by subsection (a) [amending this section] shall apply to members of the uniformed services who are not otherwise covered by section 1078a of title 10, United States Code, before the date of the enactment of this Act [Nov. 24, 2003] and who, on or after such date, first meet the eligibility criteria specified in subsection (b) of that section.''

### § 1078b. Provision of food to certain members and dependents not receiving inpatient care in military medical treatment facilities

(a) IN GENERAL.—(1) Under regulations prescribed by the Secretary of Defense, the Secretary may provide food and beverages to an individual described in paragraph (2) at no cost to the individual.

(2) An individual described in this paragraph is the following:

(A) A member or former member of the uniformed services or dependent—

(i) who is receiving outpatient medical care at a military medical treatment facility; and

(ii) whom the Secretary determines is unable to purchase food and beverages while at such facility by virtue of receiving such care.

(B) A member or former member of the uniformed services or dependent—

(i) who is a family member of an infant receiving inpatient medical care at a military medical treatment facility;

(ii) who provides care to the infant while the infant receives such inpatient medical care; and

(iii) whom the Secretary determines is unable to purchase food and beverages while at such facility by virtue of providing such care to the infant.

(C) A member or former member of the uniformed services or dependent whom the Secretary determines is under similar circumstances as a member, former member, or dependent described in subparagraph (A) or (B).

(b) REGULATIONS.—The Secretary shall ensure that regulations prescribed under this section are consistent with generally accepted practices in private medical treatment facilities.

(Added Pub. L. 112–81, div. A, title VII, § 704(a), Dec. 31, 2011, 125 Stat. 1472; amended Pub. L. 113–291, div. A, title VII, § 705, Dec. 19, 2014, 128 Stat. 3413.)

AMENDMENTS

2014—Subsec. (a)(2). Pub. L. 113–291, § 705(1), substituted ''A member or former member'' for ''A member'' wherever appearing.

Subsec. (a)(2)(C). Pub. L. 113–291, § 705(2), substituted ''member, former member, or dependent'' for ''member or dependent''.

EFFECTIVE DATE

Pub. L. 112–81, div. A, title VII, § 704(c), Dec. 31, 2011, 125 Stat. 1473, provided that: ''The amendments made by this section [enacting this section] shall take effect on the date that is 90 days after the date of the enactment of this Act [Dec. 31, 2011].''

### § 1079. Contracts for medical care for spouses and children: plans

(a) To assure that medical care is available for dependents, as described in subparagraphs (A), (D), and (I) of section 1072(2) of this title, of members of the uniformed services who are on active duty for a period of more than 30 days, the Secretary of Defense, after consulting with the other administering Secretaries, shall contract, under the authority of this section, for medical care for those persons under such insurance, medical service, or health plans as he considers appropriate. The types of health care authorized under this section shall be the same as those provided under section 1076 of this title, except as follows:

(1) With respect to dental care—

(A) except as provided in subparagraph (B), only that care required as a necessary adjunct to medical or surgical treatment may be provided; and

(B) in connection with dental treatment for patients with developmental, mental, or physical disabilities or for pediatric patients age 5 or under, only institutional and anesthesia services may be provided.

(2) Consistent with such regulations as the Secretary of Defense may prescribe regarding the content of health promotion and disease prevention visits, the schedule and method of cervical cancer screenings and breast cancer screenings, the schedule and method of colon and prostate cancer screenings, and the types and schedule of immunizations—

(A) for dependents under six years of age, both health promotion and disease prevention visits and immunizations may be provided; and

(B) for dependents six years of age or older, health promotion and disease prevention visits may be provided in connection with immunizations or with diagnostic or preventive cervical and breast cancer screenings or colon and prostate cancer screenings.

(3) Not more than one eye examination may be provided to a patient in any calendar year.

(4) Under joint regulations to be prescribed by the administering Secretaries, the services of Christian Science practitioners and nurses and services obtained in Christian Science sanatoriums may be provided.

(5) Durable equipment provided under this section may be provided on a rental basis.

(6) Services in connection with nonemergency inpatient hospital care may not be provided if such services are available at a facility of the uniformed services located within a 40-mile radius of the residence of the patient, except that those services may be provided in any case in which another insurance plan or program provides primary coverage for those services.

(7) Services of pastoral counselors, family and child counselors, or marital counselors (other than certified marriage and family therapists) may not be provided unless the patient has been referred to the counselor by a medical doctor for treatment of a specific problem with the results of that treatment to be communicated back to the medical doctor who made the referral and services of certified marriage and family therapists may be provided consistent with such rules as may be prescribed by the Secretary of Defense, includ-

ing credentialing criteria and a requirement that the therapists accept payment under this section as full payment for all services provided.

(8) Special education may not be provided, except when provided as secondary to the active psychiatric treatment on an institutional inpatient basis.

(9) Therapy or counseling for sexual dysfunctions or sexual inadequacies may not be provided.

(10) Treatment of obesity may not be provided if obesity is the sole or major condition treated.

(11) Surgery which improves physical appearance but is not expected to significantly restore functions (including mammary augmentation, face lifts, and sex gender changes) may not be provided, except that—

(A) breast reconstructive surgery following a mastectomy may be provided;

(B) reconstructive surgery to correct serious deformities caused by congenital anomalies or accidental injuries may be provided; and

(C) neoplastic surgery may be provided.

(12) Any service or supply which is not medically or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury, or bodily malfunction as assessed or diagnosed by a physician, dentist, clinical psychologist, certified marriage and family therapist, optometrist, podiatrist, certified nurse-midwife, certified nurse practitioner, or certified clinical social worker, as appropriate, may not be provided, except as authorized in paragraph (4). Pursuant to an agreement with the Secretary of Health and Human Services and under such regulations as the Secretary of Defense may prescribe, the Secretary of Defense may waive the operation of this paragraph in connection with clinical trials sponsored or approved by the National Institutes of Health if the Secretary of Defense determines that such a waiver will promote access by covered beneficiaries to promising new treatments and contribute to the development of such treatments.

(13) The prohibition contained in section 1077(b)(3) of this title shall not apply in the case of a member or former member of the uniformed services.

(14) Electronic cardio-respiratory home monitoring equipment (apnea monitors) for home use may be provided if a physician prescribes and supervises the use of the monitor for an infant—

(A) who has had an apparent life-threatening event,

(B) who is a subsequent sibling of a victim of sudden infant death syndrome,

(C) whose birth weight was 1,500 grams or less, or

(D) who is a pre-term infant with pathologic apnea,

in which case the coverage may include the cost of the equipment, hard copy analysis of physiological alarms, professional visits, diagnostic testing, family training on how to respond to apparent life threatening events, and assistance necessary for proper use of the equipment.

(15) Hospice care may be provided only in the manner and under the conditions provided in section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)), except that hospice care may be provided to an individual under the age of 21 concurrently with health care services or hospitalization for the same condition.

(16) Forensic examinations following a sexual assault or domestic violence may be provided.

(17) Breastfeeding support, supplies (including breast pumps and associated equipment), and counseling shall be provided as appropriate during pregnancy and the postpartum period.

(b) Plans covered by subsection (a) shall include provisions for payment by the patient of the following amounts:

(1) $25 for each admission to a hospital, or the amount the patient would have been charged under section 1078(a) of this title had the care being paid for been obtained in a hospital of the uniformed services, whichever amount is the greater. The Secretary of Defense may exempt a patient from paying such amount if the hospital to which the patient is admitted does not impose a legal obligation on any of its patients to pay for inpatient care.

(2) Except as provided in clause (3), the first $150 each calendar year of the charges for all types of care authorized by subsection (a) and received while in an outpatient status and 20 percent of all subsequent charges for such care during a calendar year. Notwithstanding the preceding sentence, in the case of a dependent of an enlisted member in a pay grade below E–5, the initial deductible each calendar year under this paragraph shall be limited to $50.

(3) A family group of two or more persons covered by this section shall not be required to pay collectively more than the first $300 (or in the case of the family group of an enlisted member in a pay grade below E–5, the first $100) each calendar year of the charges for all types of care authorized by subsection (a) and received while in an outpatient status and 20 percent of the additional charges for such care during a calendar year.

(4) $25 for surgical care that is authorized by subsection (a) and received while in an outpatient status and that has been designated (under joint regulations to be prescribed by the administering Secretaries) as care to be treated as inpatient care for purposes of this subsection. Any care for which payment is made under this clause shall not be considered to be care received while in an outpatient status for purposes of clauses (2) and (3).

(5) An individual or family group of two or more persons covered by this section may not be required by reason of this subsection to pay a total of more than $1,000 for health care received during any calendar year under a plan under subsection (a).

(c) The methods for making payment under subsection (b) shall be prescribed under joint regulations issued by the administering Secretaries.

(d)(1) The Secretary of Defense shall establish a program to provide extended benefits for eligible dependents, which may include the provision of comprehensive health care services, including case management services, to assist in the reduction of the disabling effects of a qualifying condition of an eligible dependent. Registration shall be required to receive the extended benefits.

(2) The Secretary of Defense, after consultation with the other administering Secretaries, shall promulgate regulations to carry out this subsection.

(3) In this subsection:

(A) The term ''eligible dependent'' means a dependent of a member of the uniformed services on active duty for a period of more than 30 days, as described in subparagraph (A), (D), or (I) of section 1072(2) of this title, who has a qualifying condition.

(B) The term ''qualifying condition'' means the condition of a dependent who is moderately or severely mentally retarded, has a serious physical disability, or has an extraordinary physical or psychological condition.

(e) Extended benefits for eligible dependents under subsection (d) may include comprehensive health care services (including services necessary to maintain, or minimize or prevent deterioration of, function of the patient) and case management services with respect to the qualifying condition of such a dependent, and include, to the extent such benefits are not provided under provisions of this chapter other than under this section, the following:

(1) Diagnosis.

(2) Inpatient, outpatient, and comprehensive home health care supplies and services which may include cost effective and medically appropriate services other than part-time or intermittent services (within the meaning of such terms as used in the second sentence of section 1861(m) of the Social Security Act).

(3) Training, rehabilitation, special education, and assistive technology devices.

(4) Institutional care in private nonprofit, public, and State institutions and facilities and, if appropriate, transportation to and from such institutions and facilities.

(5) Custodial care, notwithstanding the prohibition in section 1077(b)(1) of this title.

(6) Respite care for the primary caregiver of the eligible dependent.

(7) Such other services and supplies as determined appropriate by the Secretary, notwithstanding the limitations in subsection (a)(12).

(f)(1) Members shall be required to share in the cost of any benefits provided to their dependents under subsection (d) as follows:

(A) Members in the lowest enlisted pay grade shall be required to pay the first $25 incurred each month, and members in the highest commissioned pay grade shall be required to pay the first $250 incurred each month. The amounts to be paid by members in all other pay grades shall be determined under regulations to be prescribed by the Secretary of Defense in consultation with the administering Secretaries.

(B) A member who has more than one dependent incurring expenses in a given month under a plan covered by subsection (d) shall not be required to pay an amount greater than would be required if the member had only one such dependent.

(2) In the case of extended benefits provided under paragraph (3) or (4) of subsection (e) to a dependent of a member of the uniformed services—

(A) the Government's share of the total cost of providing such benefits in any year shall not exceed $36,000, prorated as determined by the Secretary of Defense, except for costs that a member is exempt from paying under paragraph (3); and

(B) the member shall pay (in addition to any amount payable under paragraph (1)) the amount, if any, by which the amount of such total cost for the year exceeds the Government's maximum share under subparagraph (A).

(3) A member of the uniformed services who incurs expenses under paragraph (2) for a month for more than one dependent shall not be required to pay for the month under subparagraph (B) of that paragraph an amount greater than the amount the member would otherwise be required to pay under that subparagraph for the month if the member were incurring expenses under that subparagraph for only one dependent.

(4) To qualify for extended benefits under paragraph (3) or (4) of subsection (e), a dependent of a member of the uniformed services shall be required to use public facilities to the extent such facilities are available and adequate, as determined under joint regulations of the administering Secretaries.

(5) The Secretary of Defense, in consultation with the other administering Secretaries, shall prescribe regulations to carry out this subsection.

(g)(1) When a member dies while he is eligible for receipt of hostile fire pay under section 310 or 351 of title 37 or from a disease or injury incurred while eligible for such pay, his dependents who are receiving benefits under a plan covered by subsection (d) shall continue to be eligible for such benefits until they pass their twenty-first birthday.

(2) In addition to any continuation of eligibility for benefits under paragraph (1), when a member dies while on active duty for a period of more than 30 days, the member's dependents who are receiving benefits under a plan covered by subsection (a) shall continue to be eligible for benefits under TRICARE Prime during the three-year period beginning on the date of the member's death, except that, in the case of such a dependent of the deceased who is described by subparagraph (D) or (I) of section 1072(2) of this title, the period of continued eligibility shall be the longer of the following periods beginning on such date:

(A) Three years.

(B) The period ending on the date on which such dependent attains 21 years of age.

(C) In the case of such a 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 administer-

ing 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:

(i) The date on which such dependent ceases to pursue such a course of study, as determined by the administering Secretary.

(ii) The date on which such dependent attains 23 years of age.

(3) For the purposes of paragraph (2)(C), a dependent shall be treated as being enrolled in a full-time course of study in an institution of higher education during any reasonable period of transition between the dependent's completion of a full-time course of study in a secondary school and the commencement of an enrollment in a full-time course of study in an institution of higher education, as determined by the administering Secretary.

(4) The terms and conditions under which health benefits are provided under this chapter to a dependent of a deceased member under paragraph (2) shall be the same as those that would apply to the dependent under this chapter if the member were living and serving on active duty for a period of more than 30 days.

(5) In this subsection, the term ''TRICARE Prime'' means the managed care option of the TRICARE program.

(h)(1) Except as provided in paragraphs (2) and (3), payment for a charge for services by an individual health care professional (or other noninstitutional health care provider) for which a claim is submitted under a plan contracted for under subsection (a) shall be equal to an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules as apply to payments for similar services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). The Secretary of Defense shall determine the appropriate payment amount under this paragraph in consultation with the other administering Secretaries.

(2) The Secretary of Defense, in consultation with the other administering Secretaries, shall prescribe regulations to provide for such exceptions to the payment limitations under paragraph (1) as the Secretary determines to be necessary to assure that covered beneficiaries retain adequate access to health care services. Such exceptions may include the payment of amounts higher than the amount allowed under paragraph (1) when enrollees in managed care programs obtain covered services from nonparticipating providers. To provide a suitable transition from the payment methodologies in effect before February 10, 1996, to the methodology required by paragraph (1), the amount allowable for any service may not be reduced by more than 15 percent below the amount allowed for the same service during the immediately preceding 12-month period (or other period as established by the Secretary of Defense).

(3) In addition to the authority provided under paragraph (2), the Secretary of Defense may authorize the commander of a facility of the uniformed services, the lead agent (if other than the commander), and the health care contractor to modify the payment limitations under paragraph (1) for certain health care providers when necessary to ensure both the availability of certain services for covered beneficiaries and lower costs than would otherwise be incurred to provide the services. With the consent of the health care provider, the Secretary is also authorized to reduce the authorized payment for certain health care services below the amount otherwise required by the payment limitations under paragraph (1).

(4)(A) The Secretary of Defense, in consultation with the other administering Secretaries, shall prescribe regulations to establish limitations (similar to the limitations established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)) on beneficiary liability for charges of an individual health care professional (or other noninstitutional health care provider).

(B) The regulations shall include a restriction that prohibits an individual health care professional (or other noninstitutional health care provider) from billing a beneficiary for services for more than the amount that is equal to—

(i) the excess of the limiting charge (as defined in section 1848(g)(2) of the Social Security Act (42 U.S.C. 1395w–4(g)(2))) that would be applicable if the services had been provided by the professional (or other provider) as an individual health care professional (or other noninstitutional health care provider) on a nonassignment-related basis under part B of title XVIII of such Act over the amount that is payable by the United States for those services under this subsection, plus

(ii) any unpaid amounts of deductibles or copayments that are payable directly to the professional (or other provider) by the beneficiary.

(C)(i) In the case of a dependent described in clause (ii), the regulations shall provide that, in addition to amounts otherwise payable by the United States, the Secretary may pay the amount referred to in subparagraph (B)(i).

(ii) This subparagraph applies to a dependent referred to in subsection (a) of a member of a reserve component serving on active duty pursuant to a call or order to active duty for a period of more than 30 days.

(5) To assure access to care for all covered beneficiaries, the Secretary of Defense, in consultation with the other administering Secretaries, shall designate specific rates for reimbursement for services in certain localities if the Secretary determines that without payment of such rates access to health care services would be severely impaired. Such a determination shall be based on consideration of the number of providers in a locality who provide the services, the number of such providers who are CHAMPUS participating providers, the number of covered beneficiaries under CHAMPUS in the locality, the availability of military providers in the location or a nearby location, and any other factors determined to be relevant by the Secretary.

(i)(1) A benefit may not be paid under a plan covered by this section in the case of a person enrolled in, or covered by, any other insurance, medical service, or health plan, including any plan offered by a third-party payer (as defined in section 1095(h)(1) of this title), to the extent that the benefit is also a benefit under the other plan, except in the case of a plan administered

under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) The amount to be paid to a provider of services for services provided under a plan covered by this section shall be determined under joint regulations to be prescribed by the administering Secretaries which provide that the amount of such payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(3) A contract for a plan covered by this section shall include a clause that prohibits each provider of services under the plan from billing any person covered by the plan for any balance of charges for services in excess of the amount paid for those services under the joint regulations referred to in paragraph (2), except for any unpaid amounts of deductibles or copayments that are payable directly to the provider by the person.

(4) In this subsection, the term ''provider of services'' means a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program (as defined in section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395x(dd)(2))), or other institutional facility providing services for which payment may be made under a plan covered by this section.

(j) A plan covered by this section may include provision of liver transplants (including the cost of acquisition and transportation of the donated liver) in accordance with this subsection. Such a liver transplant may be provided if—

(1) the transplant is for a dependent considered appropriate for that procedure by the Secretary of Defense in consultation with the other administering Secretaries and such other entities as the Secretary considers appropriate; and

(2) the transplant is to be carried out at a health-care facility that has been approved for that purpose by the Secretary of Defense after consultation with the other administering Secretaries and such other entities as the Secretary considers appropriate.

(k)(1) Contracts entered into under subsection (a) shall also provide for medical care for dependents of former members of the uniformed services who are authorized to receive medical and dental care under section 1076(e) of this title in facilities of the uniformed services.

(2) Except as provided in paragraph (3), medical care in the case of a dependent described in section 1076(e) shall be furnished under the same conditions and subject to the same limitations as medical care furnished under this section to spouses and children of members of the uniformed services described in the first sentence of subsection (a).

(3) Medical care may be furnished to a dependent pursuant to paragraph (1) only for an injury, illness, or other condition described in section 1076(e) of this title.

(*l*)(1) Subject to paragraph (2), the Secretary of Defense may, upon request, make payments under this section for a charge for services for which a claim is submitted under a plan contracted for under subsection (a) to a hospital that does not impose a legal obligation on any of its patients to pay for such services.

(2) A payment under paragraph (1) may not exceed the average amount paid for comparable services in the geographic area in which the hospital is located or, if no comparable services are available in that area, in an area similar to the area in which the hospital is located.

(3) The Secretary of Defense shall periodically review the billing practices of each hospital the Secretary approves for payment under this subsection to ensure that the hospital's practices of not billing patients for payment are not resulting in increased costs to the Government.

(4) The Secretary of Defense may require each hospital the Secretary approves for payment under this subsection to provide evidence that it has sources of revenue to cover unbilled costs.

(m) The Secretary of Defense may enter into contracts (or amend existing contracts) with fiscal intermediaries under which the intermediaries agree to organize and operate, directly or through subcontractors, managed health care networks for the provision of health care under this chapter. The managed health care networks shall include cost containment methods, such as utilization review and contracting for care on a discounted basis.

(n)(1) Health care services provided pursuant to this section or section 1086 of this title (or pursuant to any other contract or project under the Civilian Health and Medical Program of the Uniformed Services) may not include services determined under the CHAMPUS Peer Review Organization program to be not medically or psychologically necessary.

(2) The Secretary of Defense, after consulting with the other administering Secretaries, may adopt or adapt for use under the CHAMPUS Peer Review Organization program, as the Secretary considers appropriate, any of the quality and utilization review requirements and procedures that are used by the Peer Review Organization program under part B of title XI of the Social Security Act (42 U.S.C. 1320c et seq.).

(*o*)(1) Subject to such exceptions as the Secretary of Defense considers necessary, coverage for medical care under this section for the dependents described in paragraph (3), and standards with respect to timely access to such care, shall be comparable to coverage for medical care and standards for timely access to such care under the managed care option of the TRICARE program known as TRICARE Prime.

(2) The Secretary of Defense shall enter into arrangements with contractors under the TRICARE program or with other appropriate contractors for the timely and efficient processing of claims under this subsection.

(3) This subsection applies with respect to a dependent referred to in subsection (a) who—

(A) is a dependent of a member of the uniformed services referred to in section 1074(c)(3) of this title and is residing with the member;

(B) is a dependent of a member who, after having served in a duty assignment described in section 1074(c)(3) of this title, has relocated without the dependent pursuant to orders for a permanent change of duty station from a remote location described in subparagraph

(B)(ii) of such section where the member and the dependent resided together while the member served in such assignment, if the orders do not authorize dependents to accompany the member to the new duty station at the expense of the United States and the dependent continues to reside at the same remote location, or

(C) is a dependent of a reserve component member ordered to active duty for a period of more than 30 days and is residing with the member, and the residence is located more than 50 miles, or approximately one hour of driving time, from the nearest military medical treatment facility adequate to provide the needed care.

(4) The Secretary of Defense may provide for coverage of a dependent referred to in subsection (a) who is not described in paragraph (3) if the Secretary determines that exceptional circumstances warrant such coverage.

(5) The Secretary of Defense shall consult with the other administering Secretaries in the administration of this subsection.

(p) Subject to subsection (a), a physician or other health care practitioner who is eligible to receive reimbursement for services provided under medicare (as defined in section 1086(d)(3)(C) of this title) shall be considered approved to provide medical care authorized under this section and section 1086 of this title unless the administering Secretaries have information indicating medicare, TRICARE, or other Federal health care program integrity violations by the physician or other health care practitioner.

(q) In the case of any pharmaceutical agent (as defined in section 1074g(h)[1] of this title) provided under a contract entered into under this section by a physician, in an outpatient department of a hospital, or otherwise as part of any medical services provided under such a contract, the Secretary of Defense may, under regulations prescribed by the Secretary, adopt special reimbursement methods, amounts, and procedures to encourage the use of high-value products and discourage the use of low-value products, as determined by the Secretary.

(Added Pub. L. 85–861, §1(25)(B), Sept. 2, 1958, 72 Stat. 1448; amended Pub. L. 89–614, §2(6), Sept. 30, 1966, 80 Stat. 863; Pub. L. 92–58, §1, July 29, 1971, 85 Stat. 157; Pub. L. 95–485, title VIII, §806(a)(1), Oct. 20, 1978, 92 Stat. 1622; Pub. L. 96–342, title VIII, §810(a), (b), Sept. 8, 1980, 94 Stat. 1097; Pub. L. 96–513, title V, §§501(13), 511(36), (38), Dec. 12, 1980, 94 Stat. 2908, 2923; Pub. L. 96–552, Dec. 19, 1980, 94 Stat. 3254; Pub. L. 97–22, §11(a)(2), July 10, 1981, 95 Stat. 137; Pub. L. 97–86, title IX, §906(a)(1), Dec. 1, 1981, 95 Stat. 1117; Pub. L. 98–94, title IX, §931(a), title XII, §1268(4), Sept. 24, 1983, 97 Stat. 648, 705; Pub. L. 98–525, title VI, §632(a)(1), title XIV, §§1401(e)(4), 1405(23), Oct. 19, 1984, 98 Stat. 2543, 2617, 2623; Pub. L. 98–557, §19(7), Oct. 30, 1984, 98 Stat. 2869; Pub. L. 99–661, div. A, title VI, §652(d), title VII, §703, Nov. 14, 1986, 100 Stat. 3889, 3900; Pub. L. 100–180, div. A, title VII, §§721(a), 726(a), Dec. 4, 1987, 101 Stat. 1115, 1117; Pub. L. 100–456, div. A, title VI, §646(a), Sept. 29, 1988, 102 Stat. 1989; Pub. L. 101–189, div. A, title VII, §730(a), Nov. 29, 1989, 103 Stat. 1481; Pub. L. 101–510, div. A, title VII, §§701(a), 702(a), 703(a), (b), 712(a), title XIV, §1484(g)(1), Nov. 5, 1990, 104 Stat. 1580, 1581, 1583, 1717; Pub. L. 102–25, title III, §316(b), Apr. 6, 1991, 105 Stat. 87; Pub. L. 102–190, div. A, title VII, §§702(b), 711, 712(a), 713, Dec. 5, 1991, 105 Stat. 1400, 1402, 1403; Pub. L. 102–484, div. A, title VII, §704, title X, §§1052(13), 1053(3), Oct. 23, 1992, 106 Stat. 2432, 2499, 2501; Pub. L. 103–35, title II, §202(a)(5), May 31, 1993, 107 Stat. 101; Pub. L. 103–160, div. A, title VII, §§711, 716(c), Nov. 30, 1993, 107 Stat. 1688, 1693; Pub. L. 103–337, div. A, title VII, §§702(a), 707(a), Oct. 5, 1994, 108 Stat. 2797, 2800; Pub. L. 104–106, div. A, title VII, §§701, 731(a)–(d), Feb. 10, 1996, 110 Stat. 370, 380, 381; Pub. L. 104–201, div. A, title VII, §§701(b)(2), 711, 731, 732, 735(c), Sept. 23, 1996, 110 Stat. 2587, 2590, 2597, 2599; Pub. L. 105–85, div. A, title VII, §735, Nov. 18, 1997, 111 Stat. 1813; Pub. L. 106–398, §1 [[div. A], title VII, §§701(c)(1), 704(b), 722(b)(1), 757(a)], Oct. 30, 2000, 114 Stat. 1654, 1654A–172, 1654A–175, 1654A–185, 1654A–198; Pub. L. 107–107, div. A, title VII, §§701(b), (g)(2), 703(b), 707(a), (b), title X, §1048(c)(5), Dec. 28, 2001, 115 Stat. 1158, 1161–1163, 1226; Pub. L. 107–314, div. A, title VII, §§701(a), §702, §705(a), Dec. 2, 2002, 116 Stat. 2583, 2584; Pub. L. 108–375, div. A, title VII, §705, Oct. 28, 2004, 118 Stat. 1983; Pub. L. 109–163, div. A, title VII, §§714, 715(a), Jan. 6, 2006, 119 Stat. 3344; Pub. L. 109–364, div. A, title VII, §§701, 702, 703(b), Oct. 17, 2006, 120 Stat. 2279; Pub. L. 110–417, [div. A], title VII, §732, Oct. 14, 2008, 122 Stat. 4511; Pub. L. 111–84, div. A, title X, §1073(a)(12), Oct. 28, 2009, 123 Stat. 2473; Pub. L. 113–291, div. A, title VII, §§703(a), (c)(1), 706, Dec. 19, 2014, 128 Stat. 3411–3413; Pub. L. 114–328, div. A, title VI, §618(b), title VII, §748(b), Dec. 23, 2016, 130 Stat. 2160, 2242; Pub. L. 115–91, div. A, title VII, §§702(b)(2), 704, 739(d)(1), Dec. 12, 2017, 131 Stat. 1434, 1435, 1447; Pub. L. 115–232, div. A, title VII, §715(b), Aug. 13, 2018, 132 Stat. 1814.)

[1] See References in Text note below.

HISTORICAL AND REVISION NOTES

| *Revised section* | *Source (U.S. Code)* | *Source (Statutes at Large)* |
|---|---|---|
| 1079(a) ..... | 37:402(a)(2) (as applicable to 37:411(a)).<br>37:411(a). | June 7, 1956, ch. 374, §§102(a)(2) (as applicable to §201(a)), 201(a), (b), 204, 70 Stat. 250, 252, 253. |
| 1079(b) ..... | 37:411(b).<br>37:414. | |

In subsection (a), the words ''appointed, enlisted, inducted or called, ordered or conscripted in a uniformed service'', in 37:402(a)(2) are omitted as surplusage, since it does not matter how a member became a member. The words ''active duty for a period of more than 30 days'' are substituted for the words ''active duty or active duty for training pursuant to a call or order that does not specify a period of thirty days or less'', in 37:402(a)(2), to reflect section 101(22) and (23) of this title. The words '', under the authority of this section,'' are substituted for the words ''pursuant to the provisions of this title'' to make clear that the section provides independent procurement authority. The words ''all'', ''by the hospital'', and ''a period of'', in 37:411(a), are omitted as surplusage.

In subsection (a)(1), the word ''rooms'', in 37:411(a), is substituted for the word ''accommodations''.

In subsection (a)(5), the word ''services'' is substituted for the word ''procedures'' and the word ''performed'' is substituted for the word ''accomplished'', in 37: 411(a). The words ''or surgeon'' are inserted for clarity.

In subsection (b), the word ''variances'' is substituted for the words ''limitations, additions, exclusions''. The

words ''or care other than that provided for in sections 1076–1078 of this title'' are substituted for 37:414. The words ''definitions, and related provisions'', in 37:411(b), are omitted as surplusage, since the Secretary of an executive department has inherent authority to interpret laws and issue regulations.

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (h)(1), (4)(A), (B)(i), (i)(1), (2), and (n)(2), is act Aug. 13, 1935, ch. 531, 49 Stat. 620. Part B of title XI of the Act is classified generally to part B (§ 1320c et seq.) of subchapter XI of chapter 7 of Title 42, The Public Health and Welfare. Titles XVIII and XIX of the Act are classified generally to subchapters XVIII (§ 1395 et seq.) and XIX (§ 1396 et seq.), respectively, of chapter 7 of Title 42. Part B of title XVIII of the Act is classified generally to part B (§ 1395j et seq.) of subchapter XVIII of chapter 7 of Title 42. Section 1861(m) of the Act is classified to section 1395x(m) of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 1074g(h) of this title, referred to in subsec. (q), was redesignated section 1074g(i) of this title by Pub. L. 116–92, div. A, title VII, § 713(a)(1), Dec. 20, 2019, 133 Stat. 1446.

PRIOR PROVISIONS

Provisions similar to those in subsec. (a)(7) to (14) of this section were contained in the following appropriation acts, with the exception of the provisions similar to par. (14) which first appeared in Pub. L. 96–154:

Pub. L. 98–473, title I, § 101(h) [title VIII, §§ 8031, 8032, 8045], Oct. 12, 1984, 98 Stat. 1904, 1929, 1931.

Pub. L. 98–212, title VII, §§ 737, 738, 752, Dec. 8, 1983, 97 Stat. 1445, 1447.

Pub. L. 97–377, title I, § 101(c) [title VII, §§ 740, 741, 756], Dec. 21, 1982, 96 Stat. 1833, 1857, 1860.

Pub. L. 97–114, title VII, §§ 741, 742, 759, Dec. 29, 1981, 95 Stat. 1585, 1588.

Pub. L. 96–527, title VII, §§ 742, 743, 763, Dec. 15, 1980, 94 Stat. 3088, 3092.

Pub. L. 96–154, title VII, §§ 744, 745, 769, Dec. 21, 1979, 93 Stat. 1159, 1163.

Pub. L. 95–457, title VIII, §§ 844, 845, Oct. 13, 1978, 92 Stat. 1251.

Pub. L. 95–111, title VIII, §§ 843, 844, Sept. 21, 1977, 91 Stat. 907.

Pub. L. 94–419, title VII, §§ 742, 743, Sept. 22, 1976, 90 Stat. 1298.

Pub. L. 94–212, title VII, §§ 750, 751, Feb. 9, 1976, 90 Stat. 176.

Provisions similar to those added to subsec. (h)(2) of this section by section 1401(e)(4)(B) of Pub. L. 98–525 were contained in the following prior appropriation acts:

Pub. L. 98–473, title I, § 101(h) [title VIII, § 8077], Oct. 12, 1984, 98 Stat. 1904, 1938.

Pub. L. 98–212, title VII, § 785, Dec. 8, 1983, 97 Stat. 1453.

A prior section 1079, act Aug. 10, 1956, ch. 1041, 70A Stat. 84, related to establishment of right to vote, prior to repeal by Pub. L. 85–861, § 36B(5), Sept. 2, 1958, 72 Stat. 1570, as superseded by the Federal Voting Assistance Act of 1955 which is classified to subchapter I–D (§ 1973cc et seq.) of chapter 20 of Title 42, The Public Health and Welfare.

AMENDMENTS

2018—Subsec. (q). Pub. L. 115–232 substituted ''section 1074g(h)'' for ''section 1074g(g)''.

2017—Subsec. (a)(15). Pub. L. 115–91, § 704, inserted '', except that hospice care may be provided to an individual under the age of 21 concurrently with health care services or hospitalization for the same condition'' before period at end.

Subsec. (b). Pub. L. 115–91, § 739(d)(1), substituted ''calendar year'' for ''fiscal year'' wherever appearing.

Subsec. (q). Pub. L. 115–91, § 702(b)(2), added subsec. (q).

2016—Subsec. (g)(1). Pub. L. 114–328, § 618(b), inserted ''or 351'' after ''section 310''.

Subsec. (h)(4)(C)(ii). Pub. L. 114–328, § 748(b), struck out ''in support of a contingency operation under a provision of law referred to in section 101(a)(13)(B) of this title'' after ''30 days''.

2014—Subsec. (a)(6) to (16). Pub. L. 113–291, § 703(a)(1), redesignated pars. (7) to (17) as (6) to (16), respectively, and struck out former par. (6) which read as follows: ''Inpatient mental health services may not (except as provided in subsection (i)) be provided to a patient in excess of—

''(A) 30 days in any year, in the case of a patient 19 years of age or older;

''(B) 45 days in any year, in the case of a patient under 19 years of age; or

''(C) 150 days in any year, in the case of inpatient mental health services provided as residential treatment care.''

Subsec. (a)(17). Pub. L. 113–291, § 706, added par. (17). Former par. (17) redesignated (16).

Subsec. (e)(7). Pub. L. 113–291, § 703(c)(1), substituted ''subsection (a)(12)'' for ''subsection (a)(13)''.

Subsecs. (i) to (q). Pub. L. 113–291, § 703(a)(2), (3), redesignated subsecs. (j) to (q) as (i) to (p), respectively, and struck out former subsec. (i) which related to limitation in former subsec. (a)(6) of this section as being inapplicable to inpatient mental health services in certain instances.

2009—Subsec. (f)(2)(B). Pub. L. 111–84 struck out period after ''year''.

2008—Subsec. (f)(2). Pub. L. 110–417 substituted ''year shall not exceed $36,000, prorated as determined by the Secretary of Defense,'' for ''month shall not exceed $2,500,'' in subpar. (A) and ''year.'' for ''month'' in subpar. (B).

2006—Subsec. (a)(1). Pub. L. 109–364, § 702, amended par. (1) generally. Prior to amendment, par. (1) read as follows: ''With respect to dental care, only that care required as a necessary adjunct to medical or surgical treatment may be provided.''

Subsec. (a)(2). Pub. L. 109–364, § 703(b)(1), substituted ''the schedule and method of cervical cancer screenings and breast cancer screenings'' for ''the schedule of pap smears and mammograms'' in introductory provisions.

Subsec. (a)(2)(B). Pub. L. 109–364, § 703(b)(2), substituted ''cervical and breast cancer screenings'' for ''pap smears and mammograms''.

Subsec. (a)(17). Pub. L. 109–364, § 701, added par. (17).

Subsec. (g). Pub. L. 109–163, § 715(a), designated existing provisions as par. (1), struck out last sentence which read ''In addition, when a member dies while on active duty for a period of more than 30 days, the member's dependents who are receiving benefits under a plan covered by subsection (a) shall continue to be eligible for such benefits during the three-year period beginning on the date of the death of the member.'', and added pars. (2) to (5).

Subsec. (p)(4), (5). Pub. L. 109–163, § 714, added par. (4) and redesignated former par. (4) as (5).

2004—Subsec. (h)(4)(C). Pub. L. 108–375 added subpar. (C).

2002—Subsec. (i)(3). Pub. L. 107–314, § 701(a), designated existing provisions as subpar. (A), substituted ''Except as provided in subparagraph (B),'' for ''Except in the case of an emergency,'', and added subpars. (B) and (C).

Subsec. (p)(1). Pub. L. 107–314, § 702(1), substituted ''dependents described in paragraph (3)'' for ''dependents referred to in subsection (a) of a member of the uniformed services referred to in section 1074(c)(3) of this title who are residing with the member''.

Subsec. (p)(3), (4). Pub. L. 107–314, § 702(2), (3), added par. (3) and redesignated former par. (3) as (4).

Subsec. (q). Pub. L. 107–314, § 705(a), added subsec. (q).

2001—Subsec. (a)(5). Pub. L. 107–107, § 703(b), amended par. (5) generally. Prior to amendment, par. (5) read as follows: ''Durable equipment, such as wheelchairs, iron lungs and hospital beds may be provided on a rental basis.''

Subsec. (a)(17). Pub. L. 107–107, §701(g)(2), struck out par. (17) which read as follows:

''(17)(A) The Secretary of Defense may establish a program for the individual case management of a person covered by this section or section 1086 of this title who has extraordinary medical or psychological disorders and, under such a program, may waive benefit limitations contained in paragraphs (5) and (13) of this subsection or section 1077(b)(1) of this title and authorize the payment for comprehensive home health care services, supplies, and equipment if the Secretary determines that such a waiver is cost-effective and appropriate.

''(B) The total amount expended under subparagraph (A) for a fiscal year may not exceed $100,000,000.''

Subsec. (d) to (f). Pub. L. 107–107, §701(b), added subsecs. (d) to (f) and struck out former subsecs. (d) to (f) which related to medical care provided for retarded or handicapped dependents, the requirement of members sharing in cost of benefits provided, and the requirement that members use public facilities to the extent available and adequate, respectively.

Subsec. (h)(2). Pub. L. 107–107, §1048(c)(5), substituted ''February 10, 1996,'' for ''the date of the enactment of this paragraph''.

Subsec. (h)(4). Pub. L. 107–107, §707(b), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (j)(2) to (4). Pub. L. 107–107, §707(a), designated existing provisions of subpar. (A) of par. (2) as par. (2) and substituted ''shall be determined under joint regulations'' for ''may be determined under joint regulations'', redesignated subpar. (B) of par. (2) as par. (4) and substituted therein ''this subsection,'' for ''subparagraph (A),'', and added par. (3).

2000—Subsec. (a)(17). Pub. L. 106–398, §1 [[div. A], title VII, §701(c)(1)], designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (g). Pub. L. 106–398, §1 [[div. A], title VII, §704(b)], substituted ''three-year period'' for ''one-year period''.

Subsec. (h)(5). Pub. L. 106–398, §1 [[div. A], title VII, §757(a)], added par. (5).

Subsec. (p). Pub. L. 106–398, §1 [[div. A], title VII, §722(b)(1)], added subsec. (p).

1997—Subsec. (h)(1). Pub. L. 105–85, §735(a), added par. (1) and struck out former par. (1) which read as follows: ''Payment for a charge for services by an individual health care professional (or other noninstitutional health care provider) for which a claim is submitted under a plan contracted for under subsection (a) may not exceed the lesser of—

''(A) the amount equivalent to the 80th percentile of billed charges made for similar services in the same locality during the base period; or

''(B) an amount determined to be appropriate, to the extent practicable, in accordance with the same reimbursement rules as apply to payments for similar services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).''

Subsec. (h)(2). Pub. L. 105–85, §735(c)(2), redesignated par. (4) as (2).

Pub. L. 105–85, §735(a), struck out par. (2) which read as follows: ''For the purposes of paragraph (1)(A), the 80th percentile of charges shall be determined by the Secretary of Defense, in consultation with the other administering Secretaries, and the base period shall be a period of twelve calendar months. The Secretary of Defense shall adjust the base period as frequently as he considers appropriate.''

Subsec. (h)(3). Pub. L. 105–85, §735(c)(2), redesignated par. (5) as (3).

Pub. L. 105–85, §735(a), struck out par. (3) which read as follows: ''For the purposes of paragraph (1)(B), the appropriate payment amount shall be determined by the Secretary of Defense, in consultation with the other administering Secretaries.''

Subsec. (h)(4). Pub. L. 105–85, §735(c)(2), redesignated par. (4) as (2).

Subsec. (h)(5). Pub. L. 105–85, §735(c)(2), redesignated par. (5) as (3).

Pub. L. 105–85, §735(b), (c)(1), substituted ''paragraph (2), the Secretary of Defense'' for ''paragraph (4), the Secretary'' and inserted at end ''With the consent of the health care provider, the Secretary is also authorized to reduce the authorized payment for certain health care services below the amount otherwise required by the payment limitations under paragraph (1).''

Subsec. (h)(6). Pub. L. 105–85, §735(c)(2), redesignated par. (6) as (4).

1996—Subsec. (a). Pub. L. 104–201, §731(b)(1), substituted ''except as follows:'' for ''except that—'' in introductory provisions.

Subsec. (a)(1). Pub. L. 104–201, §731(b)(2), (3), capitalized first letter of first word and substituted a period for the semicolon at end.

Subsec. (a)(2). Pub. L. 104–201, §731(b)(2), (3), capitalized first letter of first word and substituted a period for the semicolon at end.

Pub. L. 104–201, §701(b)(2), inserted ''the schedule and method of colon and prostate cancer screenings,'' after ''pap smears and mammograms,'' in introductory provisions and ''or colon and prostate cancer screenings'' after ''pap smears and mammograms'' in subpar. (B).

Pub. L. 104–106, §701, added par. (2) and struck out former par. (2) which read as follows: ''routine physical examinations and immunizations of dependents over two years of age may only be provided when required in the case of dependents who are traveling outside the United States as a result of a member's duty assignment and such travel is being performed under orders issued by a uniformed service, except that pap smears and mammograms may be provided on a diagnostic or preventive basis;''.

Subsec. (a)(3) to (12). Pub. L. 104–201, §731(b)(2), (3), capitalized first letter of first word and substituted a period for the semicolon at end.

Subsec. (a)(13). Pub. L. 104–201, §731(a), (b)(2), substituted ''Any service'' for ''any service'' and ''paragraph (4).'' for ''paragraph (4);'' and inserted at end ''Pursuant to an agreement with the Secretary of Health and Human Services and under such regulations as the Secretary of Defense may prescribe, the Secretary of Defense may waive the operation of this paragraph in connection with clinical trials sponsored or approved by the National Institutes of Health if the Secretary of Defense determines that such a waiver will promote access by covered beneficiaries to promising new treatments and contribute to the development of such treatments.''

Subsec. (a)(14), (15). Pub. L. 104–201, §731(b)(2), (3), capitalized first letter of first word and substituted a period for the semicolon at end.

Subsec. (a)(16). Pub. L. 104–201, §731(b)(2), (4), capitalized first letter of first word and substituted a period for ''; and'' at end.

Subsec. (a)(17). Pub. L. 104–201, §731(b)(2), capitalized first letter of first word.

Subsec. (h)(1). Pub. L. 104–106, §731(a), added par. (1) and struck out former par. (1) which read as follows: ''Payment for a charge for services by an individual health-care professional (or other noninstitutional health-care provider) for which a claim is submitted under a plan contracted for under subsection (a) may be denied only to the extent that the charge exceeds the amount equivalent to the 80th percentile of billed charges made for similar services in the same locality during the base period.''

Subsec. (h)(2). Pub. L. 104–106, §731(d), substituted ''paragraph (1)(A)'' for ''paragraph (1)''.

Subsec. (h)(3). Pub. L. 104–106, §731(b), added par. (3).

Subsec. (h)(4). Pub. L. 104–201, §711, struck out ''emergency'' before ''services from nonparticipating providers.''

Pub. L. 104–106, §731(c), added par. (4).

Subsec. (h)(5). Pub. L. 104–201, §732(2), added par. (5). Former par. (5) redesignated (6).

Pub. L. 104–106, §731(c), added par. (5).

Subsec. (h)(6). Pub. L. 104–201, §732(1), redesignated par. (5) as (6).

Subsec. (j)(1). Pub. L. 104–201, § 735(c), inserted '', including any plan offered by a third-party payer (as defined in section 1095(h)(1) of this title),'' after ''or health plan''.

1994—Subsec. (a). Pub. L. 103–337, § 702(a)(1), substituted ''dependents, as described in subparagraphs (A), (D), and (I) of section 1072(2) of this title,'' for ''spouses and children''.

Subsec. (d). Pub. L. 103–337, § 702(a)(2), substituted ''as described in subparagraph (A), (D), or (I) of section 1072(2)'' for ''as defined in section 1072(2)(A) or (D)''.

Subsec. (g). Pub. L. 103–337, § 707(a), inserted at end ''In addition, when a member dies while on active duty for a period of more than 30 days, the member's dependents who are receiving benefits under a plan covered by subsection (a) shall continue to be eligible for such benefits during the one-year period beginning on the date of the death of the member.''

1993—Subsec. (a)(7). Pub. L. 103–160, § 716(c), substituted ''except that those services may be provided in any case in which another insurance plan or program provides primary coverage for those services;'' for ''except that—

''(A) those services may be provided in any case in which another insurance plan or program provides primary coverage for those services; and

''(B) the Secretary of Defense may waive the 40-mile radius restriction with regard to the provision of a particular service before October 1, 1993, if the Secretary determines that the use of a different geographical area restriction will result in a more cost-effective provision of the service;''.

Subsec. (a)(15). Pub. L. 103–35 made technical amendment to directory language of Pub. L. 102–484, § 704(1). See 1992 Amendment note below.

Subsec. (*o*). Pub. L. 103–160, § 711, added subsec. (*o*).

1992—Subsec. (a)(15). Pub. L. 102–484, § 1053(3), made technical amendment to directory language of Pub. L. 102–190, § 702(b)(1)(C). See 1991 Amendment note below.

Pub. L. 102–484, § 704(1), as amended by Pub. L. 103–35, struck out ''and'' at end of par. (15).

Subsec. (a)(16). Pub. L. 102–484, § 704(2), substituted ''; and'' for period at end.

Subsec. (a)(17). Pub. L. 102–484, § 704(3), added par. (17).

Subsec. (j)(2)(B). Pub. L. 102–484, § 1052(13), inserted a close parenthesis after ''1395x(dd)(2)''.

1991—Subsec. (a)(6). Pub. L. 102–25, § 316(b), revived par. (6) as in effect on Feb. 14, 1991, thus negating amendment to par. (6) by Pub. L. 101–510, § 703(a), from its original effective date (Feb. 15, 1991) to the effective date as amended (Oct. 1, 1991). See 1990 Amendment note and Effective Date of 1990 Amendment note below.

Subsec. (a)(7). Pub. L. 102–190, § 711, substituted ''except that—'' and subpars. (A) and (B), for ''except that such services may be provided in any case in which another insurance plan or program provides primary coverage for the services;''.

Subsec. (a)(13). Pub. L. 102–190, § 702(b)(1)(A), substituted ''paragraph (4)'' for ''clause (4)''.

Subsec. (a)(14). Pub. L. 102–190, § 702(b)(1)(B), struck out ''and'' at end.

Subsec. (a)(15). Pub. L. 102–190, § 702(b)(1)(C), as amended by Pub. L. 102–484, § 1053(3), substituted ''; and'' for period at end.

Subsec. (a)(16). Pub. L. 102–190, § 702(b)(1)(D), added par. (16).

Subsec. (i). Pub. L. 102–25, § 316(b), revived subsec. (i) as in effect on Feb. 14, 1991, thus negating amendment to subsec. (i) by Pub. L. 101–510, § 703(b), from its original effective date (Feb. 15, 1991) to the effective date as amended (Oct. 1, 1991). See 1990 Amendment note and Effective Date of 1990 Amendment note below.

Subsec. (j)(1). Pub. L. 102–190, § 713, inserted '', or covered by,'' after ''person enrolled in''.

Subsec. (j)(2)(B). Pub. L. 102–190, § 702(b)(2), inserted ''hospice program (as defined in section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395x(dd)(2)),''.

Subsec. (n). Pub. L. 102–190, § 712(a), added subsec. (n).

1990—Subsec. (a)(2). Pub. L. 101–510, § 701(a), inserted before the semicolon '', except that pap smears and mammograms may be provided on a diagnostic or preventive basis''.

Subsec. (a)(6). Pub. L. 101–510, § 703(a), substituted ''in excess of—'' for ''in excess of 60 days in any year;'' and added subpars. (A) to (C).

Subsec. (a)(8). Pub. L. 101–510, § 702(a)(1), inserted ''(other than certified marriage and family therapists)'' after ''marital counselors'' and inserted before semicolon ''and services of certified marriage and family therapists may be provided consistent with such rules as may be prescribed by the Secretary of Defense, including credentialing criteria and a requirement that the therapists accept payment under this section as full payment for all services provided''.

Subsec. (a)(13). Pub. L. 101–510, § 702(a)(2), inserted ''certified marriage and family therapist,'' after ''psychologist,''.

Subsec. (b)(2). Pub. L. 101–510, § 712(a)(1), substituted ''$150'' for ''$50'' and inserted at end ''Notwithstanding the preceding sentence, in the case of a dependent of an enlisted member in a pay grade below E–5, the initial deductible each fiscal year under this paragraph shall be limited to $50.''

Subsec. (b)(3). Pub. L. 101–510, § 712(a)(2), substituted ''$300 (or in the case of the family group of an enlisted member in a pay grade below E–5, the first $100)'' for ''$100''.

Subsec. (i). Pub. L. 101–510, § 703(b), amended subsec. (i) generally. Prior to amendment, subsec. (i) read as follows: ''The limitation in subsection (a)(6) does not apply in the case of inpatient mental health services—

''(1) provided under the program for the handicapped under subsection (d);

''(2) provided as residential treatment care;

''(3) provided as partial hospital care; or

''(4) provided pursuant to a waiver authorized by the Secretary of Defense because of extraordinary medical or psychological circumstances that are confirmed by review by a non-Federal health professional pursuant to regulations prescribed by the Secretary of Defense.''

Subsec. (j)(2)(B). Pub. L. 101–510, § 1484(g)(1), inserted ''the term'' after ''In subparagraph (A),''.

1989—Subsec. (h)(1), (2). Pub. L. 101–189 substituted ''80th percentile'' for ''90th percentile''.

1988—Subsec. (b)(1). Pub. L. 100–456, § 646(a)(1), inserted provisions authorizing Secretary of Defense to exempt a patient from paying such amount if the hospital to which the patient is admitted does not impose a legal obligation on any of its patients to pay for inpatient care.

Subsec. (m). Pub. L. 100–456, § 646(a)(2), added subsec. (m).

1987—Subsec. (a)(15). Pub. L. 100–180, § 726(a), added par. (15).

Subsec. (b)(5). Pub. L. 100–180, § 721(a), added par. (5).

1986—Subsec. (a)(7). Pub. L. 99–661, § 703, substituted ''provides primary coverage for the services'' for ''pays for at least 75 percent of the services''.

Subsec. (*l*). Pub. L. 99–661, § 652(d), added subsec. (*l*).

1984—Subsec. (a). Pub. L. 98–557, § 19(7)(B), substituted reference to other administering Secretaries for reference to Secretary of Health and Human Services in provisions preceding cl. (1).

Subsec. (a)(3). Pub. L. 98–525, § 632(a)(1), substituted ''not more than one eye examination may be provided to a patient in any calendar year'' for ''eye examinations may not be provided''.

Subsec. (a)(4). Pub. L. 98–557, § 19(7)(A), substituted reference to the administering Secretaries for reference to the Secretary of Defense and the Secretary of Health and Human Services.

Subsec. (a)(7) to (14). Pub. L. 98–525, § 1401(e)(4)(A), added cls. (7) to (14).

Subsecs. (b)(4), (c), (d). Pub. L. 98–557, § 19(7)(A), substituted reference to the administering Secretaries for reference to the Secretary of Defense and the Secretary of Health and Human Services.

Subsec. (e). Pub. L. 98–525, § 1405(23), substituted ''under subsection (d) as follows:'' for ''under subsection (d).'' in provisions preceding cl. (1).

Subsecs. (e)(1), (f). Pub. L. 98–557, §19(7)(A), substituted reference to the administering Secretaries for reference to the Secretary of Defense and the Secretary of Health and Human Services.

Subsec. (h)(2). Pub. L. 98–557, §19(7)(B), substituted reference to other administering Secretaries for reference to Secretary of Health and Human Services.

Pub. L. 98–525, §1401(e)(4)(B), substituted ''The Secretary of Defense shall adjust the base period as frequently as he considers appropriate'' for ''The base period shall be adjusted at least once a year''.

Subsec. (j)(2)(A). Pub. L. 98–557, §19(7)(A), substituted reference to the administering Secretaries for reference to the Secretary of Defense and the Secretary of Health and Human Services.

Subsec. (k)(1), (2). Pub. L. 98–557, §19(7)(B), substituted reference to other administering Secretaries for reference to Secretary of Health and Human Services.

1983—Subsec. (a). Pub. L. 98–94, §1268(4)(A), substituted ''30'' for ''thirty'' in provisions preceding par. (1).

Subsec. (a)(6). Pub. L. 98–94, §931(a)(1), added par. (6).

Subsec. (d). Pub. L. 98–94, §1268(4)(A), substituted ''30'' for ''thirty''.

Subsec. (g). Pub. L. 98–94, §1268(4)(B), struck out ''of this section'' after ''subsection (d)''.

Subsecs. (i) to (k). Pub. L. 98–94, §931(a)(2), added subsecs. (i) to (k).

1981—Subsec. (b)(4). Pub. L. 97–22 substituted ''Secretary of Health and Human Services'' for ''Secretary of Health, Education, and Welfare''.

Subsec. (h). Pub. L. 97–86 substituted reference to services of individual health-care professionals for former reference to physician services, struck out provisions that had used the concept of a predetermined charge level based upon customary charges, and inserted provisions requiring a readjustment of the base period at least once a year.

1980—Subsec. (a). Pub. L. 96–513, §511(36), (38)(A), substituted ''Secretary of Health and Human Services'' for ''Secretary of Health, Education, and Welfare'' wherever appearing, and ''that—'' for ''that:''.

Subsec. (a)(2). Pub. L. 96–342, §810(a)(1), inserted ''of dependents over two years of age'' after ''immunizations''.

Subsec. (a)(3). Pub. L. 96–342, §810(a)(2), struck out ''routine care of the newborn, well-baby care, and'' after ''(3)''.

Subsec. (b)(4). Pub. L. 96–552 added par. (4).

Pub. L. 96–513, §511(38)(B), substituted ''percent'' for ''per centum'' wherever appearing.

Subsec. (c). Pub. L. 96–513, §511(36), substituted ''Secretary of Health and Human Services'' for ''Secretary of Health, Education, and Welfare''.

Subsec. (d). Pub. L. 96–513, §§501(13), 511(36), substituted ''section 1072(2)(A) or (D) of this title'' for ''section 1072(2)(A), (C), or (E) of this title'', and ''Secretary of Health and Human Services'' for ''Secretary of Health, Education, and Welfare''.

Subsec. (e). Pub. L. 96–513, §511(36), (38)(C), substituted ''Secretary of Health and Human Services'' for ''Secretary of Health, Education, and Welfare'', and ''(d) as follows:'' for ''(d).''.

Subsec. (e)(2). Pub. L. 96–342, §810(b), substituted ''$1,000'' for ''$350''.

Subsec. (f). Pub. L. 96–513, §511(36), substituted ''Secretary of Health and Human Services'' for ''Secretary of Health, Education, and Welfare''.

Subsec. (g). Pub. L. 96–513, §511(38)(D), struck out '', United States Code,'' after ''37''.

Subsec. (h). Pub. L. 96–513, §511(36), substituted ''Secretary of Health and Human Services'' for ''Secretary of Health, Education, and Welfare''.

1978—Subsec. (h). Pub. L. 95–485 added subsec. (h).

1971—Subsec. (g). Pub. L. 92–58 added subsec. (g).

1966—Subsec. (a). Pub. L. 89–614 struck out ''dependent'' before ''spouses and children'' and substituted sentence providing that ''The types of health care authorized under this section, shall be the same as those provided under section 1076 of this title'', enumerating exceptions in pars. (1) to (5) for former provisions which required the insurance, medical service, or health plans to include (1) hospitalization in semiprivate rooms for not more than 365 days for each admission, (2) medical and surgical care incident to hospitalization, (3) obstetrical and maternity service, including prenatal and postnatal care, (4) services of physician or surgeon before or after hospitalization for bodily injury or surgical operation, (5) diagnostic tests and services incident to hospitalization, and (6) payments by patient of hospital expenses, now incorporated in subsec. (b)(1).

Subsec. (b). Pub. L. 89–614 incorporated existing provisions of subsec. (a)(6) in par. (1) and added pars. (2) and (3). Former subsec. (b) authorized the Secretary of Defense to make variances from subsec. (a) requirements as appropriate other than outpatient care or care other than provided for in sections 1076 to 1078 of this title.

Subsecs. (c) to (f). Pub. L. 89–614 added subsecs. (c) to (f).

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–163, div. A, title VII, §715(b), Jan. 6, 2006, 119 Stat. 3345, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect on October 7, 2001, and shall apply with respect to deaths occurring on or after that date.''

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–314, div. A, title VII, §701(b), Dec. 2, 2002, 116 Stat. 2583, provided that: ''The amendments made by subsection (a) [amending this section] shall take effect October 1, 2003.''

Pub. L. 107–314, div. A, title VII, §705(b), Dec. 2, 2002, 116 Stat. 2585, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to any contract under the TRICARE program entered into on or after the date of the enactment of this Act [Dec. 2, 2002].''

EFFECTIVE DATE OF 2001 AMENDMENT

Pub. L. 107–107, div. A, title VII, §707(c), Dec. 28, 2001, 115 Stat. 1164, provided that: ''The amendments made by this section [amending this section] shall take effect on the date that is 90 days after the date of the enactment of this Act [Dec. 28, 2001].''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–398, §1 [[div. A], title VII, §701(c)(3)], Oct. 30, 2000, 114 Stat. 1654, 1654A–172, provided that: ''The amendments made by paragraphs (1) and (2) [amending this section and provisions set out as a note under section 1077 of this title] shall apply to fiscal years after fiscal year 1999.''

Amendment by section 1 [[div. A], title VII, §722(b)(1)] of Pub. L. 106–398 effective Oct. 1, 2001, see section 1 [[div. A], title VII, §722(c)(1)] of Pub. L. 106–398, set out as a note under section 1074 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Pub. L. 103–337, div. A, title VII, §707(c), Oct. 5, 1994, 108 Stat. 2801, provided that: ''The amendments made by subsections (a) and (b) [amending this section and section 1076a of this title] shall apply with respect to the dependents described in such amendments of a member of a uniformed service who dies on or after October 1, 1993, while on active duty for a period of more than 30 days.''

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–35 applicable as if included in the enactment of Pub. L. 102–484, see section 202(b) of Pub. L. 103–35, set out as a note under section 155 of this title.

EFFECTIVE DATE OF 1992 AMENDMENT

Pub. L. 102–484, div. A, title X, §1053, Oct. 23, 1992, 106 Stat. 2501, provided that the amendment made by that section is effective Dec. 5, 1991.

EFFECTIVE DATE OF 1991 AMENDMENT

Pub. L. 102–25, title III, § 316(b), Apr. 6, 1991, 105 Stat. 87, provided that the amendment made by that section is effective Feb. 15, 1991.

EFFECTIVE DATE OF 1990 AMENDMENT

Pub. L. 101–510, div. A, title VII, § 701(b), Nov. 5, 1990, 104 Stat. 1580, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to the provision of pap smears and mammograms under section 1079 or 1086 of title 10, United States Code, on or after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–510, div. A, title VII, § 702(b), Nov. 5, 1990, 104 Stat. 1581, provided that: ''The amendments made by subsection (a) [amending this section] shall apply with respect to the services of certified marriage and family therapists provided under section 1079 or 1086 of title 10, United States Code, on or after the date of the enactment of this Act [Nov. 5, 1990].''

Pub. L. 101–510, div. A, title VII, § 703(d), Nov. 5, 1990, 104 Stat. 1582, as amended by Pub. L. 102–25, title III, § 316(a)(1), Apr. 6, 1991, 105 Stat. 87, provided that: ''This section and the amendments made by this section [amending this section] shall take effect on October 1, 1991, and shall apply with respect to mental health services provided under section 1079 or 1086 of title 10, United States Code, on or after that date.''

Pub. L. 101–510, div. A, title VII, § 712(c), Nov. 5, 1990, 104 Stat. 1583, provided that: ''The amendments made by this section [amending this section and section 1086 of this title] shall apply with respect to health care provided under sections 1079 and 1086 of title 10, United States Code, on or after April 1, 1991.''

EFFECTIVE DATE OF 1989 AMENDMENT

Pub. L. 101–189, div. A, title VII, § 730(b), Nov. 29, 1989, 103 Stat. 1481, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services provided on or after October 1, 1989.''

EFFECTIVE DATE OF 1988 AMENDMENT

Pub. L. 100–456, div. A, title VI, § 646(c), Sept. 29, 1988, 102 Stat. 1990, provided that: ''The amendments made by subsections (a) and (b) [amending this section and section 1086 of this title] shall apply with respect to medical care received after September 30, 1988.''

EFFECTIVE DATE OF 1987 AMENDMENT

Pub. L. 100–180, div. A, title VII, § 721(c), Dec. 4, 1987, 101 Stat. 1115, provided that: ''Paragraph (5) of section 1079(b) of title 10, United States Code, as added by subsection (a), and paragraph (4) of section 1086(b) of such title, as added by subsection (b), shall apply with respect to fiscal years beginning after September 30, 1987.''

Pub. L. 100–180, div. A, title VII, § 726(b), Dec. 4, 1987, 101 Stat. 1117, provided that: ''Paragraph (15) of section 1079(a) of such title, as added by subsection (a), shall apply with respect to costs incurred for home monitoring equipment after the date of the enactment of this Act [Dec. 4, 1987].''

EFFECTIVE DATE OF 1986 AMENDMENT

Pub. L. 99–661, div. A, title VI, § 652(e)(4), Nov. 14, 1986, 100 Stat. 3890, provided that: ''The amendment made by subsection (d) [amending this section] shall apply only with respect to care furnished under section 1079 of title 10, United States Code, on or after the date of the enactment of this Act [Nov. 14, 1986].''

EFFECTIVE DATE OF 1984 AMENDMENT

Pub. L. 98–525, title VI, § 632(a)(3), Oct. 19, 1984, 98 Stat. 2543, provided that: ''The amendments made by this subsection [amending this section and section 1086 of this title] shall apply only to health care furnished after September 30, 1984.''

Amendment by section 1401(e)(4) of Pub. L. 98–525 effective Oct. 1, 1985, see section 1404 of Pub. L. 98–525, set out as an Effective Date note under section 520b of this title.

EFFECTIVE DATE OF 1983 AMENDMENT

Pub. L. 98–94, title IX, § 931(c), Sept. 24, 1983, 97 Stat. 649, provided that: ''The amendments made by this section [amending this section and section 1086 of this title] shall take effect on October 1, 1983, except that—

''(1) clause (6) of section 1079(a) of title 10, United States Code, as added by subsection (a)(1), shall not apply in the case of inpatient mental health services provided to a patient admitted before January 1, 1983, for so long as that patient remains continuously in inpatient status for medically or psychologically necessary reasons; and

''(2) subsection (k) of section 1079 of such title, as added by subsection (a)(1), shall apply with respect to liver transplant operations performed on or after July 1, 1983.''

EFFECTIVE DATE OF 1981 AMENDMENT

Pub. L. 97–86, title IX, § 906(b), Dec. 1, 1981, 95 Stat. 1117, provided that: ''The amendments made by subsection (a) [amending this section and section 1086 of this title] shall apply with respect to claims submitted for payment for services provided after the end of the 30-day period beginning on the date of the enactment of this Act [Dec. 1, 1981].''

EFFECTIVE DATE OF 1980 AMENDMENTS

Amendment by section 501(13) of Pub. L. 96–513 effective Sept. 15, 1981, see section 701 of Pub. L. 96–513, set out as a note under section 101 of this title.

Amendment by section 511 of Pub. L. 96–513 effective Dec. 12, 1980, see section 701(b)(3) of Pub. L. 96–513.

Pub. L. 96–342, title VIII, § 810(c), Sept. 8, 1980, 94 Stat. 1097, provided that: ''The amendments made by this section [amending this section] shall apply to medical care provided after September 30, 1980.''

EFFECTIVE DATE OF 1978 AMENDMENT

Pub. L. 95–485, title VIII, § 806(b), Oct. 20, 1978, 92 Stat. 1622, provided that: ''the amendments made by subsection (a) [amending this section and section 1086 of this title] shall apply with respect to claims submitted for payment for services provided on or after the first day of the first calendar year beginning after the date of enactment of this Act [Oct. 20, 1978].''

EFFECTIVE DATE OF 1971 AMENDMENT

Pub. L. 92–58, § 2, July 29, 1971, 85 Stat. 157, provided that: ''This Act [amending this section] becomes effective as of January 1, 1967. However, no person is entitled to any benefits because of this Act for any period before the date of enactment [July 29, 1971].''

EFFECTIVE DATE OF 1966 AMENDMENT

For effective date of amendment by Pub. L. 89–614, see section 3 of Pub. L. 89–614, set out as a note under section 1071 of this title.

WAIVER OF COPAYMENTS FOR PREVENTIVE SERVICES FOR CERTAIN TRICARE BENEFICIARIES

Pub. L. 110–417, [div. A], title VII, § 711, Oct. 14, 2008, 122 Stat. 4500, as amended by Pub. L. 111–383, div. A, title X, § 1075(e)(11), Jan. 7, 2011, 124 Stat. 4375, provided that:

''(a) WAIVER OF CERTAIN COPAYMENTS.—Subject to subsection (b) and under regulations prescribed by the Secretary of Defense, the Secretary shall—

''(1) waive all copayments under sections 1079(b) and 1086(b) of title 10, United States Code, for preventive services for all beneficiaries who would otherwise pay copayments; and

''(2) ensure that a beneficiary pays nothing for preventive services during a year even if the beneficiary has not paid the amount necessary to cover the beneficiary's deductible for the year.

''(b) EXCLUSION FOR MEDICARE-ELIGIBLE BENEFICIARIES.—Subsection (a) shall not apply to a medicare-eligible beneficiary.

''(c) REFUND OF COPAYMENTS.—

''(1) AUTHORITY.—Under regulations prescribed by the Secretary of Defense, the Secretary may pay a refund to a medicare-eligible beneficiary excluded by subsection (b), subject to the availability of appropriations specifically for such refunds, consisting of an amount up to the difference between—

''(A) the amount the beneficiary pays for copayments for preventive services during fiscal year 2009; and

''(B) the amount the beneficiary would have paid during such fiscal year if the copayments for preventive services had been waived pursuant to subsection (a) during that year.

''(2) COPAYMENTS COVERED.—The refunds under paragraph (1) are available only for copayments paid by medicare-eligible beneficiaries during fiscal year 2009.

''(d) DEFINITIONS.—In this section:

''(1) PREVENTIVE SERVICES.—The term 'preventive services' includes, taking into consideration the age and gender of the beneficiary:

''(A) Colorectal screening.

''(B) Breast screening.

''(C) Cervical screening.

''(D) Prostate screening.

''(E) Annual physical exam.

''(F) Vaccinations.

''(G) Other services as determined by the Secretary of Defense.

''(2) MEDICARE-ELIGIBLE.—The term 'medicare-eligible' has the meaning provided by section 1111(b)(3) of title 10, United States Code.''

PLAN FOR PROVIDING HEALTH COVERAGE INFORMATION TO MEMBERS, FORMER MEMBERS, AND DEPENDENTS ELIGIBLE FOR CERTAIN HEALTH BENEFITS

Pub. L. 108–136, div. A, title VII, §724, Nov. 24, 2003, 117 Stat. 1534, provided that:

''(a) HEALTH INFORMATION PLAN REQUIRED.—The Secretary of Defense shall develop a plan to—

''(1) ensure that each household that includes one or more eligible persons is provided information concerning—

''(A) the extent of health coverage provided by sections 1079 or 1086 of title 10, United States Code, for each such person;

''(B) the costs, including the limits on such costs, that each such person is required to pay for such health coverage;

''(C) sources of information for locating TRICARE-authorized providers in the household's locality; and

''(D) methods to obtain assistance in resolving difficulties encountered with billing, payments, eligibility, locating TRICARE-authorized providers, collection actions, and such other issues as the Secretary considers appropriate;

''(2) provide mechanisms to ensure that each eligible person has access to information identifying TRICARE-authorized providers in the person's locality who have agreed to accept new patients under section 1079 or 1086 of title 10, United States Code, and to ensure that such information is periodically updated;

''(3) provide mechanisms to ensure that each eligible person who requests assistance in locating a TRICARE-authorized provider is provided such assistance;

''(4) provide information and recruitment materials and programs aimed at attracting participation of health care providers as necessary to meet health care access requirements for all eligible persons; and

''(5) provide mechanisms to allow for the periodic identification by the Department of Defense of the number and locality of eligible persons who may intend to rely on TRICARE-authorized providers for health care services.

''(b) IMPLEMENTATION OF PLAN.—The Secretary of Defense shall implement the plan required by subsection (a) with respect to any contract entered into by the Department of Defense after May 31, 2003, for managed health care.

''(c) DEFINITIONS.—In this section:

''(1) The term 'eligible person' means a person eligible for health benefits under section 1079 or 1086 of title 10, United States Code.

''(2) The term 'TRICARE-authorized provider' means a facility, doctor, or other provider of health care services—

''(A) that meets the licensing and credentialing certification requirements in the State where the services are rendered;

''(B) that meets requirements under regulations relating to TRICARE for the type of health care services rendered; and

''(C) that has accepted reimbursement by the Secretary of Defense as payment for services rendered during the 12-month period preceding the date of the most recently updated provider information provided to households under the plan required by subsection (a).

''(d) SUBMISSION OF PLAN.—Not later than March 31, 2004, the Secretary shall submit to the Committees on Armed Services of the Senate and House of Representatives the plan required by subsection (a), together with a schedule for implementation of the plan.''

REPORT ON ACTIONS TO ESTABLISH SPECIAL REIMBURSEMENT RATES

Pub. L. 106–398, §1 [[div. A], title VII, §757(b)(1)], Oct. 30, 2000, 114 Stat. 1654, 1654A–199, directed the Secretary of Defense, not later than Mar. 31, 2001, to submit to the Committees on Armed Services of the Senate and the House of Representatives and the General Accounting Office a report on actions taken to carry out sections 1079(h)(5) and 1097b of this title.

PROGRAMS RELATING TO SALE OF PHARMACEUTICALS

Pub. L. 102–484, div. A, title VII, §702, Oct. 23, 1992, 106 Stat. 2431, as amended by Pub. L. 103–160, div. A, title VII, §721, Nov. 30, 1993, 107 Stat. 1695; Pub. L. 103–337, div. A, title VII, §706, Oct. 5, 1994, 108 Stat. 2800; Pub. L. 106–398, §1 [[div. A], title VII, §711(b)], Oct. 30, 2000, 114 Stat. 1654, 1654A–176, directed the Secretary of Defense to conduct a demonstration project that would permit eligible persons to obtain prescription pharmaceuticals by mail, directed the Secretary to include in each managed health care program awarded or renewed after Jan. 1, 1993, a program to supply prescription pharmaceuticals through a managed care network of retail pharmacies, directed the Secretary to submit to Congress a report regarding the demonstration project not later than two years after its establishment and an additional report regarding the programs not later than Jan. 1, 1994, and provided for termination of section 702 of Pub. L. 102–484 no later than one year after Oct. 30, 2000.

CORRECTION OF OMISSION IN DELAY OF INCREASE OF CHAMPUS DEDUCTIBLES RELATED TO OPERATION DESERT STORM

Pub. L. 102–484, div. A, title VII, §721, Oct. 23, 1992, 106 Stat. 2438, provided that during the period beginning on Apr. 1, 1991, and ending on Sept. 30, 1991, the annual deductibles specified in this section or section 1086 of this title applicable to CHAMPUS beneficiaries who had served on active duty in the Persian Gulf theater of operations in connection with Operation Desert Storm would not exceed the annual deductibles in effect on Nov. 4, 1990, and provided for the credit or reimbursement of excess amounts paid.

TEMPORARY CHAMPUS PROVISIONS FOR DEPENDENTS OF OPERATION DESERT SHIELD/DESERT STORM ACTIVE DUTY PERSONNEL

Pub. L. 102–172, title VIII, §8085, Nov. 26, 1991, 105 Stat. 1192, provided that any CHAMPUS health care

provider could voluntarily waive the patient copayment for medical services provided from Aug. 2, 1990, until the termination of Operation Desert Shield/Desert Storm for dependents of active duty personnel, provided that the Government's share of medical services was not increased during such time period.

Similar provisions were contained in Pub. L. 102–28, § 105, Apr. 10, 1991, 105 Stat. 165.

Pub. L. 102–25, title III, § 312, Apr. 6, 1991, 105 Stat. 85, provided that the annual deductibles specified in subsec. (b) of this section, as in effect on Nov. 4, 1990, would apply until Oct. 1, 1991, in the case of health care provided under that section to the dependents of a member of the uniformed services who had served on active duty in the Persian Gulf theater of operations in connection with Operation Desert Storm, and that patient copayment requirements could be waived upon the provider's certification to the Secretary of Defense that the amount charged the Federal Government for such health care had not been increased above the amount that the provider would have charged the Federal Government for such health care had the payment not been waived.

TRANSITIONAL HEALTH CARE FOR MEMBERS, OR DEPENDENTS OF MEMBERS, UPON RELEASE OF MEMBER FROM ACTIVE DUTY IN CONNECTION WITH OPERATION DESERT STORM

For provision authorizing transitional health care, including health benefits contracted for under subsec. (a) of this section, for members, or dependents of members, upon release of member from active duty in connection with Operation Desert Storm, see section 313 of Pub. L. 102–25, set out as a note under section 1076 of this title.

### § 1079a. TRICARE program: treatment of refunds and other amounts collected

All refunds and other amounts collected in the administration of the TRICARE program shall be credited to the appropriation available for that program for the fiscal year in which the refund or amount is collected.

(Added Pub. L. 104–201, div. A, title VII, § 733(a)(1), Sept. 23, 1996, 110 Stat. 2597; amended Pub. L. 114–328, div. A, title VII, § 701(j)(1)(D), Dec. 23, 2016, 130 Stat. 2192.)

PRIOR PROVISIONS

Provisions similar to those in this section were contained in the following appropriations acts:

Pub. L. 104–61, title VIII, § 8094, Dec. 1, 1995, 109 Stat. 671.

Pub. L. 103–335, title VIII, § 8144, Sept. 30, 1994, 108 Stat. 2656.

AMENDMENTS

2016—Pub. L. 114–328 substituted ''TRICARE program'' for ''CHAMPUS'' in section catchline and ''the TRICARE program'' for ''the Civilian Health and Medical Program of the Uniformed Services'' in text.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–328 applicable with respect to the provision of health care under the TRICARE program beginning on Jan. 1, 2018, see section 701(k) of Pub. L. 114–328, set out as a note under section 1072 of this title.

### § 1079b. Procedures for charging fees for care provided to civilians; retention and use of fees collected

(a) REQUIREMENT TO IMPLEMENT PROCEDURES.—The Secretary of Defense shall implement procedures under which a military medical treatment facility may charge civilians who are not covered beneficiaries (or their insurers) fees representing the costs, as determined by the Secretary, of trauma and other medical care provided to such civilians.

(b) USE OF FEES COLLECTED.—A military medical treatment facility may retain and use the amounts collected under subsection (a) for—

(1) trauma consortium activities;

(2) administrative, operating, and equipment costs; and

(3) readiness training.

(Added Pub. L. 107–107, div. A, title VII, § 732(a)(1), Dec. 28, 2001, 115 Stat. 1169.)

DEADLINE FOR IMPLEMENTATION

Pub. L. 107–107, div. A, title VII, § 732(b), Dec. 28, 2001, 115 Stat. 1170, directed the Secretary of Defense to begin to implement the procedures required by subsec. (a) of this section not later than one year after Dec. 28, 2001.

### § 1079c. Provisional coverage for emerging services and supplies

(a) PROVISIONAL COVERAGE.—In carrying out the TRICARE program, including pursuant to section 1079(a)(12) of this title, the Secretary of Defense, acting through the Assistant Secretary of Defense for Health Affairs, may provide provisional coverage for the provision of a service or supply if the Secretary determines that such service or supply is widely recognized in the United States as being safe and effective.

(b) CONSIDERATION OF EVIDENCE.—In making a determination under subsection (a), the Secretary may consider—

(1) clinical trials published in refereed medical literature;

(2) formal technology assessments;

(3) the positions of national medical policy organizations;

(4) national professional associations;

(5) national expert opinion organizations; and

(6) such other validated evidence as the Secretary considers appropriate.

(c) INDEPENDENT EVALUATION.—In making a determination under subsection (a), the Secretary may arrange for an evaluation from the Institute of Medicine of the National Academies or such other independent entity as the Secretary selects.

(d) DURATION AND TERMS OF COVERAGE.—(1) Provisional coverage under subsection (a) for a service or supply may be in effect for not longer than a total of five years.

(2) Prior to the expiration of provisional coverage of a service or supply, the Secretary shall determine the coverage, if any, that will follow such provisional coverage and take appropriate action to implement such determination. If the Secretary determines that the implementation of such determination regarding coverage requires legislative action, the Secretary shall make a timely recommendation to Congress regarding such legislative action.

(3) The Secretary, at any time, may—

(A) terminate the provisional coverage under subsection (a) of a service or supply, regardless of whether such termination is before