pharmacy program is also established for any Medicare-eligible beneficiary who can demonstrate to the satisfaction of the Director, OCHAMPUS, that he or she relied upon an MTF that closed for his or her pharmaceuticals. Medicare beneficiaries who obtained pharmacy services at the facility that closed within the 12-month period prior to its closure will be deemed to be reliant on the facility. Validation that any such beneficiary obtained such services may be provided through records of the facility or by a written declaration of the beneficiary. Beneficiaries providing such a declaration are required to provide correct information. Intentionally providing false information or otherwise failing to satisfy this obligation is grounds for disqualification for health care services from facilities of the uniformed services and mandatory reimbursement for the cost of any pharmaceuticals provided based on the improper declaration.

(iv) Effective date of eligibility for Medicare-eligible beneficiaries. In any case in which, prior to the complete closure of a military medical treatment facility which is in the process of closure, the Director, OCHAMPUS, determines that the area has been adversely affected by severe reductions in access to services, the Director, OCHAMPUS may establish an effective date for eligibility for the retail pharmacy network program or mail service pharmacy program for Medicare-eligible beneficiaries prior to the complete closure of the facility.

(5) Effect of other health insurance. The double coverage rules of § 199.8 are applicable to services provided to all beneficiaries under the retail pharmacy network program or mail service pharmacy program. For this purpose, to the extent they provide a prescription drug benefit, Medicare supplemental insurance plans or Medicare HMO plans are double coverage plans and will be

the primary payor.

(6) Procedures. The Director, OCHAMPUS shall establish procedures for the effective operation of the retail pharmacy network program and mail service pharmacy program. Such procedures may include the use of appropriate drug formularies, restrictions of the quantity of pharmaceuticals to be dispensed, encouragement of the use of generic drugs, implementation of quality assurance and utilization management activities, and other appropriate matters.

(l) PRIMUS and NAVCARE clinics.
(1) Description and authority.
PRIMUS and NAVCARE clinics are contractor owned, staffed, and operated clinics that exclusively serve uniformed

services beneficiaries. They are authorized as transitional entities during the phase-in of TRICARE. This authority to operate a PRIMUS or NAVCARE clinic will cease upon implementation of TRICARE in the clinic's location, or on October 1, 1997, whichever is later.

(2) Eligible beneficiaries. All TRICARE beneficiary categories are eligible for care in PRIMUS and NAVCARE Clinics. This includes active duty members, Medicare-eligible beneficiaries and other MHSS-eligible persons not eligible for CHAMPUS.

(3) Services and charges. For care provided PRIMUS and NAVCARE Clinics, CHAMPUS rules regarding program benefits, deductibles and cost sharing requirements do not apply. Services offered and charges will be based on those applicable to care provided in military medical treatment facilities.

(4) Priority access. Access to care in PRIMUS and NAVCARE Clinics shall be based on the same order of priority as is established for military treatment facilities care under paragraph (d)(1) of this section.

(m) Consolidated schedule of beneficiary charges. The following consolidated schedule of beneficiary charges is applicable to health care services provided under TRICARE for Prime enrollees, Standard enrollees and Medicare-eligible beneficiaries. (There are no charges to active duty members. Charges for participants in other managed health care programs affiliated with TRICARE will be specified in the applicable affiliation agreements.)

(1) Cost sharing for services from TRICARE network providers.

(i) For Prime enrollees, cost sharing is as specified in the Uniform HMO Benefit in § 199.18, except that for care not authorized by the primary care manager or Health Care Finder, rules applicable to the TRICARE point of service option (see paragraph (n)(3) of this section) are applicable. For such unauthorized care, the deductible is \$300 per person and \$600 per family. The beneficiary cost share is 50 percent of the allowable charges for inpatient and outpatient care, after the deductible.

(ii) For Standard enrollees, TRICARE Extra cost sharing applies. The deductible is the same as standard CHAMPUS. Cost shares are as follows:

(A) For outpatient professional services, cost sharing will be reduced from 20 percent to 15 percent for dependents of active duty members.

(B) For most services for retired members, dependents of retired members, and survivors, cost sharing is reduced from 25 percent to 20 percent.

(C) In fiscal year 1996, the per diem inpatient hospital copayment for retirees, dependents of retirees, and survivors when they use a preferred provider network hospital is \$250 per day, or 25 percent of total charges, whichever is less. There is a nominal copayment for active duty dependents, which is the same as under the CHAMPUS program (see § 199.4). The per diem amount may be updated for subsequent years based on changes in the standard CHAMPUS per diem.

(iii) For Medicare-eligible beneficiaries, cost sharing will generally be as applicable to Medicare

participating providers.

(2) Cost sharing for non-network providers.

- (i) For TRICARE Prime enrollees, rules applicable to the TRICARE point of service option (see paragraph (n)(3) of this section) are applicable. The deductible is \$300 per person and \$600 per family. The beneficiary cost share is 50 percent of the allowable charges, after the deductible.
- (ii) For Standard enrollees, cost sharing is as specified for the basic CHAMPUS program.
- (iii) For Medicare eligible beneficiaries, cost sharing is as provided under the Medicare program.
- (3) Cost sharing under internal resource sharing agreements.
- (i) For Prime enrollees, cost sharing is as provided in military treatment facilities.
- (ii) For Standard enrollees, cost sharing is as provided in military treatment facilities.
- (iii) For Medicare eligible beneficiaries, where made applicable by the commander of the *military medical treatment facility* concerned, cost sharing will be as provided in military treatment facilities.
- (4) Cost sharing under external resource sharing.
- (i) For Prime enrollees, cost sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to institutional and related ancillary charges shall be as applicable to services provided under TRICARE Prime.
- (ii) For TRICARE Standard participants, cost sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to non-military providers, including institutional and related ancillary charges, shall be as applicable to services provided under TRICARE Extra.
- (iii) For Medicare-eligible beneficiaries, where available, cost