

**Statement of  
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**For the**

**Subcommittee on Personnel  
Senate Armed Services Committee  
United States Senate**

**FY2006 National Defense Authorization Act  
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***“Serving Those Who Serve™”***

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The Reserve Officers Association of the United States (ROA) is a professional association of commissioned and warrant officers of our nation's seven uniformed services, and their spouses. ROA was founded in 1922 during the drawdown years following the end of World War I. It was formed as a permanent institution dedicated to National Defense, with a goal to teach America about the dangers of unpreparedness. When chartered by Congress in 1950, the act established the objective of ROA to: "...support and promote the development and execution of a military policy for the United States that will provide adequate National Security." The mission of ROA is to advocate strong Reserve Components and national security, and to support Reserve officers in their military and civilian lives.

The Association's 75,000 members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen who frequently serve on periods of Active Duty to meet critical needs of the uniformed services and their families. ROA's membership also includes officers from the U.S. Public Health Service and the National Oceanic Atmospheric Administration who often are first responders during national disasters and help prepare for homeland security. ROA is represented in each state with 55 departments plus departments in Latin America, the District of Columbia, Europe, the Far East, and Puerto Rico. Each department has several chapters throughout the state and is further divided into regional chapters. ROA has more than 450 chapters worldwide.

ROA is a member of The Military Coalition where it co-chairs the Tax and Social Security Committee. ROA is also a member of the National Military/Veterans Alliance. Overall, ROA works with 75 military, veterans and family support organizations.

#### DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers Association is a private, member-supported, congressionally chartered organization. Neither ROA nor its staff receive, or have received, grants, sub-grants, contracts, or subcontracts from the federal government for the past three fiscal years. All other activities and services of the Association are accomplished free of any direct federal funding.

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## INTRODUCTION

Mr. Chairman and distinguished members of the Senate Armed Services Committee, on behalf of its 75,000 members, the Reserve Officers Association thanks the committee for the invitation and opportunity to present testimony on military health care issues.

ROA applauds the efforts by Congress to address the issue of increasing Department of Defense (DoD) health care costs and its interest to initiate dialogue and work with both the Pentagon and the beneficiary associations to find the best solution. Unfortunately, the members of Congress are caught between DoD and a coalition of beneficiary associations as particular positions are being advanced.

The health care issues that are before us are not black and white. No single source for solution is the best one. Outreach to many groups should be encouraged to solicit various concepts. ROA favors open dialogue and the generation of new ideas in support of the best solution. We hope that this hearing is just one step in a series of discussions toward finding an accord.

Health care services are vital to keeping the nation's military force strong and ready. It is also a deferred benefit and recognition of retired members for their service to the nation. **ROA strongly urges that when all cost-sharing is finally taken into account, our beneficiaries must still view DoD health care as an enhanced benefit when compared to the private sector.**

## EXECUTIVE SUMMARY

Increasing the cost-share of DoD health care beneficiaries is admittedly an emotional issue. Yet the nation and the Department of Defense are faced with ever increasing health care costs. Because of the dynamics involved, this is an issue that shouldn't be rushed. Here is a summary of the key points as seen by the Reserve Officers Association.

### **Moratorium:**

- As DoD has already directed the TRICARE contractors to move ahead on implementing the TRICARE PRIME fee increases, a moratorium on such increases should be declared to allow Congress time to review this action.

### **TRICARE Prime:**

- Adjustments to the enrollment fee are acceptable if tied to true health care costs.
- It is important to independently verify the current total cost of DoD health care benefits. Such an audit will permit Congress to validate proposals based on cost-sharing percentages.
- A two-year implementation is too abrupt. Cost-sharing adjustments should be spread over at least five years to permit household budgets to adjust.
- Annual increases should **not** be tied to the market-driven Federal Employee Health Benefits Plan (FEHBP).

### **TRICARE Standard:**

- ROA does not endorse an annual enrollment fee for either DoD or VA.

- If TRICARE Standard requires beneficiary enrollment, it should be only a one-time minimal administrative fee.
- Adjustments to TRICARE Standard should be made to the deductible.
- Because of larger co-payments of 25 percent after the deductible, the costs of TRICARE standard need to be analyzed from a total cost rather than initial cost perspective.
- TRICARE Standards cost deductible automatically adjusts with escalating health care costs.

**TRICARE Reserve Select (TRS)**

- ROA is deeply concerned that after they return from deployment, operational Reservists pay substantially higher premiums than retiree enrollment costs.
- Family Premiums for a Tier I TRS operational Reservist are \$3,336 per year for FY2006 compared to a proposed combined cost of \$1,120 for TRICARE Standard in FY2008. This is inequitable.
- We agree that today’s operational Reservists should pay a fair share of the cost of their DoD health care when not on active duty. However, a “fair share” should reflect their past and future contributions to the Nation. Congress’s role in finding that “fair share” balance cannot be overstated.
- TRICARE standard deductible increases should not be rolled over into TRS.

**On Pharmacy Co-payments:**

- ROA believes higher retail pharmacy co-payment should not apply on initial prescriptions, but on maintenance refills.
- ROA supports DoD efforts to enhance the mail-order prescription benefit.

<b>BACKGROUND</b>
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In testimony before Congress, Secretary of Defense Rumsfeld talked about the rising cost of health care. “The current health care system [as] funded is not sustainable... The Department's health care costs have almost doubled over the past five years -- from \$19 billion in 2001 to \$37 billion in Fiscal Year 2006... Using a conservative projection, these health care costs will likely reach \$64 billion in Fiscal year 2015, an estimated 12 percent of the total Department budget. By comparison, health costs were 4.5 percent of the Department’s budget back in 1990...”

“In 1995, beneficiaries paid 27 percent of their total health care costs,” his testimony continued. “Today, because there has been no change in TRICARE annual premiums for 11 years, beneficiaries currently pay not 27 percent, but just 12 percent of costs. The proposed plan would ask retirees to pay somewhat more in premiums and for certain co-payments.”

ROA clearly understands that health care costs must be brought back into alignment and that some cost will have to be borne by retirees and families of serving members, both Active and Reserve.

## DISCUSSION

A number of visible issues relate to TRICARE in calendar year 2006. The Reserve Officers Association is concerned that a myopic focus on any one issue may cause a loss of focus on other equally important issues.

The Reserve Officers Association is disappointed in how the Department of Defense Health Affairs has attempted to address such an emotionally laden issue unilaterally. ROA would like to thank Congress for its continued involvement and leadership on DoD health care issues.

While it is important to sustain the DoD health care benefit as a deferred benefit for our serving Active and Reserve Component members and their families, it is not a necessary to do two quick increases “overnight” in the TRICARE fee schedules.

While retired, these beneficiaries have accepted risks and made sacrifices in their earlier military careers that have not been asked of the remaining 99 percent of the nation’s population. TRICARE fulfills an on-going promise by the government for continued health care to those who have served or are serving.

Conversely, the Department of Defense and this nation cannot afford to carry the full burden of health care costs. The operational Active and Reserve force and their families deserve the best, both while serving and into retirement. To preserve the top health care program in the nation as a DoD benefit, the Reserve Officers Association is a proponent of cost-sharing.

ROA does not find the goal of returning the retiree beneficiary contribution to 27 percent of DoD’s health care cost as being out of line, as it was Congress’s intent in 1995. Yet, after ten years of fixed costs, these increases should be phased-in over a wider duration of time to help those retirees on fixed incomes, and then any future increases should be affixed to a formula other than the civilian health care market place.

Some associations will suggest that there should be no jumps in annual premiums and that beneficiary fees should only be raised annually by the level of retiree COLA. ROA’s concern is by using this approach to cost share, the percentage of beneficiary contribution would continue to decline, with DoD paying an every increasing share. This could give DoD justification to implement a different plan.

Secretary Rumsfeld has publicly stated that DoD should not be in the business of health care. Ever increasing health care would provide DoD with a good reason to civilianize health care for families and retirees by transferring the program over to a company such as Blue Cross/Blue Shield. Beneficiaries would pay more for less benefits, and be subjected to the profit-making pressures of the commercial market, where premium cost have increased by double digits over the last five years.

Under a freeze on fees, the current active duty retiree beneficiaries might continue paying a low cost-share, but the next generation, who is currently serving, would end-up paying more for their retirement programs. As with any deficit, the medical expenditures of the current generation would be cost-shifted to the next.

**Fuzzy Numbers on Both Sides:** The challenge for using a 27 percent base line is determining of what it is 27 percent. Yet the pentagon seems to have trouble measuring this accurately. The TRICARE Reserve Select family premium (Tier I) is set in law at 28 percent as a TRICARE Standard program. The 2006 annual premium and deductible is \$3,336 based on a \$10,834 a Federal Employee Health Benefit Plan premium base of \$10,834. Excluding deductibles, this is 28.02 percent.

Beneficiary medical expense totals have not yet been provided by DoD. Congress should ask the Pentagon for a financial breakdown. An independent audit by the Government Accountability Office (GAO) or another agency would allow Congress an opportunity to validate proposals based on cost-sharing percentages.

The numbers being used in materials by some beneficiary associations have also not been adequately delineated. ROA hopes in this testimony to provide sufficient details to support our positions.

**TRICARE Prime** has been the primary focus of DoD Health Affairs and its civilian health care contractors. A “fully loaded model” health care plan, it has been rated the #1 health care plan in national surveys for the last three years. Prime currently costs a retiree \$460 per year. DoD has suggested a two-year phase-in, 141 percent increase to \$650 for enlisted E-6 and below, a 206.5 percent increase to \$950 per year for E-7 thru E-10, and a 304 percent increase to \$1,400 per year for officers. This is still a bargain when compared to what the average U.S. family is paying. A Kaiser Family Foundation Survey reported that in 2005 an employee paid 26 percent of the employer’s annual premiums for family coverage of \$10,880, or \$2,828.80 per year for lesser health care coverage.

Single enrollees will have a 141 percent increase to \$325 for enlisted E-6 and below, a 204.35 percent increase to \$475 per year for E-7 thru E-10, and a 304 percent increase to \$700 per year for single officers. Kaiser reported that civilian workers opting for single coverage paid an average of \$643.84 per year, which could indicate the single officers’ increase may be a little high.

**TRICARE Standard:** The Reserve Officers Association has concerns with suggested enrollment fees and deductible increases for TRICARE Standard. TRICARE Standard is the system on which TRICARE Reserve Select is based. DoD Health Affairs and its contractors have benignly neglected TRICARE Standard at best.

While offered as an option to TRICARE Prime to active duty retirees, TRICARE Standard (TRS) is the required choice for serving Reservists and may be the health care

plan of choice for Guard and Reserve retirees between the ages of sixty and sixty-five because most live outside the TRICARE Prime network of health care providers.

These areas have fewer authorized TRICARE providers. It becomes incumbent upon the TRICARE beneficiary to find a physician that accepts TRICARE Standard and often the beneficiaries must administer their own TRICARE health plan. Because of its costs and problems with availability, TRICARE Standard can only be viewed as DoD's "basic model" health care program.

TRICARE Prime is DoD's voluntary health maintenance organization (HMO), while TRICARE Standard is DoD's preferred provider organization (PPO) plan and a fee for service plan.

Ironically, TRICARE Standard, which was intended by Congress to be the CHAMPUS replacement, has become more expensive than TRICARE Prime, even without DoD's suggested enrollment fee increases. With a \$150 deductible for singles and a \$300 deductible for families, TRICARE Standard beneficiaries pay co-payments (cost-share) of 25 percent per visit after the deductible.

Comparing the average cost of an office visit between TRICARE Prime and TRICARE Standard we see that costs favor the beneficiary with TRICARE Prime. (See Appendix A.) From these calculations, it appears that the TRICARE Standard retiree beneficiary will be paying much more than 27 percent of the DoD cost share goal as set for TRICARE Prime.

TRICARE Prime beneficiaries pay only \$12 per outpatient visit, and \$30 for emergency care. However, if they choose to get care under the Point of Service (POS) option with care outside the TRICARE network, there's an annual deductible (for both inpatient and outpatient care) of \$300 for an individual and \$600 for a family.

TRICARE Extra gives a discount of five percent for co-payments (cost-share) for TRICARE retired standard beneficiaries who use TRICARE health care providers from the TRICARE Prime network.

DoD Health Affairs [table one] is attached, which gives more details on current cost.

For a healthy family, TRICARE Standard can be low cost, if they don't use the health care benefits, which is why it should remain a fee for service. If a family has frequent visits, costs under TRICARE standard will surpass those of TRICARE Prime. By adding a \$140 - \$560 annual enrollment fee and increasing the annual deductible, TRICARE standard costs are being aligned with those of TRICARE PRIME. This is making the down payment on the "basic model" Standard as expensive as the "fully loaded" Prime.

	TRICARE Prime Enrollment Fee Single/family	TRICARE Standard Enrollment + Deductible Single/Family
E-6 and Below	\$325/\$650	\$325/\$650
E-7 thru E-10	\$475/\$950	\$385/\$770
Officers	\$700/\$1,400	\$560/\$1,120

**The Reserve Officers Association does not endorse annual enrollment fees for individuals who don't use the health care plan, whether it is DoD or Department of Veterans Affairs (VA).**

ROA has never objected to requiring a TRICARE enrollment, as this would include those service members and retirees who don't use the TRICARE benefit. Rather than an annual fee, this can be handled by a one time fee to cover administrative costs; perhaps in the range of \$25 – \$50, although this is atypical of the commercial market which charges only monthly premiums.

**If increases were required for TRICARE Standard, ROA would rather see an emphasis on deductible costs rather than an annual enrollment fee.**

We should also examine the levels of proposed deductibles. In the most common type of plan – preferred provider organization (PPO) plans – the average deductible for in-network services was \$323 for single coverage and \$679 for family coverage. Yet, 44 percent of them have plans requiring co-payments of \$20 or \$25 for physician visits and prescription drugs, far less the TRICARE Standard's 25 percent co-payment.

**Annual premium increases:** Once the 27 percent cost share is achieved, it is been reported that DoD wants to tie further annual increases to the premium increases of the Federal Employee Health Benefit Plan (FEHBP.) According to a Kaiser Family Foundation survey released in September 2005, the average premium growth rate in 2005 year was 9.2 percent. This outpaced both the growth in wages (2.7 percent) and inflation (3.5 percent). The FEHBP increased its premiums by 14.5 percent. FEHBP has had double-digit increase for each of the last five years. Such disparity between increased health care costs and FEHBP premium increases will cause the retiree beneficiary cost share to rise beyond 27 percent.

If DoD is unable to calculate premium cost using the 27 percent figure, other cost of living indexes could be used, such as an annual inflation rate.

**Pharmacy Co-payment changes:** DoD is suggesting an increase in co-payments in retail pharmacy from \$3 to \$5 dollars for generic prescriptions, and from \$9 to \$15 for brand drugs. Generic pharmacy prescriptions would drop from \$3 to \$0 to align with military clinics.

ROA understands the motives for this change, to encourage pharmacy beneficiaries to use the mail order pharmacy system, which is the least expensive. What DoD overlooks

is that often times the retail pharmacy network is the only source to immediately fill a prescription, as many pharmacy beneficiaries are unable to go to a military clinic for the initial prescription.

**ROA suggests that the higher retail pharmacy co-payments not apply on an initial prescription, but on refills of a serial maintenance prescription.**

**TRICARE Reserve Select:** While ROA is satisfied with a three-tier construct for cost share as developed by Congress, we are deeply concerned that the cost share for operational Reservists who have just returned from mobilization is much higher than what is paid by active duty retirees.

TRICARE Reserve Select family premium (Tier I) is based on a Federal Employee Health Benefit Plan premium base of \$10,834. Family premiums and deductible for a Tier I TRS operational Reservist are \$3,336 per year for FY2006 compared to a proposed combined cost for retired officers of \$1,120 for TRICARE Standard in FY2008. Single TRS combined costs \$1,272 compared to the suggested TRICARE standard cost of \$560. ROA finds this is inequitable.

This again gives an appearance that the Reservist is a second-class warrior in the Total Force, when Active duty personnel are not charged any fee. We agree that today's operational Reservists should pay a fair share of the cost of their DoD health care when not on active duty. However, a "fair share" should reflect their past and future contributions to the Nation. Congress's role in finding that "fair share" balance cannot be overstated.

DoD may argue that Active personnel remain on active duty, while the Selected Reservist returns to civilian status; yet neither component is deployed 100 percent. General Pace has stated that the deployed schedule of Active Personnel will be one year deployed, for every two years stateside duty. The plan for operational Army Guard or Reserve member is one year deployed, for every additional four years in "drill and training" status.

Using costing numbers for Active Duty personnel, the Pentagon has determined that the active duty member is on duty 270 days a year. A Guard or Reserve member's civilian employment is 264 days a year, plus Reserve employment per Title 10 is another 38 days. Operational Reservists are being encouraged to spend those 28 days in support of Active Commands, which normally are outside the average commute distances of civilian employment. Including travel, Reserve Duty days increase to over 50 days. Since operational support doesn't include administrative time, or professional training, another 24 days without pay can be added, at a minimum, to senior Guard and Reserve duty time, bringing Reserve contributions to 75 days or more. By the Pentagon's own numbers the average Reservist is contributing over 120 days a year between drill and deployments.

**ROA hopes that Congress re-examines the costs percentage of Guard and Reserve warriors who operational support the Total Force.**

TRICARE Reserve Select is evolving into a stand alone health plan. While it uses the TRICARE standard as an engine, its fees are based on FEHBP premiums, so it is no longer a TRICARE standard program. TRICARE standard fee increases must not be rolled over into TRS.

### **ROA Suggestions for Enhancing TRICARE Reserve Select:**

1. Many different types of orders are being cut for operational support of Active Duty. Guard and Reserve members are serving on these orders for various lengths of time. Operational support is being provided within theater, in support of theater, and on the peripheral. Examples:

1. Warfighters in Iraq and Afghanistan
2. Custom inspectors in Kuwait
3. Joint Task Force - Horn of Africa in Djibouti
4. Fleet support in Rota, Spain.
5. Air maintenance on combat aircraft in Turkey.
6. Guard duty at Guantanamo Bay
7. Active Duty command support
8. Pentagon Staffing
9. Working with wounded Marines and Sailors at National Naval Medical Center, Bethesda, MD

Each duty disrupts a Guard or Reservist's civilian career and interferes with the continuity of health care. Communication of benefits and narrow interpretation of "in support of contingency operations"<sup>1</sup> by Reserve service components has created an inconsistent policy when extending TRS to all who might qualify.

Section 701 of Public Law 108-375, 108th Congress, does not use the definition of "contingency operation." Instead, this section defines eligibility based on "service on active duty."<sup>2</sup>

Section 704, Waiver of Certain Deductibles Under TRICARE Program for Members on Active Duty for a Period of more than 30 Days, and Section 705, Authority for Payment

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<sup>1</sup>Title 10 Section 101(a), paragraph (13) The term "*contingency operation*" means *a military operation that*

“(A) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or

“(B) results in the call or order to, or retention on, active duty of members of the uniformed services under *section 688, 12301(a), 12302, 12304, 12305, or 12406 of this title, chapter 15 of this title, or any other provision of law during a war or during a national emergency declared by the President...*”

<sup>2</sup> a Guard and Reserve member as “eligible for health benefits under TRICARE Standard as provided in this section after the member completes service on active duty to which the member was called or ordered for a period of more than 30 days on or after September 11, 2001.”

by United States of additional amounts billed by health care providers to activated reserves, do contain the contingency language.

Suggested changes:

**1.a. Expand eligibility of the Tier I “earned benefit” to all members who are serving in support of the GWOT, no matter what the type of order.** Since the language only defines “active duty” Congress should direct DoD to a broader interpretation.

**1. b. Include legislative change to permit mobilized RC member to accumulate healthcare to qualify for future TRS utilization.** Suggested language footnoted.<sup>3</sup>

**2. Request a study by GAO or another agency to explain why there is such a high drop out from application to acceptance in TRS.** Over 40,000 have applied, but only 9,500 have been accepted. (See Appendix B)

**3. Provide TRS to demobilized Reservists returning to the IRR.** While Congress improved the benefit by allowing Individual Ready Reservists a year to find a Selected Reserve Billet, this is not an option for many senior members.

Rather than precluding these operational Reservists from a deserved benefit, have IRR members commit to a continued period in the IRR, subject to future recall, where these members will be required to maintain training and qualifying years.

**4. Provide TRS to demobilized recalled retired Reservists.** As an incentive to recalled “gray area” retired Reservist who volunteer for operational support should qualify for TRS. It is wrong to send them back into a “retirement” that has no benefits.

**5. TRS should be an incentive to transition Active Duty members into the Reserve.** If an AC member leaves following a deployment, they can qualify for TRS.

**6. Gray area retiree buy-in to TRS.** Gray-area Reservists are currently in limbo between TRS while drilling and TRICARE with retirement-in-pay. TRS buy-in would be at the full monthly cost, but at least this would provide a continuity of coverage for those waiting for TRICARE retirement.

**7. Employer health care option:** The Reserve Officers Association continues to support an additional option where DoD pays a stipend to employers of deployed Guard and Reserve members to continue employer health care during deployment. Because TRICARE Prime or Standard is not available in all regions that are some distance from military bases, it is an advantage to provide a continuity of health care by continuing an

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<sup>3</sup> Sec. 1076d (a) “...which the member was called or ordered for a period of more than 30 days on or after September 11, 2001, under a provision of law referred to in section 101(a)(13)(B), if the member--

“(1) served continuously on active duty for [an accumulated] 90 or more days pursuant to such call or order; and

employer's health plan. This stipend need not be higher than any DoD contribution to Active Duty TRICARE.

## **CONCLUSION**

The Reserve Officers Association encourages ongoing oversight management of DoD health care by Congress. There is an attitude of autonomy within the Pentagon that overlooks the partnership of the branches of government. ROA looks forward to working with this Committee, the Congress, and the Pentagon on this and other issues for constructive solutions. When DoD clarifies these costs, ROA is willing to take this new information back to educate our members and support increases as necessary.

**TABLE ONE**

**Retirees, Their Family Members, and Others**

	<b>TRICARE Prime</b>	<b>TRICARE Extra</b>	<b>TRICARE Standard</b>
<b>Annual Deductible</b>	None	\$150/individual or \$300/family	\$150/individual or \$300/family
<b>Annual Enrollment Fee</b>	\$230/individual \$460/family	None	None
<b>Civilian Cost Shares</b>		20% of negotiated fee	25% of allowed charges for covered service
<b>Outpatient</b>	\$12		
<b>Emergency Care</b>	\$30		
<b>Mental Health Visit</b>	\$25 \$17 (group visit)		
<b>Civilian Inpatient Cost Share</b>	Greater of \$11 per day or \$25 per admission; no separate co-payment for separately billed professional charges	Lesser of \$250/day or 25% of negotiated charges plus 20% of negotiated professional fees	Lesser of \$535/day or 25% of billed charges plus 25% of allowed professional fees
<b>Civilian Inpatient Skilled Nursing Facility Care</b>	\$11/day (\$25 minimum) charge per admission	\$250 per diem cost share or 20% cost share of total charges, whichever is less, institutional services, plus 20% cost share of separately billed professional charges	25% cost share of allowed charges for institutional services, plus 25% cost share of allowable for separately billed professional charges.
<b>Civilian Inpatient Behavioral Health</b>	\$40 per day; no charge for separately billed professional charges	20% of total charge. Plus, 20% of the allowable charge for separately billed professional services	High Volume Hospitals - 25% hospital specific per diem, plus 25% of the allowable charge for separately billed professional services; Low Volume Hospitals - \$175 per day or 25% of the billed charges, whichever is lower, plus 25% of the allowable charge for separately billed services

Appendix A  
Comparative TRICARE Costs

Example

Family	Prime	Standard	TRS Tier I
Co-payment (c)		25%	20%
Enrollment	\$460.00	-	-
Premium			\$3036
Deductible (d)	-	\$300	\$300
Premium (p)			\$3036 (p)
Office Visit #1 \$100.00	\$12.00	\$100 (d)	\$100 (d)
Office Visit #2 \$100.00	\$12.00	\$100 (d)	\$100 (d)
X-ray \$75	\$12.00	\$75.00 (d)	\$75.00 (d)
L.V. Therapy (Q0081) \$33.00 Lab (3810) 1,140.50 Operating Room (31628) 786.50 Observation Room (99201) 293.00	\$22	\$25 (d) \$285.13 (c) \$196.63 (c) \$73.25 (c)	\$25 (d) \$228.10 (c) \$157.30 (c) \$58.60 (c)
<b>Claim Total</b> <b>\$2,253.00</b>	\$22	\$580.01	\$460
Office Visit \$100	\$12	\$25.00	\$20.00
Total Cost \$2628.00*	\$530	\$880.01	\$3791.00

\* Medical costs used are for example. Actual costs to TRICARE would be adjusted for the Medicare fee schedule.