant's certification has expired or a participant becomes categorically ineligible.

(3) A request for appeal shall be submitted in writing within five working days. If the decision is an adverse one it shall include notice to the applicant of his further appeal rights as reflected in (iii) below, and that he/she has five working days to effect any such appeal.

(4) Appeal reviews shall be conducted in the first instance by the CPA or team leader in charge of the local WIC Overseas office.

(i) Written notice of a decision shall be provided to the applicant within five working days.

(ii) If the appeal is upheld, retroactive benefits shall not be provided.

(iii) At an applicant's request a denied appeal may be forwarded to the regional program manager for review, who will provide a decision on the appeal within 5 working days.

(iv) If the regional program manager denies the appeal, there shall be no further right of appeal.

(5) Complaints about discriminatory treatment shall be handled in accordance with procedures established at each local WIC Overseas site.

(h) *Operations and Administration.* (1) Information collected about WIC Overseas applicants and participants shall be collected, maintained, and disclosed in accordance with applicable laws and regulations.

(2) Information and personnel security requirements shall be consistent with applicable laws and regulations.

[69 FR 15678, Mar. 26, 2004]

§ 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) *Terminology.* Certain terminology is introduced for TRICARE Reserve Select intended to reflect critical elements that distinguish it from other long-established TRICARE health programs. For instance, the effective date

of eligibility for TRICARE has long been understood to mean that the eligible individual may obtain care under the military health system as of that date. However, that is not what it means in the context of TRICARE Reserve Select. To avoid the inevitable misunderstanding, this regulation uses the term ''qualify'' to mean that the member has satisfied all the ''qualifications'' that must be met before the member is authorized to purchase coverage. Only then may the member purchase coverage by submitting a completed request in the appropriate format along with payment of the applicable one month premium. The term ''coverage'' indicates the benefit of TRICARE Standard or Extra covering claims submitted for payment of covered services, supplies, and equipment furnished by TRICARE authorized providers, hospitals, and suppliers.

(5) *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 Program (see §199.5), the Special Supplemental Food Program (see §199.23), and the Supplemental Health Care Program (see §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 (see §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.

(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 payment of the applicable one month premium. Rules and 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 §199.17 of this Part. TRICARE Reserve Select coverage features the deductible and cost share provisions of the TRICARE Standard (and Extra) plan for active duty family members for both the member and the member's covered family members. The TRICARE Standard (and Extra) plan is described in §199.17 of this Part.

(b) *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 Assistant Secretary of Defense, Health Affairs (ASD(HA)) 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 ASD(HA).

(1) *Annual establishment of rates*. (i) TRICARE Reserve Select monthly premium rates shall be established and updated annually on a calendar year basis to maintain an appropriate relationship with the annual changes in premiums for the Blue Cross and Blue Shield Standard Service Benefit Plan under the Federal Employees Health

Benefits Program, a nationwide plan closely resembling TRICARE Standard (and Extra) coverage, or by other adjustment methodology determined to be appropriate by the ASD(HA) for each of the two types of coverage, member-only and member and family as described in paragraphs (d)(2) of this section.

(ii) Annual rates for the first year TRICARE Reserve Select was offered (calendar year 2005) were based on the Federal Blue Cross and Blue Shield annual premiums, with adjustments based on estimated differences in covered populations, as determined by the ASD(HA).

(2) *Premium adjustments.* In addition to the determinations described in paragraph (b)(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 the TRICARE Reserve Select Program.

(3) *Survivor coverage under TRICARE Reserve Select.* A surviving family member of a Reserve Component service member who qualified for TRICARE Reserve Select coverage as described in paragraph (c)(3) 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.

(c) *Eligibility for (qualifying to purchase) TRICARE Reserve Select coverage*—(1) *General.* The law authorizing the TRICARE Reserve Select program uses the term ''eligibility'' to identify conditions under which a Reserve component member may purchase coverage. For purposes of program administration, the terms ''qualifying'' or ''qualified'' shall generally be used in lieu of such terms as ''eligibility'' or ''eligible'' to refer to a Reserve component member who meets the program requirements allowing purchase of TRICARE Reserve Select coverage. The member's Service personnel office is responsible for keeping DEERS current with eligibility data.

(2) *Member Purchase.* A member who is a member of a Reserve component of the Armed Forces qualifies to purchase TRICARE Reserve Select coverage if the member meets both the following conditions:

(i) Is a member of the Selected Reserve of the Ready Reserve.

(ii) Is not enrolled in, or eligible to enroll in, a health benefits plan under Chapter 89 of Title 5, U.S.C.

(3) *Survivor coverage under TRICARE Reserve Select.* If a member of the Selected Reserve dies while in a period of TRICARE Reserve Select coverage, the family member(s) may purchase new or continue existing TRICARE Reserve Select coverage for up to six months beyond the date of the member's death.

(d) *Procedures*—(1) *Purchasing Coverage.* A qualified member may purchase one of two types of coverage: member-only coverage or member and family coverage. Immediate family members of the Reserve component member, as defined in §199.3(b)(2)(i) (except former spouses) and §199.3 (b)(2)(ii) of this Part, may be included in such family coverage. To purchase either type of TRICARE Reserve Select coverage for effective dates of coverage described below, Reserve component members qualified under §199.24(c) must submit a request in the appropriate format, along with an initial payment of the applicable monthly premium required by paragraph (b) of this section to the appropriate TRICARE contractor in accordance with deadlines and other procedures established by the ASD(HA).

(i) *Continuation Coverage.* Deadlines and other procedures may be established for a qualified member to purchase TRICARE Reserve Select coverage with an effective date immediately following the date of termination of coverage under another TRICARE program in which the member is the sponsor.

(ii) *Qualifying Life Event.* Deadlines and other procedures may be established for a qualified member 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 be the

date of the qualifying life event. It is the responsibility of the member to provide his or her personnel office with the necessary evidence required to substantiate the change in immediate family composition. Personnel officials will update DEERS in the usual manner. The appropriate TRICARE contractor will then take appropriate action upon receipt of the completed request in the appropriate format along with payment of the applicable one month premium.

(iii) *Open Enrollment*. Deadlines and other 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*. Deadlines and other 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 (c)(3) 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*. TRICARE Reserve Select members may request to change type of coverage during open enrollment 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) *Termination*. Termination of coverage for the member will result in termination of coverage for the member's family members in TRICARE Reserve Select, except as described in paragraphs (d)(1)(iv) of this section. The termination will become effective in accordance with procedures established by the ASD(HA). Members whose coverage under TRICARE Reserve Select terminates under paragraph (d)(3)(iii) or (iv) of this section will not be allowed to purchase coverage again under TRICARE Reserve Select for a period of one year following the effective the date of termination.

(i) Coverage shall terminate for members who no longer qualify for TRICARE Reserve Select as specified in paragraph (c) of this section, including when the member's service in the Selected Reserve terminates.

(ii) Coverage may terminate for members who gain coverage under another TRICARE program in which the member is the sponsor.

(iii) Coverage may terminate for members who fail to make a premium payment in accordance with procedures established by the ASD(HA).

(iv) Members may request termination of coverage at any time by submitting a completed request in the appropriate format in accordance with established deadlines and procedures.

(v) Coverage for survivors as described in paragraph (d)(1)(iv) of this section shall terminate six months after the date of death of the covered Reserve component member.

(4) *Processing*. Upon receipt of a completed request in the appropriate format, the appropriate TRICARE contractor will process enrollment actions into DEERS in accordance with deadlines and other procedures established by the ASD(HA).

(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' costs or access to care, members may be given the opportunity to change their type of coverage or terminate coverage coincident with the revisions.

(e) [Reserved]

(f) *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).

(g) *Administration.* The ASD(HA) 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, based on extraordinary circumstances.

[72 FR 46383, Aug. 20, 2007, as amended at 76 FR 57641, Sept. 16, 2011]

§ 199.25 TRICARE Retired Reserve.

(a) *Establishment.* TRICARE Retired Reserve is established for the purpose of offering the medical benefits provided under the TRICARE Standard and Extra programs to qualified members of the Retired Reserve, their immediate family members, and qualified survivors.

(1) *Purpose.* As specified in paragraph (c) of this section, TRICARE Retired Reserve is a premium-based health plan that is available for purchase by any Retired Reserve member who is qualified for non-regular retirement, but is not yet 60 years of age, unless that member is either enrolled in, or eligible to enroll in, a health benefit plan under Chapter 89 of Title 5, United States Code, as well as certain survivors of Retired Reserve members.

(2) *Statutory Authority.* TRICARE Retired Reserve is authorized by 10 U.S.C. 1076e.

(3) *Scope of the Program.* TRICARE Retired Reserve is geographically applicable to the same extent as specified in 32 CFR 199.1(b)(1).

(4) *Major Features of TRICARE Retired Reserve.* 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 Retired Reserve.

(B) Certain special programs established in 32 CFR part 199 are not available to members covered under TRICARE Retired Reserve. These include the Extended Health Care Option (ECHO) program and the Supplemental Health Care Program (see §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 Retiree Dental Program (see §199.13) is independent of this program and is otherwise available to all members who