STANDARD

TRICARE®
Standard Handbook

Your guide to program benefits

TRICARE®

DEPARTMENT OF DEFENSE
UNITED STATES OF AMERICA

August 2012

Important Information

TRICARE Web Site:	www.tricare.mil
TRICARE North Region Contractor	
Health Net Federal Services, LLC:	1-877-TRICARE (1-877-874-2273)
Health Net Web Site:	www.hnfs.com
TRICARE South Region Contractor	
Humana Military Healthcare Services, Inc.:	1-800-444-5445
Humana Military Web Site:	Humana-Military.com
TRICARE West Region Contractor	
TriWest Healthcare Alliance:	1-888-TRIWEST (1-888-874-9378)
TriWest Web Site:	www.triwest.com
TRICARE Overseas Program*	
TRICARE Overseas Program Contractor:	International SOS Assistance, Inc.
TRICARE Eurasia-Africa:	1-877-678-1207
TRICARE Latin America and Canada:	1-877-451-8659
TRICARE Pacific:	1-877-678-1208 (*Singapore*)
	1-877-678-1209 (*Sydney*)
International SOS TRICARE Overseas Program Web Site:	www.tricare-overseas.com

** For overseas contact information, visit www.tricare-overseas.com.*

An Important Note About TRICARE Program Changes

At the time of printing, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. For the most recent information, contact your regional contractor or local TRICARE Service Center. More information regarding TRICARE, including the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices, can be found online at www.tricare.mil.

Welcome to TRICARE Standard and TRICARE Extra

This *TRICARE Standard Handbook* is your guide to using:

- TRICARE Standard and TRICARE Extra
- TRICARE Reserve Select (TRS)
- TRICARE Retired Reserve (TRR)
- TRICARE Young Adult (TYA) Standard

TRICARE Standard and TRICARE Extra (*where offered, based on network availability*) are available to TRICARE-eligible beneficiaries who are not able to or choose not to enroll in a TRICARE Prime option. TRICARE-eligible beneficiaries are entitled to coverage under TRICARE Standard and TRICARE Extra. Unlike TRICARE Prime options, enrollment is **not** required, meaning there are no forms to fill out and no annual enrollment fees to pay.

Premium-based health plans are available for purchase by qualified individuals. These plans include TRS, TRR, and TYA Standard. They offer TRICARE Standard and TRICARE Extra coverage, with the same cost-shares and covered services. Individuals must qualify and apply to purchase coverage. For more information on these options, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook or visit **www.tricare.mil**.

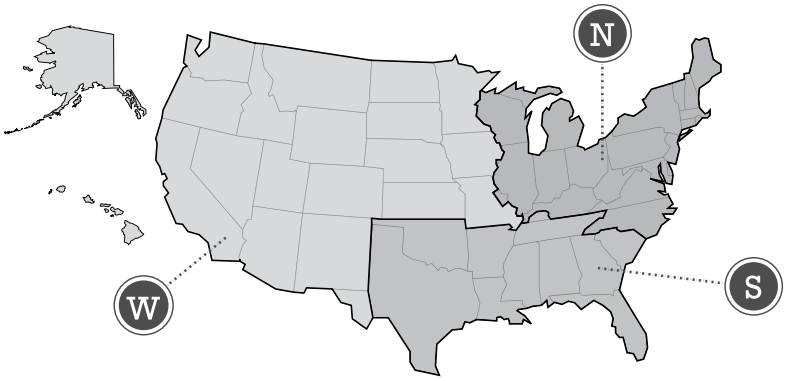
TRICARE Overseas Program (TOP) Standard is distinct from and should not be confused with TRICARE Standard and TRICARE Extra in the United States. International SOS Assistance, Inc. provides health care services and pays claims for TRICARE beneficiaries in TOP Standard. You manage your own health care and have the freedom to seek care from any TRICARE-authorized provider you choose, unless overseas restrictions apply. For more information about TOP, visit **www.tricare.mil/overseas**.

With TRICARE Standard and TRICARE Extra, you manage your own health care and have the freedom to seek care from any TRICARE-authorized provider you choose. It is important that you understand these options, how they work, and the key differences between them, so that you receive the highest quality, most convenient, and most cost-effective care.

This *TRICARE Standard Handbook* explains the different types of TRICARE providers and outlines TRICARE Standard and TRICARE Extra costs and requirements. If you have questions, there are many resources listed throughout this handbook to help you.

Your TRICARE Regional Contractor

Regional contractors administer the TRICARE program in each TRICARE region. TRICARE encourages you to visit your regional contractor's Web site, which includes information on how to access care using TRICARE Standard and TRICARE Extra. If you need assistance, you can call your regional contractor at the appropriate toll-free number listed below. Your regional contractor also has TRICARE Service Centers located throughout the region, typically at military treatment facilities, where customer service representatives are available to assist you.



TRICARE North Region

The TRICARE North Region includes Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Kentucky (*excluding the Fort Campbell area*), Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin, portions of Iowa (*Rock Island Arsenal area*), and Missouri (*St. Louis area*).

Regional Contractor	Health Net Federal Services, LLC
Phone	1-877-TRICARE (1-877-874-2273)
Web Site	www.hnfs.com

TRICARE South Region

The TRICARE South Region includes Alabama, Arkansas, Florida, Georgia, Kentucky (*Fort Campbell area only*), Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas (*excluding the El Paso area*).

Regional Contractor	Humana Military Healthcare Services, Inc.
Phone	1-800-444-5445
Web Site	Humana-Military.com

TRICARE West Region

The TRICARE West Region includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (*excluding the Rock Island Arsenal area*), Kansas, Minnesota, Missouri (*excluding the St. Louis area*), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (*the southwestern corner only, including El Paso*), Utah, Washington, and Wyoming.

Regional Contractor	TriWest Healthcare Alliance
Phone	1-888-TRIWEST (1-888-874-9378)
Web Site	www.triwest.com

Contact your regional contractor if you need assistance using TRICARE Standard and TRICARE Extra. Look in the mail and on your regional contractor's Web site for the *TRICARE Standard Health Matters* newsletter, an annual publication highlighting covered services, customer service options, news, and other important updates.

Visit **www.tricare.mil/subscriptions** to sign up for e-mail updates. Enter your e-mail address, select the *TRICARE Standard Health Matters* newsletter, and click "Save" at the bottom of the page.

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See the inside back cover of this handbook for “TRICARE Expectations for Beneficiaries.”

Choosing TRICARE Standard and TRICARE Extra

Eligibility for TRICARE Standard and TRICARE Extra

Beneficiaries who are eligible to use TRICARE Standard and TRICARE Extra include:

- Active duty family members (ADFMs)
- Family members of National Guard and Reserve members who are called or ordered to active duty for more than 30 consecutive days
- Retired service members
- Family members of retired service members
- Survivors
- Others (*e.g., certain former spouses, Medal of Honor recipients*)

Beneficiaries who are not eligible to use TRICARE Standard and TRICARE Extra include:

- Active duty service members (ADSMs)
- Activated National Guard and Reserve members
- Any beneficiary enrolled in a TRICARE Prime option (*You must disenroll before using TRICARE Standard and TRICARE Extra.*)
- Dependent parents and parents-in-law

ADSMs and activated National Guard and Reserve members must enroll in TRICARE Prime or TRICARE Prime Remote (TPR). ADFMs, retired service members and their families, survivors, and others have the choice of enrolling in a TRICARE Prime option (*where available*) or using TRICARE Standard and TRICARE Extra.

Note: During the early-eligibility period, National Guard and Reserve members may be eligible for TRICARE, but should wait until reaching their final duty location and follow command guidance when enrolling in TRICARE Prime or TPR. In the case of early eligibility, the effective date is the later of either: (a) the date of issuance of the delayed-effective active duty order, or, (b) 180 days before the date on which the period of active duty is to begin. Until then, you should coordinate care with your unit. If eligible, your family members may enroll in TRICARE Prime or TRICARE Prime Remote for Active Duty Family Members during the early-eligibility period.

Qualifying for TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult

TRICARE Reserve Select is available for purchase by qualified members of the Selected Reserve of the Ready Reserve, their family members, and qualified survivors. TRICARE Retired Reserve is available for purchase by qualified members of the Retired Reserve, their family members, and qualified survivors. TRICARE Young Adult is available for purchase by qualified dependents until reaching age 26. Qualification and enrollment in these programs varies from eligibility for TRICARE Standard and TRICARE Extra. For more information about these programs, including qualification information and instructions on how to purchase coverage, please see the *Premium-Based TRICARE Standard Health Plans* section of this handbook, or visit **www.tricare.mil**.

Keep Your DEERS Information Up To Date!

It is essential that you keep information in the Defense Enrollment Eligibility Reporting System (DEERS) up to date for you and your family. DEERS is a computerized database of uniformed service members (*active duty and retired*) worldwide, their family members, and others who are eligible for military benefits, including TRICARE. Proper and current DEERS registration is key to receiving timely, effective TRICARE benefits including doctors' appointments, prescriptions, payment of health care expenses, authorization letters, and explanations of benefits. See Figure 1.1 on the following page for options to update your DEERS information. Failure to update DEERS to accurately reflect the sponsor or family member's residential address and/or the ineligibility of a former dependent could be considered fraud and a basis for administrative, disciplinary, and/or other appropriate action.

Options for Updating and Verifying DEERS Information *Figure 1.1*

In Person[1] (*add or delete a family member or update contact information*)	• Visit a local identification card-issuing facility. • Find a facility near you at **www.dmdc.osd.mil/rsl**. • Call to verify location and business hours.
Phone[2]	• 1-800-538-9552 • 1-866-363-2883 (*TDD/TTY*)
Fax[2]	• 1-831-655-8317
Mail[2]	• Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955-6771
Online[2]	• milConnect Web site: **http://milconnect.dmdc.mil**

*1. Only sponsors (*or those appointed power of attorney*) can add or delete family members. Family members age 18 and older may update their own contact information.*

2. Use these methods to change contact information only.

Plan Overview

You may use TRICARE Standard and TRICARE Extra interchangeably as often as you like, but it is important to understand the differences between the two.

The key difference between TRICARE Standard and TRICARE Extra is in the providers that you use for care. With TRICARE Standard, you choose TRICARE-authorized non-network hospitals and providers and pay higher cost-shares. With TRICARE Extra, you choose TRICARE network hospitals and providers and receive discounted cost-shares. Expenses for care received under either TRICARE Standard or TRICARE Extra count toward the deductible and catastrophic cap.

Figure 1.2 provides a quick comparison of the two options. Specific provider types will be discussed later in this handbook. For cost details, visit **www.tricare.mil/costs**.

Social Security Number Reduction

The Department of Defense (DoD) is removing Social Security numbers (SSNs) from uniformed services identification (ID) cards as part of the continued effort to protect the privacy and security of TRICARE's 9.7 million beneficiaries. SSNs will be replaced with 10-digit DoD ID numbers. If you have DoD benefits, (*e.g., health care, commissary, exchange privileges*), an 11-digit DoD Benefits Number (DBN) is also printed on the card. This is a unique number that will ensure your records are clearly aligned with your treatments. The new DBN can be found above the bar code on the back of your uniformed services ID card. The replacement process is expected to last several years, until all current uniformed services ID cards are replaced as they come up for renewal.

Note: You do not need to make a special trip to have your ID card updated until it expires. Your health care providers and pharmacists will be able to access your benefits using either your SSN or your DBN. For more information, visit **www.tricare.mil/ssn**.

Comparison of TRICARE Standard and TRICARE Extra *Figure 1.2*

	TRICARE Standard[1]	TRICARE Extra
Provider type	**TRICARE-authorized, non-network**	**TRICARE-authorized, TRICARE network**
Outpatient cost-share, after deductible is met	• **Active duty family members (ADFMs) and TRICARE Reserve Select (TRS):** 20% of the TRICARE-allowable charge • **Retirees, their families, TRICARE Retired Reserve (TRR), and all others:** 25% of the TRICARE-allowable charge	• **ADFMs and TRS:** 15% of the negotiated rate • **Retirees, their families, TRR, and all others:** 20% of the negotiated rate

1. Non-network providers may also charge up to 15 percent above the TRICARE-allowable charge. You are responsible for paying this amount. For more information, see "TRICARE Provider Types" in the Getting Care *section of this handbook.*

Getting Care

Finding a Provider

When using TRICARE Standard and TRICARE Extra, you may receive care from any TRICARE-authorized provider without a referral. Some services require prior authorization (*discussed later in this section*). The following section describes the different types of providers.

TRICARE Provider Types

TRICARE defines a provider as a person, business, or institution that provides health care. For example, doctors, hospitals, or ambulance companies are providers. Providers must be authorized under TRICARE regulations and have their status certified by TRICARE regional contractors to provide services to TRICARE beneficiaries. Figure 2.1 provides a brief overview of TRICARE provider types.

Remember, you can use either a TRICARE network provider or TRICARE-authorized non-network provider at any time. For example, if an orthopedic surgeon and a physical therapist are treating you, one could be a TRICARE network provider and the other could be a TRICARE-authorized non-network provider.

TRICARE Provider Types ***Figure 2.1***

TRICARE-Authorized Providers

- TRICARE-authorized providers meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers may include doctors, hospitals, ancillary providers (*laboratories and radiology centers*), and pharmacies that meet TRICARE requirements. If you see a provider that is not TRICARE-authorized, you are responsible for the full cost of care; TRICARE cannot share the cost.
- There are two types of TRICARE-authorized providers: **network** and **non-network**.

TRICARE Network Providers

- You are using the TRICARE Extra option when you visit a network provider.
- Using a TRICARE network provider is your least costly option.
- Regional contractors have established networks, even in certain areas far from military treatment facilities.
- TRICARE network providers:
  - Have a signed agreement with your regional contractor to provide care
  - Agree to accept payment directly from TRICARE and accept the TRICARE-allowable charge (*less any applicable patient cost-shares paid by you*) as payment in full for their services
  - Agree to file claims for you

Non-Network Providers

- TRICARE-authorized non-network providers do not have a signed agreement with your regional contractor and are considered "out of network."
- There are two types of TRICARE-authorized non-network providers: **participating** and **nonparticipating**.

Participating

- Using a participating provider is your least costly option if you are seeing a TRICARE-authorized non-network provider.
- Participating providers:
  - May choose to participate on a claim-by-claim basis
  - Have agreed to accept payment directly from TRICARE and accept the TRICARE-allowable charge (*less any applicable patient cost-shares paid by you*) as payment in full for their services

Nonparticipating

- If you visit a nonparticipating provider, you may have to pay the provider first and later file a claim with TRICARE for reimbursement.
- Nonparticipating providers:
  - Have not agreed to accept the TRICARE-allowable charge or file your claims
  - Have the legal right to charge you up to 15 percent above the TRICARE-allowable charge for services (*You are responsible for paying this amount in addition to any applicable patient cost-shares.*)

Keep track of the types of providers you are seeing. Visits to a network provider (*TRICARE Extra*) will cost you less out of pocket, and the provider will file claims on your behalf. With a TRICARE-authorized non-network provider (*TRICARE Standard*), you will pay more out of pocket and may have to file your own claims.

Visit **www.tricare.mil/findaprovider** to find a TRICARE network or TRICARE-authorized non-network provider. You can also locate a provider in your region by using the TRICARE network provider directory located on your regional contractor's Web site.

Eligibility for TRICARE and Veterans Affairs Benefits

Certain beneficiaries are eligible for both TRICARE and U.S. Department of Veterans Affairs (VA) benefit programs, and they may choose which benefits to use. Further, a beneficiary can seek TRICARE-covered services even if he or she received treatment through VA for the same medical condition during a previous episode of care. However, TRICARE does not duplicate payments made or authorized by VA for service-connected disability care.

Note: Eligibility for VA health care for service-connected disabilities is **not** considered double coverage.

Health Care Provider Types

There are many health care provider types to familiarize yourself with:

- **Primary care providers:** Primary care includes providers such as internists, family practitioners, pediatricians, general practitioners, and obstetricians/gynecologists. It may also include nurse practitioners and physician assistants.
- **Specialty care providers:** Specialty care includes providers such as obstetricians (*child birth doctors*), orthopedic surgeons (*bone doctors*), and gastroenterologists (*stomach and intestine doctors*).
- **Ancillary care providers:** Ancillary care includes providers such as ambulance services, laboratories, radiologists (*doctors who review X-rays*), and home health care providers.

- **Facilities:** Facilities are medical centers that offer medical and surgical services. Examples of facilities are hospitals, urgent care clinics, birthing centers (*facilities with nurse-midwives that offer a natural childbirth experience*), skilled nursing facilities (*facilities for patients who need 24-hour medical support*), and ambulatory surgery centers (*facilities where patients receive minor surgeries and are discharged the same day*).
- **Behavioral health care providers:** Behavioral health care includes a broad range of military treatment facility (MTF) or civilian providers and treatments. Refer to "Behavioral Health Care Services" in the *Covered Services, Limitations, and Exclusions* section of this handbook for more information about behavioral health provider types and coverage requirements.

Emergency Care

TRICARE defines an emergency as a medical, maternity, or psychiatric condition that would lead a "prudent layperson" (*someone with average knowledge of health and medicine*) to believe that a serious medical condition exists; that the absence of immediate medical attention would result in a threat to life, limb, or sight; when a person has

severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others.

Note: Most dental emergencies, such as going to the emergency room for a severe toothache, are not a covered medical benefit under TRICARE. Active duty service members receive dental care from military dental treatment facilities and, if necessary, from civilian providers through the TRICARE Active Duty Dental Program. Active duty family members and retirees and their dependents may be eligible to enroll in either the TRICARE Dental Program or the TRICARE Retiree Dental Program, depending on their sponsor's status. For more information, see "Dental Options" in the *Covered Services, Limitations, and Exclusions* section of this handbook.

If a medical emergency occurs, call 911 or go to the nearest emergency room. If you are admitted, you may need to obtain authorization depending on the type of care. You or your provider can contact your regional contractor for assistance.

Urgent Care

Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately but does require professional attention within 24 hours. You may require urgent care for conditions such as a sprain, sore throat, or rising temperature, as each of these has the potential to develop into an emergency if treatment is delayed longer than 24 hours. Contact your regional contractor for help finding local urgent care centers.

All Other Care

For all other care, such as routine physicals, ongoing treatment for a chronic condition, visits to a specialist, or covered preventive care, you can schedule an appointment with a TRICARE network or TRICARE-authorized non-network provider. Some services may require prior authorization (*discussed later in this section*). You can learn more about the differences among routine, urgent, emergency, and specialty care at **www.tricare.mil**.

Care at a Military Treatment Facility

An MTF provides medical and/or dental care to eligible individuals, including members of the uniformed services and their dependents and is usually located on or near a military installation. You may receive care at an MTF, but only on a space-available basis. MTF appointments are limited, and you will have the lowest priority for receiving care. See Figure 2.2 for MTF appointment priorities.

Note: Access to MTFs for TRICARE Young Adult beneficiaries is based on the program selected as well as the sponsor's status.

MTF Appointment Priorities ***Figure 2.2***

1	Active duty service members
2	Active duty family members (ADFMs) enrolled in TRICARE Prime
3	Retired service members, their families, and all others enrolled in TRICARE Prime
4	ADFMs not enrolled in TRICARE Prime and TRICARE Reserve Select beneficiaries
5	Retired service members and their families not enrolled in TRICARE Prime, TRICARE Retired Reserve beneficiaries, and all other eligible beneficiaries

If you wish to receive care at an MTF, call the MTF first to see if they can provide you with the care you need. Visit **www.tricare.mil/mtf** to locate an MTF. Otherwise, seek care from a civilian TRICARE network or TRICARE-authorized non-network provider.

Note: If you are admitted to an MTF and require any service not available within the MTF (*e.g., ambulance, MRI, CT scan, specialist appointment*), those services will be covered by your TRICARE Standard benefit. The MTF will not pay for these services.

Prior Authorization for Care

You can visit the TRICARE-authorized provider of your choice whenever you need care. Referrals are not required, but some services require prior authorization.

A prior authorization is a review of the requested health care service to determine if it is medically necessary at the requested level of care. Some providers may call the regional contractor to obtain prior authorization for you. If you have questions about authorization requirements, visit **www.tricare.mil**.

The following services require prior authorization:

- Adjunctive dental services
- Extended Care Health Option services
- Home health services
- Hospice care
- Nonemergency inpatient admissions for substance use disorders or behavioral health care
- Outpatient behavioral health care visits to an authorized provider beyond the eighth visit per fiscal year (*October 1–September 30*) for a medically diagnosed and covered condition
- Transplants—all solid organ and stem cell

This list is **not** all-inclusive.

Each regional contractor has additional prior authorization requirements. Visit your regional contractor's Web site to learn about each region's requirements, which may change periodically. See the *Welcome to TRICARE Standard and TRICARE Extra* section at the beginning of this handbook for your regional contractor's Web site and toll-free number.

Combat-Related Disability Travel Reimbursement

Medically retired service members who have a determination letter from their service's Combat-Related Special Compensation Board identifying a Department of Defense-determined disability or disabilities as combat-related may be reimbursed for reasonable travel expenses for medically necessary care. Travel may be reimbursed if the contractor authorizes a referral to a specialist who is located more than 100 miles away from their primary care provider's office. You are expected to use the least costly mode of transportation and must submit receipts for all expenses. TRICARE will use government rates to estimate the reasonable cost and will reimburse the actual costs of travel expenses up to the government rate for the area concerned. Visit **www.defensetravel.dod.mil/perdiem/pdrates.html** for more information.

In some cases, a non-medical attendant who travels with the patient may also be authorized for travel reimbursement. The non-medical attendant must be a parent or guardian, or another adult family member age 21 or older.

Covered Services, Limitations, and Exclusions

TRICARE Standard and TRICARE Extra cover most care that is medically necessary and considered proven. There are special rules and limitations for certain types of care, and some types of care are not covered at all. This section is **not** all-inclusive. TRICARE policies are very specific about which services are covered and which are not. It is in your best interest to take an active role in verifying coverage.

For details on covered outpatient, inpatient, and clinical preventive services, please see *Appendix A* of this handbook. Visit your regional contractor's Web site for additional information about covered services and benefits.

Behavioral Health Care Services

For coverage details for outpatient behavioral health care services, inpatient behavioral health care services, and substance use disorder services, please see *Appendix A* of this handbook. For additional information about covered and non-covered behavioral health care services and how to access care, contact your regional contractor.

TRICARE beneficiaries (*except for active duty service members [ADSMs]*) may see a network provider authorized under TRICARE regulations to see patients independently for the first eight outpatient behavioral health care services per fiscal year (FY) (*October 1–September 30*) for a medically diagnosed and covered condition without a referral or authorization. Before the ninth visit, your behavioral health care provider must obtain prior authorization from your regional contractor.

Authorized Behavioral Health Care Providers

You may seek outpatient behavioral health care from TRICARE-authorized providers. The following types of behavioral health providers may be authorized providers under TRICARE:

- **Certified psychiatric nurse specialists** are licensed, master's-level psychiatric nurses with an additional American Nurses Association certification in behavioral health. Certified psychiatric nurse specialists include both psychiatric clinical nurse specialists and psychiatric nurse practitioners. Psychiatric clinical nurse specialists mainly perform psychotherapy, while psychiatric nurse practitioners generally provide medication management.
- **Mental health counselors** have a master's degree in counseling. They perform counseling and psychotherapy services but cannot prescribe medication. Some mental health counselors are licensed and TRICARE-certified to practice independently of physician referral and supervision. For mental health counselors who do not meet these TRICARE certification requirements, a doctor of medicine (MD) or doctor of osteopathic medicine (DO) must refer a beneficiary for therapy prior to the initial visit, and a physician must provide ongoing oversight and supervision of the therapy.
- **Pastoral counselors** have a master's degree in counseling. They perform counseling and psychotherapy services but cannot prescribe medication. In order to provide services to TRICARE beneficiaries, an MD or DO must refer a beneficiary for therapy prior to the initial visit, and a physician must provide ongoing oversight and supervision of the therapy.
- **Certified marriage and family therapists** have a master's degree in counseling with an emphasis on family and marriage therapy. They perform individual counseling and family and marriage therapy but cannot prescribe medication.
- **Licensed clinical social workers** have a master's-level degree in social work with additional training in psychotherapy and counseling. They perform psychotherapy and counseling services but cannot prescribe medication.
- **Clinical psychologists** have a doctoral-level degree (*doctor of philosophy or doctor of psychology*) in psychology. They perform psychotherapy, psychological testing, and counseling services but usually cannot prescribe medication.
- **Psychiatrists** are physicians who have a general medical degree (*MD or DO*) and have completed advanced residency training in psychiatry. Most psychiatrists treat persons with more serious conditions for which medication is helpful (*e.g., major depression, bipolar disorder, attention*

deficit/hyperactivity disorder). Psychiatrists perform psychotherapy, manage medication, and work in collaboration with the provider types listed above.

Emergency and inpatient hospital behavioral health services are considered medically necessary only when the patient's condition requires hospital personnel and facilities. All treatment for substance use disorders requires prior authorization from your regional contractor.

For more information about covered and non-covered behavioral health care services and to learn how to access behavioral health care, visit **www.tricare.mil/mentalhealth**.

Outpatient Behavioral Health Care Services

Prior authorizations may be required for certain outpatient services. Beneficiaries using TRICARE Standard and TRICARE Extra do not need referrals or prior authorizations from their regional contractors for the first eight outpatient behavioral health care visits per FY (*October 1–September 30*) to a provider authorized under TRICARE regulations to see patients independently for a medically diagnosed and covered condition. The authorized provider must obtain authorization from the regional contractor for continued treatment after the eighth visit. Care access and rules vary by beneficiary type and location.

Telemental Health Program

The Telemental Health program uses secure audio-visual conferencing to connect eligible beneficiaries, including TRICARE Standard and TRICARE Extra beneficiaries in the United States, with off-site TRICARE network providers. Telemental Health provides medically necessary behavioral health care services, including:

- Clinical consultation
- Individual psychotherapy
- Psychiatric, diagnostic interview examination
- Medication management

Telemental Health interaction may involve live, two-way audio-visual visits between patients and medical professionals. Beneficiaries can access Telemental Health services at TRICARE-authorized Telemental Health-participating facilities by using secure audio-visual conferencing to connect with off-site TRICARE network providers.

Behavioral health care limitations and referral and authorization requirements apply. Visit **www.tricare.mil/mentalhealth** or contact your regional contractor for more information.

Inpatient Behavioral Health Care Services

Prior authorization from the regional contractor is required for all nonemergency inpatient behavioral health care services. Psychiatric emergencies do not require prior authorization for admission to an inpatient unit, but authorization is required for continued stay. Admissions resulting from psychiatric emergencies should be reported to your regional contractor within 24 hours of admission or the next business day, and must be reported within 72 hours of an admission. Authorization for continued stay is coordinated between the inpatient unit and the regional contractor.

Substance Use Disorder Services

Substance use disorders include alcohol or drug abuse or dependence. Services are only covered by TRICARE-authorized institutional providers—an authorized hospital or an organized treatment program in an authorized freestanding or hospital-based substance use disorder rehabilitation facility. Treatment may include detoxification, rehabilitation in an inpatient or partial hospitalization program setting, and outpatient individual, group, and family therapy. TRICARE covers three substance use disorder rehabilitation treatment periods in a lifetime and one per benefit period. A benefit period begins with the first date of the covered treatment and ends 365 days later.

Emergency and inpatient hospital services are considered medically necessary only when the patient's condition requires hospital personnel and facilities. Generally, these services may be medically necessary in certain detoxification circumstances or for stabilization of a medical condition. All treatment for substance use disorders requires prior authorization from your regional contractor.

TRICARE Smoking Quitline

The TRICARE Smoking Quitline is a telephone support and referral triage service that is available 24 hours a day, seven days a week. Current smokers who want to quit or former smokers concerned about relapsing may call the Smoking Quitline to speak with a trained smoking-cessation coach who will recommend appropriate treatment and resources. Call the toll-free number for your region for assistance. Figure 3.1 provides contact information for the regional TRICARE Smoking Quitlines.

Note: The Smoking Quitline is only available to TRICARE beneficiaries in the United States who are not eligible for Medicare.

Regional TRICARE Smoking Quitline Contact Information *Figure 3.1*

TRICARE North Region Health Net Federal Services, LLC	1-866-459-8766
TRICARE South Region Humana Military Healthcare Services, Inc.	1-877-414-9949
TRICARE West Region TriWest Healthcare Alliance	1-866-244-6870

The Smoking Quitline is part of the Department of Defense- and TRICARE-sponsored tobacco-cessation program, which offers a variety of online tools and resources to help beneficiaries quit. The program includes live chats and step-by-step quit plans. Visit **www.ucanquit2.org** for more information.

TRICARE Pharmacy Program

TRICARE offers comprehensive prescription drug coverage and several options for filling your prescriptions. To fill a prescription, you need a written prescription and a valid uniformed services identification (ID) card or Common Access Card. The TRICARE Pharmacy benefit is administered by Express Scripts, Inc. (Express Scripts). More information on the TRICARE Pharmacy Program is available at **www.tricare.mil/pharmacy** or **www.express-scripts.com/TRICARE**.

Military Treatment Facility Pharmacies

At a military treatment facility (MTF) pharmacy, you may receive up to a 90-day supply of most medications at no cost. Most MTF pharmacies accept prescriptions written by both civilian and military providers, regardless of whether you are enrolled at the MTF.

Non-formulary medications are generally not available at MTF pharmacies. Contact the nearest MTF pharmacy to check the availability of a particular drug.

Visit **www.tricare.mil/militarypharmacy** for more information on MTF pharmacies.

TRICARE Pharmacy Home Delivery

There is no cost for TRICARE Pharmacy Home Delivery for ADSMs. For all other beneficiaries, there is no cost to receive up to a 90-day supply of generic medications. Copayments apply for brand-name and non-formulary medications. Additionally, prescriptions are delivered to you with free standard shipping, and refills can be easily ordered online, by phone, or by mail. TRICARE Pharmacy Home Delivery also provides you with convenient notifications about your order status, refill reminders, and assistance with renewing expired prescriptions. If you have questions about your prescriptions, pharmacists are available 24 hours a day, seven days a week to speak confidentially with you.

You may register for TRICARE Pharmacy Home Delivery using any of the options in Figure 3.2.

TRICARE Pharmacy Home Delivery Registration Methods *Figure 3.2*

Online	• www.express-scripts.com/TRICARE
Phone	• 1-877-363-1303 • 1-877-540-6261 (*TDD/TTY*)
Mail	• Download the registration form from **www.express-scripts.com/TRICARE**, and mail it to: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072-9954

For faster processing of your home delivery prescription, register before placing your first order. Once you are registered, your provider can fax or call in your prescriptions.

Express Scripts will send your medications directly to your home within about 14 days of receiving your prescription. If you have prescription drug coverage through other health insurance (OHI), you can use TRICARE Pharmacy Home Delivery only if the medication is not covered by your OHI or if you exceed the OHI's coverage dollar limit.

Member Choice Center

The Member Choice Center makes it easy to reduce your out-of-pocket costs by transferring your current maintenance medication prescriptions to TRICARE Pharmacy Home Delivery. If you prefer the convenience of home delivery, contact the Member Choice Center to convert your current retail or MTF prescriptions. TRICARE Pharmacy Home Delivery copayments may apply.

Visit **www.express-scripts.com/TRICARE** or call **1-877-363-1433** to get started.

TRICARE Retail Network Pharmacies

Another option for filling your prescriptions is through TRICARE retail network pharmacies. You may fill prescriptions (*one copayment for each 30-day supply*) when you present your written prescriptions and your uniformed services ID card to the pharmacist.

This option allows you to fill your prescriptions at TRICARE retail network pharmacies across the country without having to submit a claim. You have access to a network of approximately 56,000 retail pharmacies in the United States and U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Currently, there are no TRICARE retail network pharmacies in American Samoa. To find the nearest TRICARE retail network pharmacy, visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303**.

Note: In the Philippines, you must use a TRICARE-certified host nation pharmacy. Visit **www.tricare.mil/pacific** for more information or to find a certified provider.

Non-Network Pharmacies

At non-network pharmacies, you will pay the full price of your medication up front and file a claim for reimbursement. Reimbursements are subject to deductibles, out-of-network cost-shares, and TRICARE-required copayments. All deductibles must be met before any reimbursement can be made. For details about filing a claim, see the *Claims* section of this handbook.

Quantity Limits for Certain Medications

TRICARE has established quantity limits on certain medications, which means that the Department of Defense (DoD) will only pay for up to a specified, limited amount of medication each time you fill a prescription. Quantity limits are often applied to ensure medications are safely and appropriately used. Exceptions to established quantity limits may be made if the prescribing provider is able to justify medical necessity.

Prior Authorization

Some drugs require prior authorization from Express Scripts. Medications requiring prior authorization may include, but are not limited to, prescription drugs specified by the DoD Pharmacy and Therapeutics Committee, brand-name medications with generic equivalents, infusion therapy delivered in the home, medications with age limitations, and medications prescribed for quantities exceeding normal limits. For a general list of prescription drugs that are covered under TRICARE, and for drugs that require prior authorization or that have quantity limits, visit **www.pec.ha.osd.mil/formulary_search.php**. If you do not have Internet access, call Express Scripts at **1-877-363-1303** to inquire about a specific drug.

Generic Drug Use Policy

Generic drugs are medications approved by the U.S. Food and Drug Administration (FDA) and clinically equivalent to brand-name medications. Generic drugs provide the same safe, effective treatment as brand-name drugs. It is DoD policy to use generic medications instead of brand-name medications whenever possible. A brand-name drug with a generic equivalent may be dispensed only after the prescribing physician completes a clinical assessment that indicates use of the brand-name drug is medically necessary and after Express Scripts grants approval. If a generic-equivalent drug does not exist, the brand-name drug will be dispensed at the brand-name copayment. If you fill a prescription with a brand-name drug that is not considered medically necessary and a generic equivalent is available, you will be responsible for paying the entire cost of the prescription.

Providers may call the Express Scripts Prior Authorization line at **1-866-684-4488** to submit a request for a brand name drug to be dispensed instead of a generic, or a completed *Brand over Generic Prior Authorization Request Form* may be faxed to **1-866-684-4477**. To download the form, visit **www.pec.ha.osd.mil/forms_criteria.php**.

Non-Formulary Drugs

The DoD has established a uniform formulary, which is a list of covered generic and brand-name drugs. This formulary also contains a third tier of medications that are non-formulary. Prescriptions for non-formulary drugs are dispensed at a higher cost to beneficiaries.

Non-formulary medications include any drug in a therapeutic class determined to be not as clinically effective or as cost-effective as other drugs in the same class. For an additional cost, all third-tier drugs are available through TRICARE Pharmacy Home Delivery and most are available through retail network pharmacies. You may be able to fill non-formulary prescriptions at formulary costs if your provider establishes medical necessity by completing and submitting the appropriate TRICARE pharmacy medical-necessity form. Forms and medical-necessity criteria are available online at **www.pec.ha.osd.mil/forms_criteria.php** or by calling Express Scripts at **1-877-363-1303**.

If medical necessity is approved, ADSMs may receive non-formulary medications through TRICARE Pharmacy Home Delivery or at retail network pharmacies at no cost. ADSMs may not fill prescriptions for non-formulary medications unless medical necessity is established. For all other eligible beneficiaries, if medical necessity is approved, beneficiaries may receive non-formulary medications at the formulary cost through TRICARE Pharmacy Home Delivery or at retail network pharmacies.

Note: Non-formulary drugs are generally not available at MTFs.

To learn more about medications and common drug interactions, check for generic equivalents, or determine if a drug is a non-formulary medication, visit the TRICARE Formulary Search Tool at **www.pec.ha.osd.mil/formulary_search.php**.

For information on how to save money and make the most of your pharmacy benefit, visit **www.tricare.mil/pharmacy** or **www.express-scripts.com/TRICARE**.

Specialty Medication Care Management

Specialty medications are usually high-cost; self-administered; injectable, oral, or infused drugs that treat serious chronic conditions (*e.g., multiple sclerosis, rheumatoid arthritis, hepatitis C*). These drugs typically require special storage and handling and are not readily available at your local pharmacy. Specialty medications may also have side effects that require pharmacist and/or nurse monitoring.

The Specialty Medication Care Management program is structured to improve your health through continuous health evaluation, ongoing monitoring, assessment of educational needs, and management of medication use. This program provides:

- Access to proactive, clinically based services for specific diseases designed to help you get the most benefit from your medication
- Monthly refill reminder calls
- Scheduled deliveries to your specified location
- Specialty consultation with a pharmacist/nurse at any point during your therapy

These services are provided to you at no additional cost when you receive your medications through TRICARE Pharmacy Home Delivery, and participation is voluntary. If you or your provider orders a specialty medication from TRICARE Pharmacy Home Delivery, you will receive additional information from Express Scripts about the Specialty Medication Care Management program and how to get started.

Using TRICARE Pharmacy Home Delivery to fill specialty medication prescriptions provides you with access to the Specialty Medication Care Management program benefits described above. You may submit a specialty medication prescription by mail or your provider may submit it by fax. If you are currently using another pharmacy to fill your specialty medication prescription, you can contact the Member Choice Center at **1-877-363-1433** to switch to the Specialty Medication Care Management program. With specific mailing instructions from you or your provider, TRICARE Pharmacy Home Delivery will ship your specialty medication to your home. For your convenience and safety, TRICARE Pharmacy Home Delivery will contact you to arrange delivery before the medication is shipped.

Note: Some specialty medications may not be available through TRICARE Pharmacy Home Delivery because the medication's manufacturer limits the drug's distribution to specific pharmacies. If you submit a prescription for a limited-distribution medication, TRICARE Pharmacy Home Delivery will either forward your prescription to a pharmacy of your choice that can fill it or will provide you with instructions about where to send the prescription to have it filled. To determine if your specialty medication is available through TRICARE Pharmacy Home Delivery, visit **www.pec.ha.osd.mil/formulary_search.php**.

Dental Options

ADSMs receive dental care from military dental treatment facilities (DTFs) and, if necessary, from civilian providers through the TRICARE Active Duty Dental Program (ADDP). For other beneficiaries, TRICARE offers two premium-based dental programs—the TRICARE Dental Program (TDP) and the TRICARE Retiree Dental Program (TRDP). Each benefit is administered by a separate dental contractor and has its own monthly premiums and cost-shares.

TRICARE Active Duty Dental Program

The ADDP, administered by United Concordia Companies, Inc., provides civilian dental care to ADSMs who are either referred for care by a DTF to the civilian dental community or who serve duty and reside greater than 50 miles from a DTF. The ADDP is available in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). For more information about the ADDP, visit **www.tricare.mil/addp** or **www.addp-ucci.com**.

TRICARE Dental Program

The TDP is a voluntary, premium-based DoD dental program available to eligible active duty family members (ADFMs) and eligible National Guard and Reserve members and their family members. ADSMs (*and National Guard and Reserve members called to active duty for a period of more than 30 consecutive days or eligible for the pre-activation benefit up to 180 days prior to their report date*) are not eligible for the TDP. MetLife administers this TRICARE dental benefit. For more information about the TDP, visit **www.tricare.mil/tdp**.

TRICARE Retiree Dental Program

The TRDP is a voluntary, premium-based dental insurance benefit administered by the Federal Services division of Delta Dental of California (Delta Dental). The TRDP offers comprehensive, cost-effective dental coverage for purchase by uniformed services retirees and their eligible family members, retired National Guard and Reserve members (*including those who are entitled to retired pay but will not begin receiving it until age 60*) and their eligible family members, certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors. For more information about the TRDP, visit **www.trdp.org** or call Delta Dental toll-free at **1-888-838-8737**.

Maternity Care

Prenatal care is important, and TRICARE strongly recommends that those who are pregnant or who anticipate becoming pregnant seek appropriate medical care. TRICARE Standard and TRICARE Extra cover all necessary maternity care, from your first obstetric visit through six weeks after your child is born. Covered services include:

- Obstetric visits throughout your pregnancy
- Medically necessary fetal ultrasounds
- Hospitalization for labor, delivery, and postpartum care
- Anesthesia for pain management during labor and delivery
- Medically necessary cesarean sections
- Management of high-risk or complicated pregnancies

Newborns are covered separately. To ensure your newborn is covered by TRICARE, you must register your child in the Defense Enrollment Eligibility Reporting System (DEERS) at a uniformed services ID card-issuing facility. For more information, see "Having a Baby or Adopting a Child" in the *Changes to Your TRICARE Coverage* section of this handbook.

The following services are **not** covered:

- Fetal ultrasounds that are not medically necessary (*e.g., to determine your baby's sex*), including three- and four-dimensional ultrasounds
- Services and supplies related to noncoital reproductive procedures (*e.g., artificial insemination*)
- Management of uterine contractions with drugs that are not FDA-approved for that use (*i.e., off-label use*)
- Home uterine activity monitoring and related services
- Unproven procedures (*e.g., lymphocyte or paternal leukocyte immunotherapy for the treatment of recurrent miscarriages, salivary estriol test for preterm labor*)
- Umbilical cord blood collection and storage, except for patients who undergo umbilical stem-cell transplantation for a covered transplant
- Private hospital rooms (*TRICARE generally does not cover private rooms [*unless this is the only option*]; however, some MTFs may have private postpartum rooms.*)

Maternity Ultrasounds

TRICARE covers medically necessary maternity ultrasounds, including those needed to:

- Estimate gestational age due to unknown date of last menstrual period, irregular periods, size/date difference of greater than two weeks, or pregnancy while on oral contraceptive pills (*Confirmation of estimated gestational age is not a medically necessary indication.*)
- Evaluate fetal growth when the fundal height growth is significantly greater than expected (*more than 1 cm per week*) or less than expected (*less than 1 cm per week*)

- Conduct a biophysical evaluation for fetal well-being when the mother has certain conditions (*e.g., insulin-dependent diabetes mellitus, hypertension, systemic lupus, congenital heart disease, renal disease, hyperthyroidism, prior pregnancy with unexplained fetal demise, multiple gestations, post-term pregnancy after 41 weeks, intrauterine growth retardation, oligohydramnios, polyhydramnios, preeclampsia, decreased fetal movement, isoimmunization*)
- Evaluate a suspected ectopic pregnancy
- Determine the cause of vaginal bleeding
- Diagnose or evaluate multiple births
- Confirm cardiac activity (*e.g., when fetal heart rate is not detectable by Doppler, suspected fetal demise*)
- Evaluate maternal pelvic masses or uterine abnormalities
- Evaluate suspected hydatidiform mole
- Evaluate fetus condition in late registrants for prenatal care

A physician is not obligated to perform ultrasonography on a patient who is at low risk and has no medical indications.

Some providers offer patients routine ultrasound screening as part of the scope of care after 16–20 weeks of gestation. **TRICARE does not cover routine ultrasound screenings**. TRICARE only covers maternity ultrasounds with valid medical indication that constitutes medical necessity. Refer to **www.tricare.mil** or your regional contractor's Web site for additional details on maternity ultrasound coverage.

Hospice Care

If you or another TRICARE-eligible family member is faced with a terminal illness, TRICARE covers hospice care. Hospice care emphasizes supportive services, rather than cure-oriented treatment, for patients with a life expectancy of six months or less. This benefit allows for personal care and home health aid services, which are otherwise limited under TRICARE's basic program options.

Hospice Benefit Coverage

The hospice benefit covers four levels of care:

- Routine home care
- Continuous home care
- Inpatient respite care
- General hospice inpatient care

Note: Respite care is covered when necessary and is limited to no more than five days at a time. General inpatient care is limited to varying short-term stays.

Hospice patients may shift among the levels of care, depending on their needs, the needs of family members caring for them, and the determinations of the medical team managing their care. Care may include:

- Counseling
- Medical equipment, supplies, and medications
- Medical social services
- Medically necessary short-term inpatient care
- Nursing care
- Other covered services related to the terminal illness
- Physical and occupational services
- Physician services
- Speech and language pathology

Care is managed by the hospice care team in consultation with the patient and his or her family. The hospice care team evaluates and approves changes in the level of care.

Note: Hospice care is only covered in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

For more information on TRICARE's hospice coverage, visit **www.tricare.mil**.

TRICARE Extended Care Health Option

The TRICARE Extended Care Health Option (ECHO) provides services to ADFMs who qualify based on specific mental or physical disabilities. ECHO offers beneficiaries integrated services and supplies beyond those offered by the basic TRICARE health benefit programs.

Active duty sponsors with family members seeking ECHO registration must enroll in their service's Exceptional Family Member Program (EFMP) (*unless waived in specific situations*) and register for ECHO with their regional contractor in order to be eligible for ECHO benefits. There is no retroactive registration for the ECHO program. Prior authorization must be obtained from the regional contractor for all ECHO services. For more information about EFMP, contact your service branch's EFMP representative or visit **www.militaryhomefront.dod.mil/tf/efmp**.

Note: ECHO is **not** available for all of the TRICARE programs described in this handbook. Visit **www.tricare.mil/echo** for more information.

Conditions qualifying an ADFM for ECHO coverage may include, but are not limited to:

- Moderate or severe mental retardation
- Serious physical disability
- Extraordinary physical or psychological condition of such complexity that the beneficiary is homebound
- Diagnosis of a neuromuscular developmental condition or other condition in an infant or toddler (*under age 3*) that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability
- Multiple disabilities, which may qualify if there are two or more disabilities affecting separate body systems

ECHO Benefits

ECHO provides coverage for the following products and services:

- Applied behavior analysis (ABA)* (*which includes the DoD Enhanced Access to Autism Services Demonstration, discussed later in this section*) and other services that are not available through schools or other local community resources
- Assistive services (*e.g., those from a qualified interpreter or translator*)
- Durable equipment, including adaptation and maintenance
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC) (*limited to the 50 United States, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands*)
- Rehabilitative services
- Respite care (*during any month when at least one other ECHO benefit is received and limited to the 50 United States, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands*)
  - ECHO respite care: Up to 16 hours of care in a month when another ECHO service is provided
  - EHHC respite care: Up to eight hours per day, five days per week (*for those who qualify*)
- Training for special education and use of assistive-technology devices
- Institutional care when a residential environment is required
- Transportation under certain limited circumstances

For more information on the ECHO program, including costs and maximum cost-shares (*i.e., ECHO cap*), visit **www.tricare.mil/echo**.

** ABA services are limited to only those ECHO-eligible and enrolled beneficiaries with a diagnosis of autism spectrum disorder.*

DoD Enhanced Access to Autism Services Demonstration

The DoD Enhanced Access to Autism Services Demonstration was established to test the feasibility and advisability of permitting TRICARE reimbursement for educational interventions for autism spectrum disorders delivered by paraprofessional providers known as tutors.

This demonstration provides information that will enable DoD to determine the following:

- If there is increased access to these services
- If the services are reaching those most likely to benefit from them
- If the quality of these services is meeting the appropriate standard of care currently accepted by the professional community of providers, including the Behavior Analyst Certification Board
- That state licensure and certification requirements, where applicable, are being met

The DoD Enhanced Access to Autism Services Demonstration allows non-certified paraprofessional providers, or tutors, to provide autism-related services (*in particular, ABA*), under the supervision of a TRICARE-authorized certified therapist, to eligible ADFMs in the United States. TRICARE beneficiaries must be registered in ECHO to receive benefits through the DoD Enhanced Access to Autism Services Demonstration.

Note: The allowed cost of services provided by the DoD Enhanced Access to Autism Services Demonstration accrues to the ECHO FY government maximum cost-share.

For more information about the DoD Enhanced Access to Autism Services Demonstration, visit **www.tricare.mil/echo** and click on "Autism Services Demonstration."

Limitations and Exclusions

In general, TRICARE excludes services and supplies that are **not** medically or psychologically necessary for the diagnosis or treatment of a covered illness (*including mental disorder*), injury, or for the diagnosis and treatment of pregnancy or well-child care. All services and supplies (*including inpatient institutional costs*) related to a non-covered condition or treatment, or provided by an unauthorized provider, are excluded.

For a list of medical, surgical, and behavioral health care services that may not be covered unless exceptional circumstances exist, please see *Appendix A* of this handbook. Visit your regional contractor's Web site for more information.

Claims

Health Care Claims

If you are using the TRICARE Extra option, your provider will submit claims on your behalf. If you are using the TRICARE Standard option, you may be required to submit your own health care claims. Submit all claims, except claims for care received overseas, to the claims processor for the region **where you live**.

In the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*), claims must be filed within one year of either the date of service or the date of inpatient discharge. Overseas, claims must be filed within three years of either the date of service or the date of inpatient discharge. You must submit proof of payment with overseas claims.

To file a claim, obtain and fill out a *TRICARE DoD/CHAMPUS Medical Claim—Patient's Request for Medical Payment* (DD Form 2642). You can download forms and instructions from the TRICARE Web site at **www.tricare.mil/claims** or from your regional contractor's Web site. You can also obtain forms and instructions at a TRICARE Service Center or a military treatment facility (MTF). Fill out the form completely and sign it. The initial claim form may be signed by the beneficiary (*if age 18 and legally competent*), the sponsor, spouse, parent, or guardian of the beneficiary. However, any forms submitted based on later requests for additional information needed to process a claim must be signed by the beneficiary (*if 18 or older, or the parent/guardian must sign if the beneficiary is under 18*).

When filing a claim, attach a readable copy of the provider's bill to the claim form, making sure it contains the following:

- Patient's name
- Sponsor's Social Security number (SSN) or Department of Defense Benefits Number (DBN) (*Eligible former spouses should use their SSN or DBN, not the sponsor's.*)
- Provider's name and address (*If more than one provider's name is on the bill, circle the name of the person who provided the service for which the claim is filed.*)
- Date and place of each service
- Description of each service or supply furnished
- Charge for each service
- Diagnosis (*If the diagnosis is not on the bill, complete block 8a on the form.*)

Note: Providers submit inpatient facility claims.

You may be required to pay up front for services if you see a TRICARE-authorized non-network provider who chooses not to participate on the claim. In this case, TRICARE will reimburse you directly for the TRICARE-allowable charge, less any applicable deductible and cost-share. Remember that nonparticipating providers may charge you up to 15 percent above the TRICARE-allowable charge for services in addition to your cost-share and/or deductible.

If you receive care while traveling in the United States, file your TRICARE claims in the region where you live, not the region where you received care. If you receive care while traveling overseas (*including U.S. territories*), you must file your TRICARE claims with the TRICARE Overseas Program (TOP) claims processor. Always keep a copy of the paperwork for your records. Figure 4.1 on the following page lists stateside regional claims-processing information. Figure 4.2 on the following page lists TOP claims-processing information.

Visit **www.tricare.mil/claims** for more information on processing claims.

Pharmacy Claims

You will not need to file pharmacy claims to fill prescriptions at an MTF pharmacy, through TRICARE Pharmacy Home Delivery, or at a TRICARE retail network pharmacy. However, if you fill a prescription at a non-network pharmacy in the United States or U.S. territories (*American*

Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*), you must pay the full price of your prescription up front and file a claim for reimbursement.

To file a pharmacy claim:

1. Download *DD Form 2642* at **www.tricare.mil/claims**.
2. Complete the form and attach the required paperwork, as described on the form.
3. Mail the form and paperwork to:

   Express Scripts, Inc.
   TRICARE Claims
   P.O. Box 66518
   St. Louis, MO 63166-6518

Prescription claims require the following information for each drug:

- The patient's name
- Prescription name, strength, date filled, days' supply, quantity dispensed, and price
- National Drug Code, if available
- Prescription number
- Name and address of the pharmacy
- Name and address of the prescribing physician

Contact Express Scripts, Inc. (Express Scripts) at **1-877-363-1303** with questions about filing claims.

** Currently, there are no TRICARE retail network pharmacies in American Samoa.*

Regional Claims-Processing Information ***Figure 4.1***

TRICARE North Region	TRICARE South Region	TRICARE West Region
Send claims to: Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740	**Send claims to:** TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031	**Send claims to:** West Region Claims P.O. Box 77028 Madison, WI 53707-1028
Check the status of your claim at **www.myTRICARE.com** or **www.hnfs.com**.	Check the status of your claim at **www.myTRICARE.com** or **Humana-Military.com**.	Check the status of your claim at **www.triwest.com**.

TRICARE Overseas Program Claims-Processing Information ***Figure 4.2***

Active Duty Service Members (ADSMs) (*all overseas areas*)	**Send claims to:** TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707-7968
Non-ADSMs, TRICARE Eurasia-Africa (*Africa, Europe, and the Middle East*)	**Send claims to:** TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976
Non-ADSMs, TRICARE Latin America and Canada (*Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands*)	**Send claims to:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985
Non-ADSMs, TRICARE Pacific (*Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific Remote countries*)	**Send claims to:** TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985

Coordinating Benefits with Other Health Insurance

TRICARE is the last payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs and plans as identified by the TRICARE Management Activity.

If you have other health insurance (OHI), follow the OHI's rules for filing claims and file the claim with the OHI first. If there is an amount your OHI does not cover, you can file the claim with TRICARE for reimbursement. It is important to meet your OHI's requirements. If your OHI denies a claim for failure to follow its rules, such as obtaining care without authorization or using a non-network provider, TRICARE may also deny your claim.

Keep your regional contractor and health care providers informed about your OHI so they can coordinate your benefits and help ensure there is no delay (*or denial*) in the payment of your claims.

Note: Many employers, including state and local governments, offer TRICARE-eligible employees a TRICARE supplement as an incentive not to enroll in the employer's primary group health plan. Please inform your employers of the illegality of this practice and report any continued noncompliance to the TRICARE Program Integrity unit at:

TRICARE Program Integrity
16401 East Centretech Parkway
Aurora, CO 80011-9066

You may also report noncompliance to your TRICARE regional contractor's program integrity unit online at **www.tricare.mil/fraud**.

College Health Plans as OHI

Some colleges and universities offer student health plans for purchase from commercial insurers in addition to providing access to basic student health services (*usually covered as part of student fees*). Depending on the nature of a school-sponsored commercial insurance plan, these purchased health plans may be considered OHI. Access to basic student health services, such as a campus infirmary provided as part of a student fee, is generally not considered OHI. When a dependent student purchases OHI, TRICARE pays second to the OHI coverage.

Veterans Affairs Benefits as OHI

If you are entitled to U.S. Department of Veterans Affairs (VA) benefits, you may choose whether you see a TRICARE or VA provider. If you are **not** Medicare-eligible, VA coverage is considered OHI and TRICARE pays second to any out-of-pocket costs for VA services.

If you are entitled to Medicare Part A due to age or another reason, you are considered Medicare-eligible and generally must have Medicare Part B to keep your TRICARE benefit.* TRICARE beneficiaries with Medicare Part A and Part B are covered by TRICARE For Life (TFL), TRICARE's Medicare-wraparound coverage. Under TFL, Medicare acts as your primary insurance, and TRICARE acts as your secondary payer. VA care is **not** covered by Medicare, so if you seek care from a VA provider while you are using your TRICARE benefit, TFL pays first and Medicare pays nothing. In this situation, you pay the TRICARE Standard fiscal year deductible, cost-shares, and remaining billed charges. Alternatively, you may choose to use your VA benefit when seeing VA providers. To minimize your out-of-pocket costs once you are covered by TFL, seek care from providers who participate in both TRICARE and Medicare.

** Certain beneficiaries may not need Medicare Part B to keep their TRICARE benefit. For more information, visit **www.tricare.mil/tfl**.*

How TRICARE Calculates Payment with OHI

TRICARE regulations require coordination of benefits with OHI coverage. Due to these regulations, TRICARE does not always pay the OHI copayment or the balance remaining after the OHI payment. However, your liability is usually eliminated. Payment calculations differ by provider status as follows:

TRICARE Network Providers and Most Inpatient Facilities

If your OHI pays more than the TRICARE-allowable amount, no TRICARE payment is authorized, the charge is considered paid in full, and the provider may not bill you. Otherwise, TRICARE pays the lesser of:

- The TRICARE-allowable amount less the OHI payment
- The amount TRICARE would have paid without OHI
- The beneficiary's liability (*OHI copayment and/or deductible*)

*TRICARE-Authorized Non-Network Providers Who Accept TRICARE Assignment (*Participating*)*

TRICARE pays the lesser of:

- The TRICARE-allowable amount less the OHI payment
- The amount TRICARE would have paid without OHI
- The beneficiary's liability (*OHI copayment and/or deductible*)

*Providers Who Do Not Accept TRICARE Assignment (*Nonparticipating*)*

Nonparticipating providers may only bill you up to 15 percent above the TRICARE-allowable charge. If your OHI paid more than 115 percent of the TRICARE-allowable charge, no TRICARE payment is authorized, the charge is considered paid in full, and the provider may not bill you. Otherwise, TRICARE pays the lesser of:

- 115 percent of the allowed amount less the OHI payment
- The amount TRICARE would have paid without OHI
- The beneficiary's liability (*OHI copayment and/or deductible*)

Staff Model and Group Health Maintenance Organizations and Other OHI Plan Providers

If you are enrolled in one of these OHI plans, the provider and/or group either work directly for the health maintenance organization (HMO) or are paid a monthly or annual amount rather than a fee for each service. Under these plans, you may only receive a copayment receipt; an itemized bill or explanation of benefits (EOB) may not be available.

In these cases, you can submit *DD Form 2642* with a copy of the receipt. For processing, the copayment is considered the billed amount. Deductibles and cost-shares are applied, and you may only receive partial reimbursement of your HMO copayment.

Pharmacy Claims and OHI

When you have OHI, your OHI pays first for pharmacy coverage, and OHI rules apply. After your OHI has paid, TRICARE may reimburse you for part or all of your out-of-pocket costs, including copayments. Your best option with OHI is to use a retail pharmacy that is both covered by your OHI and is a TRICARE retail network pharmacy.

You are not eligible to use TRICARE Pharmacy Home Delivery if you have OHI with a prescription plan, including a Medicare Part D prescription program, unless you meet one of the following requirements:

- The medication you need is not covered by your OHI
- You have met your OHI's benefit cap (*i.e., you have met your benefit's maximum-coverage limit*)

Once you have met one of these requirements, you may submit your prescription to TRICARE Pharmacy Home Delivery. See "TRICARE Pharmacy Home Delivery" in the *Covered Services, Limitations, and Exclusions* section of this handbook for instructions on how to use the home delivery program.

Contact Express Scripts at **1-877-363-1303** with questions about filing OHI pharmacy claims.

Third-Party Liability

The Federal Medical Care Recovery Act allows TRICARE to be reimbursed for treatment costs if you are injured in an accident caused by someone else. The *Statement of Personal Injury—Possible Third Party Liability* (DD Form 2527) will be sent to you if a claim appears to have third-party liability involvement. Within 35 calendar days, you must complete and sign this form and follow the directions for returning it to the appropriate claims processor. You can download *DD Form 2527* at **www.tricare.mil/claims** or from your regional contractor's Web site.

Explanation of Benefits

A TRICARE EOB is not a bill. It is an itemized statement that shows the action TRICARE has taken on your claims. An EOB is for your information and files.

After reviewing the EOB, you have the right to appeal certain decisions regarding your claims and must do so in writing within 90 days of the date of the EOB notice. You should keep EOBs with your health insurance records for future reference. (*For more information about appeals, see the* For Information and Assistance *section of this handbook*.)

For a sample of the EOB in your region and for descriptions of the information in the EOB, see the following figure numbers in *Appendix B* of this handbook:

- **North Region:** Figure 9.1
- **South Region:** Figure 9.2
- **West Region:** Figure 9.3

Changes to Your TRICARE Coverage

TRICARE Standard and TRICARE Extra continue to provide health coverage for you and your family as you experience major life events. However, you will need to take specific actions to make sure you remain TRICARE-eligible. For each life event listed in this section, the first step is to update your information in the Defense Enrollment Eligibility Reporting System (DEERS).

Note: TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), and TRICARE Young Adult (TYA) each have program-specific rules regarding changes to your coverage. For more information on these options, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook.

You have several options for updating and verifying DEERS information. See "Keep Your DEERS Information Up To Date!" in the *Choosing TRICARE Standard and TRICARE Extra* section of this handbook for details.

The following segments provide information about what to do when you get married or divorced, have a child, move, retire, and more.

Getting Married or Divorced

Marriage

It is extremely important for sponsors to register new spouses in DEERS to ensure they are eligible for TRICARE. To register a new spouse in DEERS, the sponsor will need to provide a copy of the marriage certificate to the nearest uniformed services identification (ID) card-issuing facility. The new spouse will also be required to show two forms of ID (*e.g., any combination of Social Security card, driver's license, birth certificate, current military ID card, or Common Access Card [CAC]*). Once the spouse is registered in DEERS, he or she will receive a uniformed services ID card and will be eligible for TRICARE. When accessing care, the spouse will be asked to show his or her ID card.

Divorce

Sponsors must update DEERS in the event of a divorce. The sponsor will need to provide a copy of the divorce decree, dissolution, or annulment.

Children

After a divorce, any children who retain eligibility under the sponsor remain TRICARE-eligible until reaching age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support*), as long as his or her DEERS information is current. To extend benefits for your college student beyond age 21, contact DEERS to verify what documentation is needed. See "Keep Your DEERS Information Up To Date!" in the *Choosing TRICARE Standard and TRICARE Extra* section of this handbook for contact information.

Dependent children who age out of TRICARE coverage, but have not yet reached age 26, may be eligible to purchase TYA. It is available for purchase by unmarried adult children without access to an employer-sponsored health plan. For more information on TYA, see "TRICARE Young Adult" in the *Premium-Based TRICARE Standard Health Plans* section of this handbook.

Although a child normally does not get his or her own uniformed services ID card until reaching age 10, a child younger than 10 should have an ID card if in the custody of a parent or guardian who is not TRICARE-eligible or who is not the custodial parent. Patient privacy may be a factor for divorced parents attempting to obtain information about received health care services.

Note: Dependent children with disabilities may remain TRICARE-eligible beyond the normal age limits. Check with DEERS for eligibility criteria.

Former Spouses

Certain former spouses are eligible to continue TRICARE Standard and TRICARE Extra coverage as long as they:

- Do not remarry (*If a former spouse remarries, the loss of benefits remains applicable even if the remarriage ends in death or divorce.*)
- Are not covered by an employer-sponsored health plan
- Are not also a former spouse of a North Atlantic Treaty Organization or Partners for Peace nation member
- Meet the requirements of one of the two situations described in Figure 5.1.

Former spouses who are TRICARE-eligible must change their personal information in DEERS so their name and Social Security number (SSN) or Department of Defense Benefits Number (DBN) are listed for the primary contact information. The former spouse's TRICARE eligibility is shown in DEERS under his or her own SSN or DBN, not the sponsor's.

Having a Baby or Adopting a Child

Children are automatically covered by TRICARE Standard and TRICARE Extra at the time of birth or adoption. Coverage will be continuous as long as you register your child in DEERS within 365 days of birth. Register your child in DEERS at a uniformed services ID card-issuing facility. A birth certificate or certificate of live birth from the hospital is required. If your child is not registered in DEERS within one year after the date of birth or adoption, DEERS will show "loss of eligibility," and the child will no longer be TRICARE-eligible until registered in DEERS.

If at least one other family member is enrolled in TRICARE Prime, children are automatically covered as TRICARE Prime beneficiaries for 60 days after birth or adoption.

Note: TRS and TRR each have program-specific rules about enrolling new children. For more information on these requirements, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook. TYA does not cover dependents of enrollees.

Going to College or Another Approved Institution of Higher Learning

Children of a TRICARE-eligible sponsor remain TRICARE-eligible until reaching age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support*), as long as his or her DEERS information is current. To extend benefits for a dependent student beyond age 21, contact DEERS to verify what documentation is needed prior to his or her 21st birthday. See "Keep Your DEERS Information Up To Date!" in the *Choosing TRICARE Standard and TRICARE Extra* section of this handbook for contact information.

Eligibility Situations for Former Spouses ***Figure 5.1***

A	• The former spouse must have been married to the same service member or former member for at least 20 years, and at least 20 of those years must have been creditable in determining the member's eligibility for retirement pay. • If this requirement is met, the former spouse is eligible for TRICARE coverage after the date of the divorce, dissolution, or annulment.[1] Eligibility continues as long as the preceding requirements continue to be met and the former spouse does not remarry.
B	• The former spouse must have been married to the same service member or former member for at least 20 years, and at least 15—but less than 20—of those married years must have been creditable in determining the member's eligibility for retirement pay. • If this requirement is met, the former spouse is eligible for TRICARE coverage for only one year from the date of the divorce, dissolution, or annulment.[1]

1. For divorce decrees, dissolutions, or annulments on or before September 29, 1988, contact DEERS for verification of eligibility.

TRICARE Standard and TRICARE Extra provide continuous coverage when your child goes to college. Coverage remains the same, but your child may need to find a new provider. Advise your son or daughter to save all health care receipts in case you need to file a claim for reimbursement.

Note: In most cases, dependent students going overseas to attend college or another approved institution of higher learning on their own are eligible for TRICARE Overseas Program (TOP) Standard.

TRICARE benefits end when a dependent student reaches age 23 or when full-time student status ends, whichever comes first. For example, if a dependent student turns 23 on January 3, but does not graduate until May, coverage ends at midnight on January 2. However, if a dependent student graduates with a bachelor's degree while age 22 and enrolls in a full-time graduate program, he or she remains TRICARE eligible until reaching age 23.

Dependent children who have aged out of TRICARE coverage at age 21 and dependent students who have aged out of TRICARE coverage at age 23 may be eligible to purchase TYA until reaching age 26. TYA is available for purchase by unmarried adult children without access to an employer-sponsored health plan. For more information on TYA, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook.

Note: Dependent children with disabilities may remain TRICARE-eligible beyond the normal age limits. Check with DEERS for eligibility criteria.

Health Care Options for College and Other Students

Some colleges and universities offer student health plans for purchase from commercial insurers in addition to providing access to basic student health services (*usually covered as part of student fees*). Depending on the nature of a school-sponsored commercial insurance plan, such purchased health plans may be considered other health insurance (OHI). Access to basic student health services, such as a campus infirmary, provided as part of a student fee is generally not considered OHI.

When a dependent student has purchased OHI, TRICARE pays second to such OHI coverage.

Traveling

Traveling within the United States

If you need emergency care while traveling in the United States, visit the nearest emergency room or call 911.

If you seek care from a TRICARE network provider, the provider will file the claim with your regional contractor for you. If you seek care from a TRICARE-authorized non-network provider, you may have to pay up front, save your receipts, and file the claim with your regional contractor. Claims are always filed with the regional contractor where you are enrolled, not with the regional contractor in the area where you are traveling.

Traveling Overseas

If you need emergency care while traveling overseas, go to the nearest emergency care facility or call the Medical Assistance number for the overseas area where you are traveling. If you are admitted, contact the TOP Regional Call Center **before leaving the facility**, preferably within 24 hours or the next business day, to coordinate authorization, continued care, and payment. Contact the TOP Regional Call Center for urgent care assistance. See Figure 5.2 on the following page for TOP contact information.

Use TOP Standard to receive care from any host nation provider when traveling overseas, unless local restrictions apply. TOP Standard, including cost-shares and deductibles, is similar to the stateside program. TRICARE Extra is not available overseas. TRICARE nonparticipating non-network providers may charge up to 15 percent above the TRICARE-allowable amount in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). However, there is no limit to the amount nonparticipating non-network providers may bill in overseas locations.

Note: When seeking care from a host nation (*overseas*) provider, you should be prepared to pay up front for services and then file a claim with the TOP claims processor. To process your claims

reimbursements quickly and efficiently, you must submit proof of payment with all claims. For more information on proof of payment requirements overseas, visit **www.tricare.mil/proofofpayment**. In the Philippines, you must use a TRICARE-certified provider. Visit **www.tricare.mil/pacific** for more information or to find a certified provider.

Filling Prescriptions on the Road

You may use any TRICARE pharmacy option when traveling, but be sure your DEERS information is current. To fill a prescription, you need a valid uniformed services ID card. At overseas host nation pharmacies, you will pay up front and file a claim with the TOP contractor.

TRICARE Retail Network Pharmacy

You can fill prescriptions at any TRICARE retail network pharmacy in the United States and U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Currently, there are no TRICARE retail network pharmacies in American Samoa.

Visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303** to find the nearest TRICARE retail network pharmacy.

Military Treatment Facility Pharmacy

If you are traveling, you can fill a new prescription at any military treatment facility (MTF) pharmacy free of charge if the medication is on the MTF formulary and in stock. All you will need is the written prescription and your uniformed services ID card or CAC. An MTF pharmacy will determine if you can obtain a refill of a prescription that was originally filled at another MTF.

TRICARE Pharmacy Home Delivery

If you will be staying away from home for a longer period of time, you can plan ahead to receive prescriptions through TRICARE Pharmacy Home Delivery. Provide Express Scripts, Inc. (Express Scripts) with your temporary address so prescriptions can be mailed to you at your travel destination. TRICARE Pharmacy Home Delivery is only available overseas if you have an APO/FPO address. Mail may be subject to local customs regulations.

Note to retired service members: If you and your family are living or traveling overseas without serving in an official capacity, you do not have APO/FPO mail access. Therefore, you cannot receive medications by mail through TRICARE Pharmacy Home Delivery. For assistance, visit **www.express-scripts.com/TRICARE** or call **1-877-363-1303**.

TRICARE Overseas Program Contact Information *Figure 5.2*

TRICARE Eurasia-Africa	TRICARE Latin America and Canada	TRICARE Pacific
Africa, Europe, and the Middle East	Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands	Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries
TOP Regional Call Center[1] +44-20-8762-8384 (*overseas*) 1-877-678-1207 (*stateside*) tricarelon@internationalsos.com **Medical Assistance**[1] +44-20-8762-8133	**TOP Regional Call Center**[1] +1-215-942-8393 (*overseas*) 1-877-451-8659 (*stateside*) tricarephl@internationalsos.com **Medical Assistance**[1] +1-215-942-8320	**TOP Regional Call Centers**[1] Singapore: +65-6339-2676 (*overseas*) 1-877-678-1208 (*stateside*) sin.tricare@internationalsos.com Sydney: +61-2-9273-2710 (*overseas*) 1-877-678-1209 (*stateside*) sydtricare@internationalsos.com **Medical Assistance**[1] Singapore: +65-6338-9277 Sydney: +61-2-9273-2760

*1. For toll-free contact information, visit **www.tricare-overseas.com**. Only call Medical Assistance numbers to coordinate overseas emergency care.*

Non-Network Pharmacy

If there is no other option, you can fill prescriptions at any non-network pharmacy. You will be required to pay for prescriptions up front and file a claim with Express Scripts for reimbursement. See the *Claims* section of this handbook for details about filing a pharmacy claim.

Filling Prescriptions Overseas

Your pharmacy coverage is limited overseas. TRICARE recommends that you fill all of your prescriptions before traveling overseas. TRICARE retail network pharmacies are only located in the United States and U.S. territories of Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. Currently, there are no TRICARE retail network pharmacies in American Samoa. You must have an APO/FPO address to use TRICARE Pharmacy Home Delivery overseas, and the prescription must be from a U.S.-licensed provider. Be prepared to pay up front for medications and file a claim with the TOP claims processor for reimbursement when traveling overseas.

Note: In the Philippines, you must use a TRICARE-certified pharmacy. Visit **www.tricare.mil/pacific** for more information or to find a certified provider.

Moving

Moving within the United States

Whether you are moving to another area within the same TRICARE region or to a different TRICARE region, moving with TRICARE Standard and TRICARE Extra is easy. All you need to do is update your personal information in DEERS, find a new network or TRICARE-authorized non-network provider, and continue to receive care when you need it.

Visit **www.tricare.mil/findaprovider** to find a TRICARE-authorized provider. The regional contractors also have TRICARE network provider directories on their Web sites to locate TRICARE network providers in each region.

If you move to a new region, be sure to learn who your new regional contractor is and where to file your claims. See the *Claims* section of this handbook for details.

Moving Overseas

You can use TOP Standard and receive care from any host nation provider without a referral, unless local TOP restrictions require seeing only approved providers. TOP Standard, including cost-shares and deductibles, is similar to the stateside program and is administered by International SOS Assistance, Inc. There are some limits for overseas health care services and pharmacy coverage.

Note: In the Philippines, you must use a TRICARE-certified host nation provider and pharmacy. Visit **www.tricare.mil/pacific** for more information or to find a certified provider.

Contact the TOP Regional Call Center for the overseas area where you are moving or visit **www.tricare-overseas.com** to find a host nation provider. For TOP contact information, see Figure 5.2 earlier in this section. For a list of U.S. Embassies and Consular Offices worldwide, visit **www.usembassy.state.gov**.

Separating from the Service

If an active duty sponsor separates from the uniformed services, TRICARE coverage may or may not continue, depending on the circumstances of the separation. TRICARE offers transitional health care options through the premium-free Transitional Assistance Management Program (TAMP) and the premium-based Continued Health Care Benefit Program (CHCBP), which offer temporary coverage until you have a new health care plan.

Contact a Beneficiary Counseling and Assistance Coordinator to discuss your family's eligibility for these programs. For more information, visit **www.tricare.mil**.

Transitional Assistance Management Program

TAMP provides 180 days of transitional health care benefits to cover certain members of the uniformed services and their families while they

transition to civilian life. The sponsor and eligible family members may be covered for health benefits under TAMP if the sponsor is:

- Involuntarily separating from active duty under honorable conditions
- A National Guard or Reserve member separating from a period of active duty that lasted more than 30 consecutive days in support of a contingency operation
- Separating from active duty following involuntary retention (*stop-loss*) in support of a contingency operation
- Separating from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation
- Separating from active duty with an agreement to become a member of the Selected Reserve of the Ready Reserve of a Reserve component
- Separating from active duty due to sole survivorship discharge

If you qualify for coverage under TAMP, you will have 180 days of transitional health benefits after the sponsor separates from service. During this 180-day period, you may enroll in a TRICARE Prime option if you reside in a TRICARE Prime Service Area, or you will be covered under TRICARE Standard and TRICARE Extra. Rules and processes for these programs will apply. Your costs will be the same as those for active duty family members (ADFMs).

Continued Health Care Benefit Program

CHCBP is a Department of Defense premium-based health care program administered by Humana Military Healthcare Services, Inc. (Humana Military). CHCBP offers temporary transitional health coverage (*18–36 months*) after TRICARE eligibility ends. If you qualify, you can purchase CHCBP coverage within 60 days of loss of eligibility for either regular TRICARE or TAMP coverage. CHCBP acts as a bridge between military health care benefits and your new civilian health care plan. CHCBP benefits are comparable to TRICARE Standard and TRICARE Extra with the same benefits, providers, and program rules. The main difference is that you pay premiums to participate. CHCBP enrollees are not legally entitled to space-available care at MTFs. For more information about CHCBP, visit Humana Military's Web site at **Humana-Military.com** or call **1-800-444-5445**. For more information, visit **www.tricare.mil/chcbp**.

TRICARE Reserve Select®

TRS is a premium-based health plan that members of the Selected Reserve of the Ready Reserve may qualify to purchase. TRS provides comprehensive health care coverage and patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra, but TRS beneficiaries must pay monthly premiums. TRS beneficiaries may access care from any TRICARE-authorized providers, unless overseas restrictions apply. ADFM annual deductibles and cost-shares apply. For more information on this option, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook.

TRICARE Retired Reserve®

TRR is a premium-based health plan that members of the Retired Reserve may qualify to purchase. TRR provides comprehensive health care coverage and patient cost-shares and deductibles similar to TRICARE Standard and TRICARE Extra, but TRR beneficiaries must pay monthly premiums. TRR beneficiaries may access care from any TRICARE-authorized providers, unless overseas restrictions apply. Retiree annual deductibles and cost-shares apply. For more information on this option, see the *Premium-Based TRICARE Standard Health Plans* section of this handbook.

Retiring from Active Duty

When an active duty sponsor retires, he or she will experience a "change in status." When the sponsor's status is updated in DEERS, you will receive a new uniformed services ID card showing the new "retired" status.

Until retirement, your sponsor is enrolled in either TRICARE Prime or TRICARE Prime Remote (TPR). If the sponsor does not reenroll into TRICARE Prime, he or she will use TRICARE Standard and TRICARE Extra.

Note: TPR is not available to retirees.

When your status changes to family member of a retired service member, the TRICARE Standard and TRICARE Extra cost-shares and catastrophic cap will increase. Here are a few of the other TRICARE Standard and TRICARE Extra changes you will experience when your active duty sponsor retires:

TRICARE Standard and TRICARE Extra Changes upon Sponsor Retirement from Active Duty *Figure 5.3*

Outpatient Cost-Shares and Copayments	• Increase to retired family rates
Catastrophic Cap	• Increases to retired family rate
Health Care Services	• Eye examinations no longer covered • Hearing aids no longer covered
Medicare Eligibility	• Must purchase Medicare Part B (*when eligible*) to remain TRICARE-eligible

Note: Some specialized services are covered in connection with the medical or surgical treatment of a covered illness or injury.

Visit **www.tricare.mil/costs** for additional information regarding program costs.

Becoming Entitled to Medicare

Active Duty Status

Active duty service members (ADSMs) and ADFMs who are entitled to premium-free Medicare Part A remain eligible for TRICARE programs without signing up for Medicare Part B. To avoid a break in TRICARE coverage, ADSMs and ADFMs must sign up for Medicare Part B before the sponsor retires. ADSMs and ADFMs can sign up for Part B during a special enrollment period without having to pay monthly late enrollment premium surcharges. The special enrollment period is available anytime the sponsor is on active duty or within the first eight months following the month that (a) the sponsor retires, or (b) TRICARE coverage ends, whichever is first.

Retired Status

Once active duty status ends, if you or a family member is entitled to premium-free Medicare Part A, Medicare Part B is **required** to remain TRICARE-eligible. TRICARE benefits will be terminated for any period of time during which you have only Medicare Part A.

Survivor Coverage

If your sponsor dies while serving on active duty for a period of more than 30 consecutive days, you are automatically eligible for transitional TRICARE survivor benefits as long as your DEERS information is up to date and you are either of the following:

- A surviving spouse and do not remarry (*If you remarry, TRICARE eligibility cannot be regained later, even if you divorce or your new spouse dies.*)
- A surviving unmarried child younger than age 21 (*or age 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provided over 50 percent of the financial support*)
  Note: Dependent children with disabilities may remain eligible beyond normal age limits. Check DEERS for eligibility criteria.

Surviving Spouse: You remain eligible as a "transitional survivor" for three years following your sponsor's death and will have ADFM benefits and costs. After three years, you remain TRICARE-eligible as a "survivor" and will pay retiree rates and enrollment fees.

Surviving Children: Surviving children whose sponsor died on or after October 7, 2001, remain eligible as ADFMs. Unlike spouses, eligibility will not change after three years, and children remain covered as ADFMs until eligibility ends due to the age limits previously noted or for another reason (*e.g., marriage*).

Upon the death of a sponsor, you will receive a letter telling you about your program options and how your benefits will eventually change. Visit **www.tricare.mil/deers** if you have any questions.

Loss of Eligibility

Upon loss of TRICARE eligibility, each family member will automatically receive a certificate of creditable coverage. The certificate of creditable coverage is a document that serves as evidence of prior health care coverage under TRICARE so that you cannot be excluded from a new health care plan for preexisting conditions. Certificates may be issued in the following circumstances:

- Upon the sponsor's separation from active duty, a certificate will be issued to the sponsor listing all eligible family members.
- Upon the loss of eligibility for a dependent child (*age 21, or 23 if enrolled in a full-time course of study at an approved institution of higher learning, and if the sponsor provides over 50 percent of the financial support*), a certificate will be issued to the dependent child. (*At this point, if the child qualifies, he or she may choose to continue TRICARE coverage by purchasing TYA*.)
- Upon loss of coverage after divorce, a certificate will be issued to the former spouse as soon as the information is updated in DEERS.

Certificates automatically reflect the most recent period of continuous coverage under TRICARE. Certificates issued upon request of a beneficiary will reflect each period of continuous coverage under TRICARE that ended within the 24 months prior to the date of loss of eligibility. Each certificate identifies the name of the sponsor or family member for whom it is issued, the dates TRICARE coverage began and ended, and the certificate issue date.

Requests for certificates may be made in writing, via fax, or by phone. Written (*mailed or faxed*) requests for a certificate must include:

- Sponsor's name and Social Security number or DoD Benefits Number
- Name of person for whom the certificate is requested
- Reason for the request
- Name and address to whom and where the certificate should be sent
- Signature of the requester

Mail written requests to:

Defense Manpower Data Center
Support Office
ATTN: Certificate of Creditable Coverage
400 Gigling Road
Seaside, CA 93955-6771

Fax requests to **1-831-655-8317**.

Call DMDC directly at **1-800-538-9552** to request or check the status of your certificate. DMDC will review each request. Certificates can take up to three weeks to process. However, if your request is urgent, you can request that processing be expedited and your certificate can be faxed directly to a particular number.

Additional information is available at **www.tricare.mil/certificate**.

For Information and Assistance

Beneficiary Counseling and Assistance Coordinators

Beneficiary Counseling and Assistance Coordinators (BCACs) can help you with TRICARE and Military Health System inquiries and concerns and can advise you about obtaining health care. BCACs are located at military treatment facilities (MTFs) and TRICARE Regional Offices. To locate a BCAC, visit **www.tricare.mil/bcacdcao** and use the online directory.

Debt Collection Assistance Officers

Debt Collection Assistance Officers (DCAOs) are located at MTFs and TRICARE Regional Offices to help you resolve health care collection-related issues. Contact a DCAO if you received a negative credit rating or have been contacted by a collection agency due to an issue related to TRICARE services.

When you visit a DCAO for assistance, you must bring or submit paperwork associated with a collection action or adverse credit rating, including debt collection letters, explanation of benefits (EOB) statements, and medical and/or dental bills from providers. The more information you provide, the faster the cause of the problem can be determined. The DCAO will research your claim, provide you with a written resolution of your collection problem, and inform the collection agency that action is being taken to resolve the issue. DCAOs cannot provide legal advice or repair your credit rating, but they can help you through the debt collection process by providing documentation for the collection or credit-reporting agency to explain the circumstances relating to the debt. To find a DCAO near you, visit the DCAO directory online at **www.tricare.mil/bcacdcao**.

Appealing a Decision

If you believe a service or claim was improperly denied, in whole or in part, you (*or another appropriate party*) may file an appeal. An appeal must involve an appealable issue. For example, you have the right to appeal TRICARE decisions regarding denial of your claims. You may also appeal the denial of a requested authorization of services even though no care has been provided and no claim submitted.

There are some things you may not appeal. For example, you may not appeal the denial of a service provided by a health care provider not eligible for TRICARE certification.

When services are denied based on a medical-necessity or a benefit decision, you will be automatically notified in writing. The notification will include an explanation of what was denied and the reasoning behind the decision.

Appeal Requirements

Your appeal must meet the requirements listed in Figure 6.1.

Filing an Appeal

Appeals must be filed with your regional contractor within 90 days from the date that appears on the EOB or denial notification letter. If you are not satisfied with a decision rendered on an appeal, there may be further levels of appeal available to you. For specific information about filing an appeal in your region, visit your regional contractor's Web site or contact your regional contractor.

Prior authorization denial appeals may be either expedited or non-expedited, depending on the urgency of the situation. You or an appointed representative must file for an expedited review of a prior authorization denial based on medical necessity within three calendar days after receipt of the initial denial. A non-expedited review of a denial must be filed no later than 90 days after receipt of the initial denial.

TRICARE Appeal Requirements ***Figure 6.1***

1	An appropriate appealing party must submit the appeal. Proper appealing parties include: • You, the beneficiary • Non-network participating providers If a party other than those listed above submits the appeal, you will generally be required to complete and sign an *Appointment of Representative* form, which is available on your regional contractor's Web site. Appeals submitted without this form will not be processed, except in the following cases: • A custodial parent submits an appeal on behalf of a minor beneficiary • An attorney files an appeal without specific appointment by the proper appealing party **Note:** Network providers are not appropriate appealing parties, but may be appointed as a representative, in writing, by you.
2	The appeal must be submitted in writing. See Figure 6.2 on the following page for the appeals submission address for your region.
3	The issue in dispute must be an appealable issue. The following are not appealable issues: • Allowable charges • Eligibility • Denial of services from an unauthorized provider • Denial of treatment plan when an alternative treatment plan is selected
4	An appeal must be filed within 90 days of the date on the explanation of benefits or denial notification letter.
5	There must be an amount in dispute to file an appeal. In cases involving an appeal of a denial of an authorization in advance of receiving the actual services, the amount in dispute is deemed to be the estimated TRICARE-allowable charge for the services requested. There is no minimum amount to request a reconsideration.

Appeals should contain the following:

- Beneficiary's name, address, and telephone number
- Appealing party's or representative's signature

A description of the issue or concern must include:

- The specific issue in dispute
- A copy of the previous denial determination notice

You may submit supporting documentation, but the timely filing of the appeal should not be delayed while gathering the documentation. If you intend to obtain supporting documentation that is not readily available, file your appeal and state in the appeal letter your intention to submit additional documentation and the estimated date of submission. Remember, you must meet the 90-day filing deadline or your request for reconsideration will generally not be accepted.

Send your appeal to your regional contractor. See Figure 6.2 for regional appeals filing information. For overseas appeals information, visit **www.tricare-overseas.com**.

Pharmacy Claims Appeals

If you disagree with the determination on your pharmacy claim (*i.e., if your claim is denied*), you or your appointed representative has the right to request a reconsideration. The request (*or appeal*) for reconsideration must be in writing, signed, and postmarked or received by Express Scripts **within 90 calendar days** from the date of the decision and must include a copy of the claim decision.

Express Scripts, Inc.
P.O. Box 60903
Phoenix, AZ 85082-0903

Additional documentation in support of the appeal may be submitted; however, because the request for reconsideration must be postmarked or received within 90 calendar days of the date of the decision, the request for reconsideration should not be delayed pending acquisition of additional documentation. If additional documentation will be submitted at a later date, the letter requesting reconsideration must state that additional documentation will be submitted and specify the expected date of submission. Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed.

Regional Appeals Filing Information ***Figure 6.2***

TRICARE North Region	TRICARE South Region	TRICARE West Region
Claims Appeals: Health Net Federal Services, LLC TRICARE Claim Appeals P.O. Box 105266 Atlanta, GA 30348-5266 **Claims Appeals Fax:** 1-888-458-2554 **Prior Authorization Appeals:** Health Net Federal Services, LLC TRICARE Authorization Appeals P.O. Box 105087 Atlanta, GA 30348-5087 **Prior Authorization Appeals Fax:** 1-888-881-3622 **Appeals Online:** www.hnfs.com	**Claims Appeals:** TRICARE South Region Appeals P.O. Box 202002 Florence, SC 29502-2002 **Prior Authorization Appeals:** Humana Military Healthcare Services, Inc. ATTN: Clinical Appeals P.O. Box 740044 Louisville, KY 40201-9973 **Behavioral Health Appeals:** ValueOptions Behavioral Health ATTN: Appeals and Reconsideration Department P.O. Box 551138 Jacksonville, FL 32255-1138	**Claims Appeals:** TriWest Healthcare Alliance Claims Appeals P.O. Box 86036 Phoenix, AZ 85080 **Prior Authorization Appeals:** TriWest Healthcare Alliance Reconsideration Department P.O. Box 86508 Phoenix, AZ 85080

Filing a Grievance

A grievance is a written complaint or concern about a non-appealable issue regarding a perceived failure by any member of the health care delivery team—including TRICARE-authorized providers, military providers, regional contractors, or subcontractor personnel—to provide appropriate and timely health care services, access, or quality, or to deliver the proper level of care or service.

The grievance process allows full opportunity to report, in writing, any concern or complaint regarding health care quality or service. Any TRICARE civilian or military provider; TRICARE beneficiary; sponsor; or parent, guardian, or other representative of an eligible dependent child may file a grievance. Your regional contractor is responsible for the investigation and resolution of all grievances. Grievances are generally resolved within 60 days of receipt. Following resolution, the party who submitted the grievance will be notified of the review completion.

Grievances may include such issues as:

- The quality of health care or services (*i.e., accessibility, appropriateness, level of care, continuity, timeliness of care*)
- The demeanor or behavior of providers and their staffs
- The performance of any part of the health care delivery system
- Practices related to patient safety

When filing a grievance, include the following:

- Beneficiary's name, address, and telephone number
- Sponsor's Social Security number or Department of Defense Benefits Number
- Beneficiary's date of birth
- Beneficiary's signature

Description of the issue or concern must include:

- Date and time of the event
- Name(s) of the provider(s) and/or person(s) involved
- Location of the event (*address*)
- Nature of the concern or complaint
- Details describing the event or issue
- Any appropriate supporting documents

File grievances with your regional contractor. See Figure 6.3 for grievance-filing information. For overseas grievance information, visit **www.tricare-overseas.com**.

Regional Grievance-Filing Information *Figure 6.3*

TRICARE North Region	TRICARE South Region	TRICARE West Region
Mail: Health Net Federal Services, LLC TRICARE Grievances P.O. Box 105338 Atlanta, GA 30348-5338 **Fax:** 1-888-317-6155 **Online:** www.hnfs.com	**Mail:** Regional Grievance Coordinator Humana Military Healthcare Services, Inc. 8123 Datapoint Drive Suite 400 San Antonio, TX 78229 **For behavioral health care concerns, send your information to:** Grievance Specialist ValueOptions P.O. Box 551188 Jacksonville, FL 32255-1188	**Mail:** TriWest Healthcare Alliance ATTN: Customer Relations Dept. P.O. Box 42049 Phoenix, AZ 85080

Reporting Suspected Fraud and Abuse

Fraud happens when a person or organization takes action to deliberately deceive others to gain an unauthorized benefit. Health care abuse occurs when providers supply services or products that are medically unnecessary or that do not meet professional standards.

You are an important partner in the ongoing fight against federal fraud and abuse. An EOB is a statement of services and/or supplies received, making it one of the first lines of defense against health care fraud. Each EOB provides a toll-free number to call if you have concerns about services you believe are billed fraudulently. You can also visit the TRICARE fraud and abuse Web site at **www.tricare.mil/fraud** for direct links to your regional contractor's fraud and abuse reporting office. Through your regional contractor's Web site, you can use claims tools to view your EOBs and claims history and track the costs TRICARE pays. **TRICARE strongly encourages you to read your EOBs carefully.**

To report fraud or abuse regarding the pharmacy program, contact Express Scripts, Inc.:

- **Phone:** 1-800-332-5455, ext. 367079
- **E-mail:** fraudtip@express-scripts.com

Figure 6.4 provides regional fraud and abuse reporting information. You can also report fraud or abuse issues directly to TRICARE at **fraudline@tma.osd.mil**. For overseas fraud and abuse reporting information, visit **www.tricare-overseas.com**.

Regional Fraud and Abuse Reporting Information *Figure 6.4*

TRICARE North Region	TRICARE South Region	TRICARE West Region
Phone: 1-800-977-6761 **Fax:** 1-888-881-3644 **Online:** www.hnfs.com **Mail:** Health Net Federal Services, LLC Program Integrity P.O. Box 105310 Atlanta, GA 30348-5310	**Phone:** 1-800-333-1620 **Online:** Humana-Military.com **Mail:** Humana Military Healthcare Services, Inc. ATTN: Program Integrity 500 W. Main Street, 19th Floor Louisville, KY 40202	**Phone:** 1-888-584-9378 **Fax:** 1-602-564-2171 **Online:** www.triwest.com

Premium-Based TRICARE Standard Health Plans

TRICARE Reserve Select

TRICARE Reserve Select (TRS) is a premium-based, worldwide health plan that qualified Selected Reserve of the Ready Reserve members and qualified survivors may purchase. This section explains how to qualify for and purchase TRS coverage and summarizes the program's health care benefits and costs. TRS offers qualified members and survivors:

- Comprehensive health coverage similar to TRICARE Standard and TRICARE Extra (*in the United States*) or the TRICARE Overseas Program (TOP) Standard (*overseas*)
- Two types of coverage: TRS member-only and TRS member-and-family
- Access to covered services from any TRICARE-authorized health care provider (*unless overseas restrictions apply*)
- Access to care at military treatment facilities (MTFs) on a space-available basis (*TRS members and their families have the same MTF appointment priority as active duty family members not enrolled in TRICARE Prime.*)

For more information, visit **www.tricare.mil/trs**.

Qualifying for TRICARE Reserve Select

National Guard and Reserve members may qualify to purchase TRS coverage if they are:

- Members of the Selected Reserve of the Ready Reserve
- Not eligible for, or enrolled in, the Federal Employees Health Benefits (FEHB) program

Survivors of National Guard and Reserve members may qualify to purchase TRS coverage for up to six months from the date of the sponsor's passing if both of the following apply:

- Their deceased sponsor was covered by TRS on the date of his or her death
- They currently are immediate family members of the deceased sponsor (*spouses cannot have remarried*)

Note: Surviving family members who are eligible for or enrolled in the FEHB program may still purchase TRS.

To qualify for TRS:

- Log on to the Web-based Defense Manpower Data Center (DMDC) Reserve Component Purchased TRICARE Application at **www.dmdc.osd.mil/appj/reservetricare**.
  - To use the Web site, you will need a Department of Defense (DoD) Self-Service Logon (DS Logon), Defense Finance and Accounting Service (DFAS) account, or DoD Common Access Card (CAC).
  - To obtain a DS Logon online, you can visit **www.dmdc.osd.mil/identitymanagement**. To obtain a DS Logon in person, visit a TRICARE Service Center (TSC), or a U.S. Department of Veterans Affairs (VA) Regional Office to complete an in-person proofing process.
- Select "Purchase Coverage" and follow the instructions.
  - If you certify that you are eligible for or enrolled in FEHB, you do not qualify and cannot purchase TRS.
  - If you certify that you are not eligible for or enrolled in FEHB, you will be guided through the process of selecting a TRS start date and electing which family members you want covered.
- Print and sign the completed *Reserve Component Health Coverage Request* form (DD Form 2896-1).* (*Members who do not qualify will not be able to complete or print the form. Contact your National Guard or Reserve personnel office for assistance. Visit* ***www.defenselink.mil/ra/html/tricare.html*** *for a list of TRS points of contact [*POCs*].*)

Sponsors or survivors who qualify will be able to purchase TRS.

* *If you experience a technical problem, contact the DMDC Support Center at* ***1-800-477-8227****.*

Purchasing TRICARE Reserve Select

Mail the completed and signed *DD Form 2896-1* with the premium payment amount printed on the form (*initial enrollment requires two months' premium payment*) to your regional contractor by the applicable deadline. Figure 7.1 provides information on purchasing TRS coverage. See the *Welcome to TRICARE Standard and TRICARE Extra* section at the beginning of this handbook for regional contractor contact information.

Purchasing TRICARE Reserve Select Coverage — *Figure 7.1*

General Enrollment	You may purchase TRICARE Reserve Select (TRS) coverage to begin the first of any month when you are eligible. • Deadline: Application form must be postmarked or received no later than the last day of the month before coverage is to begin. • Effective date: Coverage begins on the first day of the first or second month (*whichever you select on the form*).
Loss of Other TRICARE Coverage	If you lose coverage under another TRICARE health care plan under your sponsor's account and qualify for TRS, you may purchase TRS with no break in coverage. • Deadline: Application form must be postmarked or received no later than 30 days after the loss of other TRICARE coverage. • Effective date: TRS coverage begins on the day after you lose your prior TRICARE coverage. **Note:** You may be able to print the completed form up to 60 days before other coverage ends and submit it in advance of the other TRICARE coverage end date.
Change in Family Composition	If the composition of your immediate family changes due to a qualifying life event (*e.g., marriage, birth, adoption, death*), you may request changes to your TRS coverage. See "TRICARE Reserve Select Changes in Coverage" later in this section for more details. • Deadline: Application form must be postmarked or received no later than 60 days after date of the change. • Effective date: TRS coverage date coincides with the date of change in the family.
Survivor Coverage	If TRS coverage is in effect when the sponsor passes away, qualified survivors may receive coverage under TRS for six months from the date of the sponsor's passing. If TRS member-and-family coverage is in effect at the time of death: • The Defense Enrollment Eligibility Reporting System (DEERS) will automatically transfer covered family members to TRS survivor coverage. • TRS survivor coverage will automatically end six months after the date of your sponsor's passing. • Deadline to opt out: If survivors do not want TRS survivor coverage, a written letter or a *Reserve Component Health Coverage Request* form (DD Form 2896-1) must be postmarked or received no later than 60 days after the date of the sponsor's death. Premiums will be refunded if there have been no claims for health care submitted during this 60-day period. If TRS member-only coverage is in effect at the time of death: • Eligible survivors may qualify to purchase TRS survivor coverage. • Purchased TRS survivor coverage may continue for six months from the date of the sponsor's passing. • Deadline to purchase coverage: The TRS survivor coverage request must be postmarked or received no later than 60 days after the date of your sponsor's passing. **Note:** Surviving family members who are eligible for or enrolled in the Federal Employees Health Benefits program may still purchase TRS.

TRICARE Reserve Select Covered Services

TRS coverage is similar to TRICARE Standard and TRICARE Extra or TOP Standard. Some exceptions may apply. For more information, see the *Covered Services, Limitations, and Exclusions* section of this handbook.

TRICARE Reserve Select Costs and Fees

Monthly Premiums

Premiums are adjusted annually, effective January 1. Visit **www.tricare.mil/costs** for the most current cost information.

On your application, you can elect to use your credit card to make either the initial premium payment only or the initial payment and automatic monthly payments. After the initial payment, all monthly premium payments must be made by either automated electronic funds transfer (EFT) or automated credit/debit card (*i.e., Visa/MasterCard*) payment. Contact your regional contractor to set up your automatic payments. Payments are due no later than the last day of each month, and payments are applied to the following month of coverage. **Do not miss payment due dates—failure to pay total amounts due will result in termination of coverage and a 12-month purchase lockout.** Your termination date will date back to your previous paid-through date.

Annual Outpatient Deductible

You must meet the outpatient deductible each fiscal year (FY) (*October 1–September 30*) before TRICARE outpatient cost-sharing begins. For more information on deductibles, visit **www.tricare.mil/costs**.

Outpatient Costs

Figure 7.2 lists the cost-shares for outpatient services after your annual deductible is met.

TRS Outpatient Costs *Figure 7.2*

Type of Provider	Outpatient Cost-Share
TRICARE Network	15% of the negotiated rate
TRICARE-Authorized Non-Network	20% of the TRICARE-allowable charge; nonparticipating providers may charge fees up to 15% above the TRICARE-allowable charge

Overseas Care

Overseas providers and beneficiaries are reimbursed for billed charges, and reimbursement is based on TRICARE-allowable charges. Authorized providers overseas may bill above the TRICARE-allowable charge, and you may be responsible for any difference between the TRICARE-allowable charge and the billed amount, unless you see a participating provider. Participating providers agree to accept the TRICARE-allowable charge, and any cost-share or deductible amounts for which you are responsible, as payment in full.

Note: TRICARE nonparticipating non-network providers may charge up to 15 percent above the TRICARE-allowable amount in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*). However, there is no limit to the amount nonparticipating non-network providers may bill in overseas locations.

If you live in the Philippines, you are required to visit certified health care and pharmacy providers. In other locations, check to see if restrictions on approved providers apply in your area. For more information about approved providers, visit **www.tricare.mil/pacific** or call your TOP Regional Call Center. For TOP contact information, visit **www.tricare-overseas.com**.

Catastrophic Cap

The TRS catastrophic cap is $1,000 per family, per FY. The catastrophic cap is the maximum amount you will pay for health care each FY, except as noted. The cap applies to all TRICARE-covered services—annual deductibles, outpatient and inpatient cost-shares, and pharmacy copayments based on TRICARE-allowable charges. Monthly premiums, payments above the TRICARE-allowable charge, and payments for non-covered services are not credited toward the catastrophic cap.

TRICARE Reserve Select Changes in Coverage

Changes in Family Composition

When you experience a change in your family composition due to a qualifying life event (*e.g., marriage, birth, adoption, death*), you may request changes to your TRS coverage.

- You must always report all family changes in DEERS. For more information, visit **www.tricare.mil/deers**.
- To add a DEERS-registered family member to TRS coverage, follow instructions listed in "Purchasing TRICARE Reserve Select" earlier in this section.
- To remove a family member from coverage, follow the procedure for "Elect to End Coverage" later in this section.

Note: Newborns or newly adopted children are not automatically covered under TRS. Newborns and newly adopted children are only covered from the date of birth or adoption if they are registered in DEERS and the TRS request is received or postmarked within 60 days of birth or adoption.

TRICARE Reserve Select Termination of Coverage

Elect to End Coverage

You may choose to end TRS coverage at any time. You may end either the entire plan or coverage for an individual family member. **Do not simply stop making payments.** You must take the following action to end your coverage:

- Log on to the DMDC Reserve Component Purchased TRICARE Application at **www.dmdc.osd.mil/appj/reservetricare** (*as described earlier in "Qualifying for TRICARE Reserve Select"*) and follow the instructions to disenroll.
- Print, sign, and mail your completed *DD Form 2896-1* to your TRICARE regional contractor. The effective end date is either the last day of the month in which the request was postmarked or received, or the last day of a future month as specified in the request.

A 12-month TRS purchase lockout will go into effect. That means you **cannot** have TRS coverage in effect for one year.

Nonpayment

Your premium payment is due no later than the last day of the month for the next month's coverage. Failure to pay total premium amounts due will result in a termination of coverage due to nonpayment. A 12-month TRS purchase lockout will go into effect.

Change in Status

If you are ever recalled to active duty service for more than 30 consecutive days, you and your family may become eligible for non-premium TRICARE plans. At that time, your TRS coverage automatically ends and any unused premiums already paid will be refunded. The 12-month TRS purchase lockout does **not** apply.

If you want TRS coverage to continue after your other TRICARE coverage ends, you must qualify for and purchase TRS coverage again, as early as 30 days prior to your activation end date or Transitional Assistance Management Program end date and no later than 30 days after the other TRICARE coverage ends. See "Qualifying for TRICARE Reserve Select" and "Purchasing TRICARE Reserve Select" earlier in this section for instructions.

Your TRS coverage will also automatically end if you leave the Selected Reserve. You may purchase TRS coverage again if you requalify, and a purchase lockout will **not** apply.

Change in Federal Employees Health Benefits Program Eligibility or Enrollment

You must take action to disenroll from TRS if you become eligible for or enrolled in the FEHB program. See "Elect to End Coverage" earlier in this section for more information on how to disenroll. No TRS purchase lockout will go into effect.

If you fail to end coverage as required, your Reserve component may terminate your coverage, and you will be responsible for any health care received after the effective date of termination.

TRICARE Retired Reserve

TRICARE Retired Reserve (TRR) is a premium-based, worldwide health plan that qualified Retired Reserve members and qualified survivors may purchase. This section explains how to qualify for and purchase TRR coverage and summarizes the program's health care benefits and costs. TRR offers qualified members and survivors:

- Comprehensive health coverage similar to TRICARE Standard and TRICARE Extra (*in the United States*) or TOP Standard (*overseas*)
- Two types of coverage: TRR member-only and TRR member-and-family
- Access to covered services from any TRICARE-authorized health care provider (*unless overseas restrictions apply*)
- Access to care at MTFs on a space-available basis

For more information, visit **www.tricare.mil/trr**.

Qualifying for TRICARE Retired Reserve

Retired Reserve members may qualify to purchase TRR coverage if they are:

- Members of the Retired Reserve who are qualified for non-regular retirement
- Under age 60
- Not eligible for, or enrolled in, the FEHB program

Survivors of Retired Reserve members may qualify to purchase TRR coverage if all of the following apply:

- Their deceased sponsor was covered by TRR on the date of his or her death
- They currently are immediate family members of the deceased sponsor (*spouses cannot have remarried*)
- TRR coverage would begin before the date the deceased sponsor would have reached age 60

Note: Survivors of TRR members may purchase or continue coverage until the date the deceased sponsor would have reached age 60.

To qualify for TRR:

- Log on to the Web-based DMDC Reserve Component Purchased TRICARE Application at **www.dmdc.osd.mil/appj/reservetricare**.
  - To use the Web site, you will need a DS Logon, DFAS account, or CAC.
  - To obtain a DS Logon online, you can visit **www.dmdc.osd.mil/identitymanagement**. To obtain a DS Logon in person, visit a TSC, or a VA Regional Office to complete an in-person proofing process.
- Select "Purchase Coverage" and follow the instructions.
  - If you certify that you are eligible for or enrolled in FEHB, you do not qualify and cannot purchase TRR.
  - If you certify that you are not eligible for or enrolled in FEHB, you will be guided through the process of selecting a TRR start date and electing which family members you want covered.
- Print and sign the completed *DD Form 2896-1.** (*Members who do not qualify will not be able to complete or print the form. Contact your National Guard or Reserve personnel office for assistance. Visit **www.defenselink.mil/ra/html/tricare.html** for a list of TRR POCs.*)

Sponsors or survivors who qualify will be able to purchase TRR.

** If you experience a technical problem, contact the DMDC Support Center at **1-800-477-8227**.*

Purchasing TRICARE Retired Reserve

Mail the completed and signed *DD Form 2896-1* with the premium payment amount printed on the form (*initial enrollment requires two months' premium payment*) to your regional contractor by the applicable deadline. Figure 7.3 on the following page provides information on purchasing TRR coverage. See the *Welcome to TRICARE Standard and TRICARE Extra* section at the beginning of this handbook for regional contractor contact information.

Purchasing TRICARE Retired Reserve Coverage *Figure 7.3*

General Enrollment	You may purchase TRICARE Retired Reserve (TRR) coverage to begin in any month of the year. • Deadline: Application form must be postmarked or received no later than the last day of the month before coverage is to begin. • Effective date: Coverage begins on the first day of the first or second month (*whichever you select on the form*).
Loss of Other TRICARE Coverage	If you lose coverage under another TRICARE health care plan under your sponsor's account and qualify for TRR, you may purchase TRR with no break in coverage. • Deadline: Application form must be postmarked or received no later than 30 days after the loss of other TRICARE coverage. • Effective date: TRR coverage begins on the day after you lose your prior TRICARE coverage.
Change in Family Composition	If the composition of your immediate family changes (*e.g., marriage, birth, adoption, death*), you may purchase TRR coverage. See "TRICARE Retired Reserve Changes in Coverage" later in this section for more details. • Deadline: Application form must be postmarked or received no later than 60 days after date of the change. • Effective date: TRR coverage date coincides with the date of change in the family.
Survivor Coverage	If TRR coverage is in effect when the sponsor passes away, qualified survivors may purchase or continue TRR coverage until the day the sponsor would have turned 60. See "General Enrollment" above for instructions to purchase new TRR coverage at any time. If TRR member-and-family coverage is in effect at the time of death: • The Defense Enrollment Eligibility Reporting System (DEERS) will automatically convert TRR member-and-family coverage to TRR survivor coverage. • Deadline to opt out: If survivors do not want TRR survivor coverage, a written letter or a *Reserve Component Health Coverage Request* form (DD Form 2896-1) must be postmarked or received no later than 60 days after the date of the sponsor's death. Premiums will be refunded if there have been no claims for health care submitted during this 60-day period. If TRR member-only coverage is in effect at the time of death: • Eligible survivors may qualify to purchase TRR survivor coverage. • Deadline: See "Change in Family Composition" above if you want coverage to coincide with the date of your sponsor's death.

TRICARE Retired Reserve Covered Services

TRR coverage is similar to TRICARE Standard and TRICARE Extra or TOP Standard. Some exceptions may apply. For more information, see the *Covered Services, Limitations, and Exclusions* section of this handbook.

TRICARE Retired Reserve Costs and Fees

Monthly Premiums

Premiums are adjusted annually, effective January 1. Visit **www.tricare.mil/costs** for the most current cost information.

On your application, you can elect to use your credit card to make either the initial premium payment only or the initial payment and automatic monthly payments. After the initial payment, all monthly premium payments must be made by either automated EFT or automated credit/debit card (*i.e., Visa/MasterCard*) payment. Contact your regional contractor to set up your automatic payments. Payments are due no later than the last day of each month and apply to the following month of coverage. **Do not miss payment due dates—failure to pay total amounts due will result in termination of coverage and a 12-month purchase lockout.** Your termination date will date back to your previous paid-through date.

Annual Outpatient Deductible

You must meet the outpatient deductible each FY (*October 1–September 30*) before TRICARE outpatient cost-sharing begins. For more information on deductibles, visit **www.tricare.mil/costs**.

Outpatient Costs

Figure 7.4 lists the amounts you will pay for outpatient services after your annual deductible is met.

TRR Outpatient Costs *Figure 7.4*

Type of Provider	Outpatient Cost-Share
TRICARE Network	20% of the negotiated rate
TRICARE-Authorized Non-Network	25% of the TRICARE-allowable charge; nonparticipating providers may charge fees up to 15% above the TRICARE-allowable charge

Overseas Care

Overseas providers and beneficiaries are reimbursed for billed charges, and reimbursement is based on TRICARE-allowable charges. Authorized providers overseas may bill above the TRICARE-allowable charge, and you may be responsible for any difference between the TRICARE-allowable charge and the billed amount, unless you see a participating provider. Participating providers agree to accept the TRICARE-allowable charge, and any cost-share or deductible amounts for which you are responsible, as payment in full.

Note: TRICARE nonparticipating non-network providers may charge up to 15 percent above the TRICARE-allowable amount in the United States and U.S. territories. However, there is no limit to the amount nonparticipating non-network providers may bill in overseas locations.

If you live in the Philippines, you are required to visit certified health care and pharmacy providers. For more information about certified providers, visit **www.tricare.mil/pacific** or call your TOP Regional Call Center. In other locations, check to see if restrictions on certified providers apply in your area. For TOP contact information, visit **www.tricare-overseas.com**.

Catastrophic Cap

The TRR catastrophic cap is $3,000 per family, per FY. The catastrophic cap is the maximum amount you will pay for health care each FY, except as noted below. The cap applies to all TRICARE-covered services—annual deductibles, outpatient and inpatient cost-shares, and pharmacy copayments based on TRICARE-allowable charges. Monthly premiums, payments above the TRICARE-allowable charge, and payments for non-covered services are not credited toward the catastrophic cap.

TRICARE Retired Reserve Changes in Coverage

Changes in Family Composition

When you experience a change in your family composition (*e.g., marriage, birth, adoption, death*), you may request changes to your TRR coverage.

- You must always report all family changes to DEERS. For more information, visit **www.tricare.mil/deers**.
- To add a DEERS-registered family member to TRR coverage, follow the instructions listed in "Purchasing TRICARE Retired Reserve" earlier in this section.
- To remove a family member from coverage, follow the procedure for "Elect to End Coverage" later in this section.

Note: Newborns or newly adopted children are not automatically covered under TRR. Newborns and

newly adopted children are only covered from the date of birth or adoption if they are registered in DEERS and the TRR request is received or postmarked within 60 days of birth or adoption.

TRICARE Retired Reserve Termination of Coverage

Elect to End Coverage

You may choose to end TRR coverage at any time. You may end either the entire plan or coverage for an individual family member. **Do not simply stop making payments**. You must take the following actions to end your coverage:

- Log on to the DMDC Reserve Component Purchased TRICARE Application at **www.dmdc.osd.mil/appj/reservetricare** (*as described earlier in "Qualifying for TRICARE Retired Reserve"*) and follow the instructions to disenroll.
- Print, sign, and mail your completed *DD Form 2896-1* to your TRICARE regional contractor. The effective end date is either the last day of the month in which the request was postmarked or received, or the last day of a future month as specified in the request.

A 12-month TRR purchase lockout will go into effect. That means you **cannot** have TRR coverage in effect for one year.

Nonpayment

Your premium payment is due no later than the last day of the month for the next month's coverage. Failure to pay total premium amounts due will result in a termination of coverage due to nonpayment. A 12-month TRR purchase lockout will go into effect.

Change in Status

If you are ever recalled to active duty for more than 30 consecutive days, you and your family become eligible for non-premium TRICARE plans. At that time, your TRR coverage automatically ends and any unused premiums already paid will be refunded. The 12-month TRR purchase lockout does **not** apply.

If you want TRR coverage to continue after your other TRICARE coverage ends, you must qualify for and purchase TRR coverage again no later than 30 days after the other TRICARE coverage ends. See "Qualifying for TRICARE Retired Reserve" and "Purchasing TRICARE Retired Reserve" earlier in this section for instructions.

Change in Federal Employees Health Benefits Program Eligibility or Enrollment

You must take action to disenroll from TRR if you become eligible for or enrolled in the FEHB program. See "Elect to End Coverage" earlier in this section for more information on how to disenroll. No TRR purchase lockout will go into effect.

If you fail to end coverage as required, your Reserve component may terminate your coverage, and you will be responsible for any health care received after the effective date of termination.

Your TRR coverage will also automatically end when you reach age 60 and become eligible for TRICARE retiree benefits.

TRICARE Young Adult

The TRICARE Young Adult (TYA) program is a premium-based health care plan available for purchase by qualified dependents. TYA offers TRICARE Prime and TRICARE Standard coverage worldwide. TYA includes medical and pharmacy benefits, but excludes dental coverage.

Who Is Eligible?

If you are an adult-age dependent, your sponsor's status determines whether you are eligible for TYA Prime and/or TYA Standard. See Figure 7.5 on the following page for eligibility information based on your sponsor's status.

Note: Special eligibility conditions may exist.

You may generally purchase TYA coverage if you are all of the following:

- A dependent of a TRICARE-eligible uniformed service sponsor
- Unmarried
- At least age 21 (*or age 23 if previously enrolled in a full-time course of study at an approved institution of higher learning and if the sponsor provides over 50 percent of the financial support*), but have not yet reached age 26

You may **not** purchase TYA coverage if you are:

- Eligible to enroll in an employer-sponsored health plan as defined in TYA regulations
- Otherwise eligible for TRICARE program coverage
- Married

Purchasing TRICARE Young Adult

TYA offers open enrollment, so, if you qualify, you may purchase coverage at any time. The *TRICARE Young Adult Application* is available at **www.tricare.mil/tya**. When applying, you must verify that you are not married and not eligible to enroll in an employer-sponsored health plan.

Note: If you are not already in DEERS, your sponsor must add you to the system before starting the application process. For information on adding family members to DEERS, visit **www.tricare.mil/deers**.

Once you complete and sign the application, take it, along with your initial premium payment, to a TRICARE Service Center, or mail or fax it to your regional contractor.

Your completed application must include the initial premium payment, paid by personal check, cashier's check, money order, or credit/debit card. After the initial payment, premiums must be paid in advance by monthly automated electronic payment.

Enrollment in TRICARE Young Adult

After enrolling in TYA, you and your sponsor may visit a uniformed services identification (ID) card-issuing facility to obtain an ID card for you. You must bring two forms of ID—one must be an unexpired government-issued ID card with a picture. If you enroll in TYA Standard, your coverage will begin the first day of the following month after your enrollment application is processed and payment is received. If you enroll in TYA Prime, your coverage will follow the 20th-of-the-month rule: As long as your enrollment application is received by the 20th of the month, coverage can begin on the first day of the next month. If it is received after the 20th of the month, it will start the first day of the following month.

Note: You may be eligible for the Continued Health Care Benefit Program after TYA coverage ends, unless you have been locked out of TYA coverage. Visit **www.tricare.mil/chcbp** for more information.

Covered Services

The TYA benefit includes TRICARE Prime and TRICARE Standard. TYA includes medical and pharmacy benefits, but excludes dental coverage. TYA Prime enrollees have TRICARE Prime access to care through their assigned military or civilian primary care managers. All TYA enrollees are eligible for care at MTFs, but

Eligibility to Purchase TRICARE Young Adult Coverage Based on Sponsor Status *Figure 7.5*

Sponsor Status	TRICARE Prime[1]	TRICARE Prime Remote[1]	TRICARE Standard	Uniformed Services Family Health Plan[1]	TRICARE Overseas Program (TOP) Prime[1]	TOP Prime Remote[1]	TOP Standard
Active Duty	✔	✔	✔	✔	✔	✔	✔
Retired	✔	✘	✔	✔	✘	✘	✔
Selected Reserve of the Ready Reserve[2]	✘	✘	✔	✘	✘	✘	✔
Retired Reserve[2]	✘	✘	✔	✘	✘	✘	✔

1. *To enroll in this program, it must be offered in your geographic area, and you must meet all other eligibility criteria (*such as command sponsorship overseas*).*
2. *If you are an adult child of a non-activated member of the Selected Reserve of the Ready Reserve or of the Retired Reserve, your sponsor must be enrolled in TRICARE Reserve Select or TRICARE Retired Reserve for you to be eligible to purchase TYA coverage.*

TYA Standard enrollees have access only on a space-available basis. TYA is only available for individuals and is not offered as a family plan. For more information on covered services, visit **www.tricare.mil/coveredservices**.

Note: Expectant mothers enrolled in a TYA program option receive maternity care for the duration of their pregnancy. However, the child will not be covered by TRICARE under the mother's sponsorship.

TRICARE Young Adult Costs and Fees

TYA premiums are adjusted annually, effective January 1. Ongoing premiums must be paid in advance by automated payment. Premiums are not credited to deductibles or catastrophic caps.

TYA Prime has the same copayments as TRICARE Prime and TOP Prime. TYA Standard has the same cost-shares as TRICARE Standard and TRICARE Extra in the United States and TOP Standard overseas. Copayments and cost-shares are credited to your family's catastrophic cap. For TYA Standard, TYA cost-shares contribute to individual and family deductibles, which vary based on your sponsor's category.

For more information on costs, visit **www.tricare.mil/costs**.

Ending TRICARE Young Adult Coverage

Choosing to End Coverage

You may choose to end TYA coverage at any time by completing the fields related to terminating coverage on the *TRICARE Young Adult Application* and submitting it to your regional contractor. If you decide to end TYA coverage, you will be locked out from purchasing TYA coverage for 12 months from the date of termination. There will be no lockout if the coverage is terminated because you gain access to employer-sponsored coverage.

Nonpayment

Your premium payment is due no later than the last day of the month for the next month's coverage. Failure to pay total premium amounts due and any insufficient fund fees owed will result in a termination of coverage. A 12-month TYA purchase lockout will go into effect.

Change in Status

Your sponsor must always report all family and status changes to DEERS.

Your TYA coverage ends when any of the following occurs:

- You reach age 26
- You get married
- You become eligible for an employer-sponsored health plan under your own employment as defined in TYA regulations
- You gain other TRICARE coverage
- You lose eligibility because your sponsor ends TRICARE coverage

Appendix A

TRICARE Standard and TRICARE Extra cover most care that is medically necessary and considered proven. There are special rules and limitations for certain types of care, and some types of care are not covered at all. **This section is not all-inclusive.** TRICARE policies are very specific about which services are covered and which are not. It is in your best interest to take an active role in verifying coverage. Visit **www.tricare.mil/coveredservices** for additional information about covered services and benefits.

Outpatient Services

Figure 8.1 provides coverage details for outpatient services. **Note:** This figure is **not** all-inclusive.

Outpatient Services: Coverage Details *Figure 8.1*

Service	Description
Ambulance Services	The following ambulance services are covered: • Emergency transfers between a beneficiary's home, accident scene, or other location and a hospital • Transfers between hospitals • Ambulance transfers from a hospital-based emergency room to a hospital more capable of providing the required care • Transfers between a hospital or skilled nursing facility and another hospital-based or freestanding outpatient therapeutic or diagnostic department/facility The following are excluded: • Use of an ambulance service instead of taxi service when the patient's condition would have permitted use of regular private transportation • Transport or transfer of a patient primarily for the purpose of having the patient nearer to home, family, friends, or personal physician • Medicabs or ambicabs that function primarily as public passenger conveyances transporting patients to and from their medical appointments **Note:** Air or boat ambulance is only covered when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the beneficiary to the nearest hospital with appropriate facilities, and the patient's medical condition warrants speedy admission or is such that transfer by other means is not advisable.
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Generally covered if prescribed by a physician and if directly related to a medical condition. Covered DMEPOS generally include: • DMEPOS that are medically necessary and appropriate and prescribed by a physician for a beneficiary's specific use • Duplicate DMEPOS items that are necessary to provide a fail-safe, in-home life-support system (*In this case, "duplicate" means an item that meets the definition of DMEPOS and serves the same purpose, but may not be an exact duplicate of the original DMEPOS item. For example, a portable oxygen concentrator may be covered as a backup for a stationary oxygen generator.*) **Note:** Prosthetic devices must be U.S. Food and Drug Administration-approved.

Outpatient Services: Coverage Details (continued)

Service	Description
Emergency Services	TRICARE defines an emergency as a medical, maternity, or psychiatric condition that would lead a "prudent layperson" (*someone with average knowledge of health and medicine*) to believe that a serious medical condition exists; that the absence of immediate medical attention would result in a threat to life, limb, or sight; when a person has severe, painful symptoms requiring immediate attention to relieve suffering; or when a person is at immediate risk to self or others. However, most dental emergencies, such as going to the emergency room for a severe toothache, are not a covered medical benefit under TRICARE.
Home Health Care	Covers part-time or intermittent skilled nursing services and home health care services for those confined to the home (*All care must be provided by a participating home health care agency and be authorized in advance by the regional contractor.*)
Individual Provider Services	Covers office visits; outpatient, office-based medical and surgical care; consultation, diagnosis, and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; rehabilitation services (*e.g., physical and occupational therapy and speech pathology services*); and medical supplies used within the office.
Laboratory and X-ray Services	Generally covered if prescribed by a physician (*Some exceptions apply, e.g., chemo-sensitivity assays and bone-density studies for routine osteoporosis screening.*)

Inpatient Services

Figure 8.2 provides coverage details for inpatient services. **Note:** This figure is **not** all-inclusive.

Inpatient Services: Coverage Details ***Figure 8.2***

Service	Description
Hospitalization (*semiprivate room/ special care units when medically necessary*)	Covers general nursing; hospital, physician, and surgical services; meals (*including special diets*); drugs and medications; operating and recovery room care; anesthesia; laboratory tests; X-rays and other radiology services; medical supplies and appliances; and blood and blood products **Note:** Surgical procedures designated "inpatient only" may only be covered when performed in an inpatient setting.
Skilled Nursing Facility Care (*semiprivate room*)	Covers skilled nursing services; meals (*including special diets*); physical, occupational, and speech therapy; drugs furnished by the facility; and necessary medical supplies and appliances (*TRICARE covers an unlimited number of skilled nursing days if they are medically necessary.*) **Note:** TRICARE does not cover purely custodial care. Skilled nursing care is only covered in the United States and U.S. territories (*American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands*).

Figure 8.3 provides coverage details for clinical preventive services. **Note:** This figure is **not** all-inclusive.

Clinical Preventive Services: Coverage Details *Figure 8.3*

Service	Description
Comprehensive Health Promotion and Disease Prevention Examinations	A comprehensive clinical preventive examination is covered if it includes an immunization, Pap smear, mammogram, colon cancer screening, or prostate cancer screening. School enrollment physicals for children ages 5–11 are also covered.
Targeted Health Promotion and Disease Prevention Services	The screening examinations listed below may be covered if provided in conjunction with a comprehensive clinical preventive examination. The intent is to maximize preventive care.

Cancer Screenings	• **Colonoscopy:**
	  • Average risk: Individuals at average risk for colon cancer are covered once every 10 years beginning at age 50.
	  • Increased risk: Once every five years for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp before age 60, or in two or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. Once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second-degree relatives.
	  • High risk: Once every one to two years for individuals with a genetic or clinical diagnosis of hereditary non-polyposis colorectal cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20–25 or 10 years younger than the earliest age of diagnosis, whichever is earlier. For individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis, or Crohn's disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10–12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.
	• **Fecal occult blood testing:** Conduct testing annually starting at age 50.
	• **Breast cancer:**
	  • **Clinical breast examination:** For women under age 40, a clinical breast examination may be performed during a preventive health visit. For women age 40 and older, a clinical breast examination should be performed annually.
	  • **Mammograms:** Covered annually for all women beginning at age 40. Covered annually beginning at age 30 for women who have a 15 percent or greater lifetime risk of breast cancer (*according to risk assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model*), or who have any of the following risk factors:
	  • History of breast cancer, ductal carcinoma in situ, lobular carcinoma in situ, atypical ductal hyperplasia, or atypical lobular hyperplasia
	  • Extremely dense breasts when viewed by mammogram
	  • Known BRCA1 or BRCA2 gene mutation[1]
	  • First-degree relative (*parent, child, sibling*) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves[1]

1. Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

Clinical Preventive Services: Coverage Details (continued)

Service	Description
Cancer Screenings (*continued*)	• Radiation therapy to the chest between ages 10 and 30 • History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes[1] • **Breast screening magnetic resonance imaging (MRI):** Covered annually, in addition to the annual screening mammogram, beginning at age 30 for women who have a 20 percent or greater lifetime risk of breast cancer (*according to risk-assessment tools based on family history such as the Gail model, the Claus model, and the Tyrer-Cuzick model*), or who have any of the following risk factors: • Known BRCA1 or BRCA2 gene mutation[1] • First-degree relative (*parent, child, sibling*) with a BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves[1] • Radiation to the chest between ages 10 and 30 • History of Li-Fraumeni, Cowden, or hereditary diffuse gastric cancer syndrome, or a first-degree relative with a history of one of these syndromes[1] • **Proctosigmoidoscopy or sigmoidoscopy:** • Average risk: Once every three to five years beginning at age 50. • Increased risk: Once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colorectal cancer. • High risk: Annual flexible sigmoidoscopy, beginning at age 10–12, for individuals with known or suspected familial adenomatous polyposis. • **Prostate cancer:** A digital rectal examination and prostate-specific antigen screening is covered annually for certain high-risk men ages 40–49 and all men over age 50. • **Routine Pap smears:** Covered annually for women starting at age 18 (*younger if sexually active*) or less often at patient and provider discretion (*though not less than every three years*). Human papillomavirus (HPV) DNA testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women age 30 and older. • **Skin cancer:** Examinations are covered at any age for a beneficiary who is at high risk due to family history or increased sun exposure.
Cardiovascular Diseases	• **Cholesterol test (*non-fasting*):** Testing is covered for a lipid panel at least once every five years, beginning at age 18. • **Blood pressure screening:** Screening is covered annually for children ages 3–6 and a minimum of every two years after reaching age 6 (*children and adults*).
Eye Examinations	• **Well-child care coverage (*infants and children until reaching age 6*):** • Infants (*until reaching age 3*): One eye and vision screening is covered at birth and at 6 months. • Children (*from age 3 until reaching age 6*): One routine eye examination is covered every two years. Active duty family member (ADFM) children are covered for one routine eye examination annually. • **Adults and children (*over age 6*):** ADFMs receive one eye examination each year. • **Diabetic patients (*any age*):** Eye examinations are not limited. One eye examination per year is recommended. • **Retired service members, their families, and others:** Not covered after reaching age 6.

1. Listing of the BRCA1 and BRCA2 gene mutations as additional risk factors does not imply or constitute TRICARE coverage of BRCA1 or BRCA2 genetic testing as a clinical preventive service.

Clinical Preventive Services: Coverage Details (continued)

Service	Description
Hearing	Preventive hearing examinations are only allowed under the well-child care benefit. A newborn audiology screening should be performed on newborns before hospital discharge or within the first month after birth. Evaluative hearing tests may be performed at other ages during routine examinations.
Immunizations	Age-appropriate doses of vaccines, including annual influenza vaccines, are covered as recommended by the Centers for Disease Control and Prevention (CDC). The HPV vaccine is a limited benefit and may be covered when the beneficiary has not been previously vaccinated or completed the vaccine series. • Females: The HPV vaccine Gardasil (HPV4) or Cervarix (HPV2) is covered for females ages 11–26. The series of injections must be completed before reaching age 27 for coverage under TRICARE. • Males: The HPV vaccine Gardasil (HPV4) is covered for all males ages 11–21 and is covered for males ages 22–26 who meet certain criteria. A single dose of the shingles vaccine Zostavax® is covered for beneficiaries age 60 and older. Coverage is effective the date the recommendations are published in the CDC's *Morbidity and Mortality Weekly Report*. Refer to the CDC's Web site at **www.cdc.gov** for a current schedule of recommended vaccines. **Note:** Immunizations for ADFMs whose sponsors have permanent change of station orders to overseas locations are also covered. Immunizations for personal overseas travel are not covered.
Infectious Disease Screening	TRICARE covers screening for the following infectious diseases: hepatitis B, rubella antibodies, and HIV, and screening and/or prophylaxis for tetanus, rabies, hepatitis A and B, meningococcal meningitis, and tuberculosis.
Patient and Parent Education Counseling	Counseling services expected of good clinical practice that are included with the appropriate office visit are covered at no additional charge for dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sexual practices; tobacco, alcohol, and substance abuse; dental health promotion; accident and injury prevention; stress; bereavement; and suicide risk assessment.
School Physicals	Covered for children ages 5–11 if required in connection with school enrollment. **Note:** Annual sports physicals are not covered.
Well-Child Care (*birth until reaching age 6*)	Covers routine newborn care; comprehensive health promotion and disease prevention examinations; vision and hearing screenings; height, weight, and head circumference measurement; routine immunizations; and developmental and behavioral appraisal. TRICARE covers well-child care in accordance with American Academy of Pediatrics® (AAP) and CDC guidelines. Your child can receive preventive-care well-child visits as frequently as the AAP recommends, but no more than nine visits in two years. Visits for diagnosis or treatment of an illness or injury are covered separately under outpatient care.

Outpatient Behavioral Health Care Services

Figure 8.4 provides coverage details for outpatient behavioral health care services. **Note:** This figure is **not** all-inclusive.

Behavioral Health Care Services: Outpatient Coverage Details *Figure 8.4*

Service	Description

Outpatient Psychotherapy (*physician referral and supervision may be required when seeing mental health counselors and is always required when seeing pastoral counselors*)	The following outpatient psychotherapy limits apply:
	• **Psychotherapy:** Two sessions per week, in any combination of the following types:
	  • Individual (*adult or child*): 60 minutes per session; may extend to 120 minutes for crisis intervention
	  • Family or conjoint: 90 minutes per session; may extend to 180 minutes for crisis intervention
	  • Group: 90 minutes per session
	• **Collateral visits:** Up to 60 minutes per visit (*Collateral visits are counted as individual psychotherapy sessions. Beneficiaries have the option of combining collateral visits with other individual or group psychotherapy visits.*)

Psychoanalysis	Psychoanalysis differs from psychotherapy and requires prior authorization. After prior authorization is obtained, treatment must be given by approved providers.
Psychological Testing and Assessment	Testing and assessment is covered when medically or psychologically necessary and provided in conjunction with otherwise-covered psychotherapy. Psychological tests are considered to be diagnostic services and are not counted toward the limit of two psychotherapy visits per week. **Limitations:** • Testing and assessment is generally limited to six hours per fiscal year (FY).[1] Any testing beyond six hours requires a review for medical necessity. **Exclusions:** Psychological testing is not covered for the following circumstances: • Academic placement • Job placement • Child custody disputes • General screening in the absence of specific symptoms • Teacher or parental referrals • Testing to determine whether a beneficiary has a learning disability • Diagnosed specific learning disorders or learning disabilities
Medication Management	If you are taking prescription medications for a behavioral health condition, you must be under the care of a provider who is authorized to prescribe those medications. Your provider will manage the dosage and duration of your prescription to ensure you are receiving the best care possible. Medication management appointments are medical appointments and do not count toward the first eight outpatient behavioral health care visits per FY.[1]

1. October 1–September 30.

Inpatient Behavioral Health Care Services

Prior authorization is required for all nonemergency inpatient behavioral health care services. Psychiatric emergencies do **not** require prior authorization for inpatient admission, but authorization is required for continued stay. Admissions resulting from psychiatric emergencies should be reported to your regional contractor within 24 hours of admission or the next business day, and must be reported within 72 hours of an admission. Authorization for continued stay is coordinated between the inpatient unit and the regional contractor.

Figure 8.5 provides coverage details for inpatient behavioral health care services. **Note:** This figure is **not** all-inclusive.

Behavioral Health Care Services: Inpatient Coverage Details ***Figure 8.5***

Service	Description
Acute Inpatient Psychiatric Care	May be covered on an emergency or nonemergency basis. Prior authorization from your regional contractor is required for all nonemergency inpatient admissions. In emergency situations, authorization is required for continued stay. **Limitations:** • Patients age 19 and older: 30 days per fiscal year (FY)[1] or in any single admission • Patients age 18 and under: 45 days per FY[1] or in any single admission • Inpatient admissions for substance use disorder detoxification and rehabilitation count toward the 30- or 45-day limit (*Limitations may be waived if determined to be medically or psychologically necessary.*)
Psychiatric Partial Hospitalization Program (PHP)	Psychiatric PHPs provide interdisciplinary therapeutic services at least three hours a day, five days a week, in any combination of day, evening, night, and weekend treatment programs. The following rules apply: • Prior authorization from your regional contractor is required. PHP admissions are not considered emergencies. • Facilities must be TRICARE-authorized. • PHPs must agree to participate in TRICARE. **Limitations:** PHP care is limited to 60 treatment days (*whether full- or partial-day treatment*) per FY.[1] These 60 days are not offset by or counted toward the 30- or 45-day inpatient limit. (*Limitations may be waived if determined to be medically or psychologically necessary.*)
Residential Treatment Center (RTC) Care	RTC care provides extended care for children and adolescents with psychological disorders that require continued treatment in a therapeutic environment. The following rules apply: • Facilities must be TRICARE-authorized. • Unless therapeutically contraindicated, the family and/or guardian should actively participate in the continuing care of the patient through either direct involvement at the facility or geographically distant family therapy. • Prior authorization from your regional contractor is always required. RTC admissions are not considered emergencies. • RTC care is considered elective and will not be covered for emergencies.

1. October 1–September 30.

Behavioral Health Care Services: Inpatient Coverage Details (continued)

Service	Description
Residential Treatment Center (RTC) Care (*continued*)	• Admission primarily for substance use rehabilitation is not authorized for psychiatric RTC. • Care must be recommended and directed by a psychiatrist or clinical psychologist. **Limitations:** • Care is limited to 150 days per FY[1] or for a single admission. • RTC care is only covered for patients until reaching age 21. • RTC care does not count toward the 30- or 45-day inpatient limit. (*Limitations may be waived if determined to be medically or psychologically necessary.*)

1. October 1–September 30.

Substance Use Disorder Services

Figure 8.6 provides coverage details for substance use disorder services (*up to three benefit periods per beneficiary, per lifetime*). **Note:** This figure is **not** all-inclusive.

Behavioral Health Care Services: Substance Use Disorder Services *Figure 8.6*

Service	Description
Inpatient Detoxification	TRICARE covers emergency and inpatient hospital services for the treatment of the acute phases of substance use withdrawal (*detoxification*) when the patient's condition requires the personnel and facilities of a hospital or substance use disorder rehabilitation facility (SUDRF). **Limitations:** • Diagnosis-related group exempt facility: seven days per episode • Services count toward 30- or 45-day inpatient behavioral health care limits • Services do not count toward the 21-day rehabilitation limit
SUDRF Rehabilitation	Rehabilitation of a substance use disorder may occur in an inpatient (*residential*) or partial hospitalization setting. TRICARE covers 21 days of rehabilitation per benefit period in a TRICARE-authorized facility, whether in an inpatient or partial hospitalization or a combination of both.[1] **Limitations:** • 21-day rehabilitation limit per episode • Three episodes per lifetime • Days for rehabilitation count toward the 30- or 45-day limit for acute inpatient psychiatric care (*Limitations may be waived if determined to be medically or psychologically necessary.*)
SUDRF Outpatient Care	Outpatient substance use care must be provided by an approved SUDRF. **Limitations:** • Individual or group therapy: 60 visits per benefit period[1] • Family therapy: 15 visits per benefit period[1] • Partial hospitalization care: 21 treatment days per FY[2] (*Limitations may be waived if determined to be medically or psychologically necessary.*)

1. A benefit period begins with the first day of covered treatment and ends 365 days later.
2. October 1–September 30.

Services or Procedures with Significant Limitations

Figure 8.7 features medical, surgical, and behavioral health care services that may not be covered unless exceptional circumstances exist. This chart is **not** all-inclusive. Check your regional contractor's Web site for more information.

Services or Procedures with Significant Limitations *Figure 8.7*

Service	Description
Bariatric Surgery	These procedures are covered for the treatment of morbid obesity under certain limited circumstances. For more information, contact your regional contractor or visit **www.tricare.mil/coveredservices**.
Botulinum Toxin (Botox®) Injections	Botulinum toxin injections for cosmetic procedures, myofascial pain, and fibromyalgia are not covered. Cost-sharing may apply for injections to treat certain other defined conditions.
Breast Pumps	Heavy-duty, hospital-grade electric breast pumps (*including services and supplies related to the use of the pump*) for mothers of premature infants are covered. An electric breast pump is covered while the premature infant remains hospitalized during the immediate postpartum period. Hospital-grade electric breast pumps may also be covered after the premature infant is discharged from the hospital with a physician-documented medical reason. This documentation is also required for premature infants delivered in non-hospital settings. Breast pumps of any type, when used for reasons of personal convenience, are excluded, even if prescribed by a physician.
Cardiac and Pulmonary Rehabilitation	Both are covered only for certain indications. Phase III cardiac rehabilitation for lifetime maintenance performed at home or in medically unsupervised settings is excluded.
Cosmetic, Plastic, or Reconstructive Surgery	Surgery is only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement after neoplastic surgery, or reconstruct the breast after mastectomy.
Cranial Orthotic Device or Molding Helmet	Cranial orthotic devices are covered for adjunctive use for infants from three to 18 months of age whose synostosis has been surgically corrected, but who still have moderate to severe cranial deformities. Cranial orthotic devices are excluded for treatment of nonsynostotic positional plagiocephaly or for the treatment of craniosynostosis before surgery.
Dental Care and Dental X-rays	Both are covered only for adjunctive dental care (*i.e., dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition*). Prior authorization is required for adjunctive dental care.
Education and Training	Education and training are only covered under the TRICARE Extended Care Health Option and diabetic outpatient self-management training services. Diabetic outpatient self-management training services must be performed by programs approved by the American Diabetes Association®. The provider's "Certificate of Recognition" from the American Diabetes Association must accompany the claim for reimbursement.

Services or Procedures with Significant Limitations (continued)

Service	Description
Eyeglasses or Contact Lenses	Active duty service members (ADSMs) may receive eyeglasses at military treatment facilities at no cost. For all other beneficiaries, the following are covered: • Contact lenses and/or eyeglasses for treatment of infantile glaucoma • Corneal or scleral lenses for treatment of keratoconus • Scleral lenses to retain moisture when normal tearing is not present or is inadequate • Corneal or scleral lenses to reduce corneal irregularities other than astigmatism • Intraocular lenses, contact lenses, or eyeglasses for loss of human lens function resulting from intraocular surgery, ocular injury, or congenital absence **Note:** Adjustments, cleaning, and repairs for eyeglasses are not covered.
Facility Charges for Non-Adjunctive Dental Services	Generally, dental care is not covered as a TRICARE medical benefit, but instead is covered under the dental program. This includes situations that are of an emergency nature. Benefits under TRICARE Standard related to dental procedures include only hospital and anesthesia charges related to routine dental care for children under age 5, or those with disabilities, in addition to dental care related to some medical conditions.
Food, Food Substitutes and Supplements, or Vitamins	Medically necessary nutritional formulas are covered when used as the primary source of nutrition for enteral, parenteral, or oral nutritional therapy. Intraperitoneal nutrition therapy is covered for malnutrition as a result of end-stage renal disease. Vitamins may be cost-shared only when used as a specific treatment of a medical condition. Additionally, prenatal vitamins that require a prescription may be cost-shared, but are covered for prenatal care only.
Genetic Testing	Testing is covered when medically proven and appropriate, and when the results of the test will influence the medical management of the patient. Routine genetic testing is not covered.
Hearing Aids	Hearing aids are covered only for active duty family members (ADFMs) who meet specific hearing loss requirements. • Hearing aids are excluded under any circumstance for retirees, retiree family members, TRICARE Reserve Select (TRS) members, and TRICARE Retired Reserve (TRR) members. • TRICARE Young Adult coverage for hearing aids is derived from the young adult's sponsor status. If the sponsor is an ADSM, hearing aids are covered the same as for an ADFM. If the sponsor is a TRS member, retiree, or TRR member, hearing aids are excluded under any circumstance.
Laser/LASIK/ Refractive Corneal Surgery	Surgery is covered only to relieve astigmatism following a corneal transplant.
Private Hospital Rooms	Private rooms are **not** covered unless ordered for medical reasons or because a semiprivate room is not available. Hospitals that are subject to the TRICARE diagnosis-related group (DRG) payment system may provide the patient with a private room, but will receive only the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.
Shoes, Shoe Inserts, Shoe Modifications, and Arch Supports	Shoe and shoe inserts are covered only in very limited circumstances. Orthopedic shoes may be covered if they are a permanent part of a brace. For individuals with diabetes, extra-depth shoes with inserts or custom-molded shoes with inserts may be covered.

Limitations and Exclusions

The following specific services **are excluded under any circumstance. This list is not all-inclusive.** Check your regional contractor's Web site for additional information.

- Acupuncture (*may be offered at some military treatment facilities and approved for certain active duty service members, but is not covered for care received by civilian providers*)
- Alterations to living spaces
- Artificial insemination and all other such reproductive technologies
- Autopsy services or post-mortem examinations
- Birth control/contraceptives (*non-prescription*)
- Camps (*e.g., for weight loss*)
- Charges that providers may apply to missed or rescheduled appointments
- Counseling services that are not medically necessary for the treatment of a diagnosed medical condition (*e.g., educational, vocational, and socioeconomic counseling; stress management; lifestyle modification*)
- Custodial care
- Diagnostic admissions
- Domiciliary care
- Dyslexia treatment
- Electrolysis
- Elevators or chair lifts
- Exercise equipment, spas, whirlpools, hot tubs, swimming pools, health club memberships, or other such charges or items
- Experimental or unproven procedures (*unless authorized under specific exceptions in the TRICARE regulations*)
- Foot care (*routine*), except if required as a result of a diagnosed, systemic medical disease affecting the lower limbs such as severe diabetes
- General exercise programs, even if recommended by a physician and regardless of whether rendered by an authorized provider
- Inpatient stays:
  - For rest or rest cures
  - To control or detain a runaway child, whether or not admission is to an authorized institution
  - To perform diagnostic tests, examinations, and procedures that could have been and are performed routinely on an outpatient basis
  - In hospitals or other authorized institutions above the appropriate level required to provide necessary medical care
- Learning-disability services
- Medications:
  - Drugs prescribed for cosmetic purposes
  - Fluoride preparations
  - Food supplements
  - Homeopathic and herbal preparations
  - Multivitamins
  - Over-the-counter products (*except insulin and diabetic supplies*)
  - Weight reduction products
- Megavitamins and orthomolecular psychiatric therapy
- Mind-expansion and elective psychotherapy
- Naturopaths
- Non-surgical treatment of obesity or morbid obesity
- Personal, comfort, or convenience items, such as beauty and barber services, radio, television, and telephone
- Postpartum inpatient stay for a mother to stay with a newborn infant (*usually primarily for the purpose of breast-feeding the infant*) when the infant (*but not the mother*) requires the extended stay, or continued inpatient stay of a newborn infant primarily for purposes of remaining with the mother when the mother (*but not the newborn infant*) requires extended postpartum inpatient stay
- Preventive care, such as routine, annual, or employment-requested physical examinations; routine screening procedures; or immunizations, except as provided under the clinical preventive services benefit (*See "Clinical Preventive Services" earlier in this section.*)
- Psychiatric treatment for sexual dysfunction
- Services and supplies:
  - Provided under a scientific or medical study, grant, or research program
  - Furnished or prescribed by an immediate family member

  - For which the beneficiary has no legal obligation to pay or for which no charge would be made if the beneficiary or sponsor were not TRICARE-eligible
  - Furnished without charge (*i.e., cannot file claims for services provided free of charge*)
  - For the treatment of obesity such as diets, weight-loss counseling, weight-loss medications, wiring of the jaw, or similar procedures (*For bariatric surgery, see "Services or Procedures with Significant Limitations" earlier in this section*.)
  - Inpatient stays directed or agreed to by a court or other governmental agency (*unless medically necessary*)
  - Required as a result of occupational disease or injury for which any benefits are payable under a workers' compensation or similar law, whether such benefits have been applied for or paid, except if benefits provided under these laws are exhausted
  - That are (*or are eligible to be*) fully payable under another medical insurance or program, either private or governmental, such as coverage through employment or Medicare (*In such instances, TRICARE is the secondary payer for any remaining charges.*)
- Sex changes or sexual inadequacy treatment, with the exception of treatment of ambiguous genitalia that has been documented to be present at birth
- Smoking-cessation supplies
- Sterilization reversal surgery
- Surgery performed primarily for psychological reasons (*such as psychogenic surgery*)
- Therapeutic absences from an inpatient facility, except when such absences are specifically included in a treatment plan approved by TRICARE
- Transportation, except by ambulance
- X-ray, laboratory, and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms, except for cancer screening and other tests allowed under the clinical preventive services benefit

Appendix B

Sample Explanation of Benefits Statements

The following pages list figures and reference details for each regional contractor's explanation of benefits (EOB) statement.

- **North Region:** Figure 9.1
- **South Region:** Figure 9.2
- **West Region:** Figure 9.3

How to Read Your TRICARE Summary EOB (SEOB) for the North Region

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the North Region.
2. **Regional Contractor:** The Health Net Federal Services, LLC logo appears here.
3. **Mail-to Name and Address:** The TRICARE SEOB is mailed directly to the patient (*or patient's parent or guardian for minors*) at the address on file. **Note:** Be sure your doctor has updated your records with your current address.
4. **Date of Notice:** PGBA prepared your TRICARE SEOB on this date.
5. **Insured ID:** Your claim is processed using the insured ID of the service member (*active duty, retired, or deceased*) who is your TRICARE sponsor. For security reasons, only the last four digits of your insured's ID appear on the SEOB.
6. **Patient Name:** The name of the patient who received care and for whom the claim(s) were submitted.
7. **Claims Processed From:** The reporting period of claims activity contained in the SEOB.
8. **Provider of Service:** This section lists who provided your medical care.
9. **Total Paid This Reporting Period:** The total amount paid to your provider(s).
10. **Total Patient Responsibility:** The total amount your provider(s) may bill you.
11. **Benefit Period Summary:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. Your annual deductible and maximum out-of-pocket expense is calculated by fiscal year (*October 1–September 30*).
12. **Sponsor Name:** The name of the service member who is your TRICARE sponsor.
13. **Patient Name:** The name of the patient who received care and for whom this claim was filed.
14. **Insured ID:** The last four digits of the insured's ID.
15. **Provider:** The provider of your services.
16. **Amount Other Insurance Paid:** The amount your primary health insurance paid (*if TRICARE is your secondary insurance*).

    Amount You Paid: The amount (*if any*) you paid the provider of medical services, as indicated on the claim.
17. **Amount Your Provider May Bill You:** The amount you are responsible for after TRICARE benefits were applied.

    Amount Paid To Your Provider: Benefits paid to the provider of services.

    Amount Paid To You: Benefits paid to you.
18. **Claim Number:** A unique number assigned by TRICARE for tracking purposes.
19. **Date(s) of Service:** The date(s) you received care.
20. **Service Provided:** This section describes the services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and laboratories use to identify the services you received.
21. **APC #:** Ambulatory Payment Classification (APC) program. A number assigned by Medicare or TRICARE that consists of one or more grouped medical procedure codes.
22. **Remarks:** If you see a code or a number here, refer to the "Remarks" section at the bottom of the SEOB for more information about your claim.
23. **Claim Summary:** Explains the action taken on your claim. You will find the following totals: amount your provider charged, amount allowed by TRICARE, and the non-covered amount.
24. **Beneficiary Liability Summary:** You may be responsible for a portion of the fee your doctor billed. If so, that amount will be itemized here. It will include any charges applied to your annual deductible and any copayment or cost-share you must pay to the provider of services.

North Region Explanation of Benefits Statement Sample *Figure 9.1*

(1)
PGBA, LLC
TRICARE NORTH REGION CLAIMS
P.O BOX 870140
SURFSIDE BEACH, SC 29587-9740

TRICARE SUMMARY EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claims.
Keep this notice for your records.

Health Net® FEDERAL SERVICES | TRICARE®

(2)

(3)
PATIENT, PARENT/GUARDIAN
ADDRESS
CITY STATE ZIP CODE

This is not a bill. Any amount you may owe your provider should not be sent directly to us.

(4)
June 10, 2011

SUMMARY EXPLANATION OF BENEFITS (5)

This summary information is for claims processed for PATIENT, covered under sponsor ID *****6789. You will receive this summary if you had claims activity the previous reporting period.

This document outlines your share of the charges for services. You should use this to determine how much you need to pay. If there is a discrepancy, use this summary to discuss the charges with your provider.

(6) **Patient Name: PATIENT**

(7) **Claims Processed from 05/12/11 to 06/10/11**

(8) Provider of Service:	Amount We Paid Your Provider:	Amount Your Provider May Bill You:
PROVIDER OF MEDICAL CARE 1	$ 4. 10	$ 1. 37
PROVIDER OF MEDICAL CARE 2	$ 79. 30	$ 19. 82
(9) Total Paid This Reporting Period:	$ 83. 40	
(10) Total Patient Responsibility:		$ 21. 19

(11) This reporting period we applied $0.00 to your individual and family deductibles. We applied $21.19 to your catastrophic cap for the fiscal year beginning October 2010.

As of June 7, 2011, a total of $150.00 of your $150.00 individual deductible and $300.00 of your $300.00 family deductible has been applied. A total of $1,000.00 of your $1,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

We're honored to serve you through the TRICARE program for your commitment to the U. S. Uniformed Services.

CN: 100524N0000002

TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

The following important information shows how much we covered and how much you may owe your provider for services PATIENT received.

(12) **Sponsor Name:** SPONSOR (13) **Patient Name:** PATIENT (14) **Sponsor SSN:** ***-**-6789

(15) Provider: **PROVIDER OF MEDICAL CARE 1**
(18) Claim #: **0118LLG00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: (16) **0. 00**

Amount Your Provider May Bill You: **1. 37**
Amount Paid To Your Provider: (17) **4. 10**
Amount Paid To You: **0. 00**

(19) Date(s) of Service Begin	End	(20) Service Provided	(21) APC #	(22) Remarks	Your Provider Charged	(23) Allowed Amount	Amount Not Covered	Deductible	(24) Copayment	Cost Share
05/22/11	05/22/11	Hospital services (0260)		1, 2, 3	500.00	5.47	494.53	0.00	0.00	1.37
TOTAL:					500.00	5.47	494.53	0.00	0.00	1.37

Provider: **PROVIDER OF MEDICAL CARE 2**
Claim #: **0118XXH00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: **0. 00**

Amount Your Provider May Bill You: **19. 82**
Amount Paid To Your Provider: **79. 30**
Amount Paid To You: **0. 00**

Date(s) of Service Begin	End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
05/23/11	05/23/11	Medical care (99214)		2, 3, 4	150.00	99.12	50.88	0.00	0.00	19.82
TOTAL:					150.00	99.12	50.88	0.00	0.00	19.82

REMARKS:

1. THE AMOUNT ALLOWED WAS THE LESSER OF BILLED CHARGES, CONTRACTED RATE, STATE PREVAILING, OR THE TRICARE MAXIMUM ALLOWABLE CHARGE.
2. HAVE YOU CONSIDERED USING THE TRICARE MAIL ORDER PHARMACY SERVICE? IT CAN SAVE YOU UP TO 66% ON THE COST OF YOUR MEDICATIONS. CALL 1-877-363-1433 OR CHECK ONLINE AT WWW.EXPRESS-SCRIPTS.COM/TRICARE FOR MORE INFORMATION.
3. CHOOSING NETWORK PROVIDERS CAN SAVE YOU MONEY AND TIME. USE THE PROVIDER LOCATOR AT WWW.HNFS.COM TO FIND THE NETWORK PROVIDERS YOU NEED CLOSE TO YOU.
4. CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

CN: 100524N0000002

Figure 9.1

How to Read Your TRICARE Summary EOB (SEOB) for the South Region

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the South Region.
2. **Regional Contractor:** The Humana Military Healthcare Services, Inc. logo appears here.
3. **Mail-to Name and Address:** We mail the TRICARE SEOB directly to the patient (*or patient's parent or guardian for minors*) at the address on file. **Note:** Be sure your doctor has updated your records with your current address.
4. **Date of Notice:** PGBA prepared your TRICARE SEOB on this date.
5. **Insured ID:** Your claim is processed using the insured ID of the service member (*active duty, retired, or deceased*) who is your TRICARE sponsor. For security reasons, only the last four digits of your insured's ID appear on the SEOB.
6. **Patient Name:** The name of the patient who received medical care and for whom the claim(s) were submitted.
7. **Claims Processed From:** The reporting period of claims activity contained in the SEOB.
8. **Provider of Service:** This section lists who provided your medical care.
9. **Total Paid This Reporting Period:** The total amount we paid to your provider(s).
10. **Total Patient Responsibility:** The total amount your provider(s) may bill you.
11. **Benefit Period Summary:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. Your annual deductible and maximum out-of-pocket expense is calculated by fiscal year (*October 1–September 30*).
12. **Sponsor Name:** The name of the service member who is your TRICARE sponsor.
13. **Patient Name:** The name of the patient who received care and for whom this claim was filed.
14. **Insured ID:** The last four digits of the insured's ID.
15. **Provider:** The provider of your services.
16. **Amount Other Insurance Paid:** The amount your primary health insurance paid (*if TRICARE is your secondary insurance*).

    Amount You Paid: The amount (*if any*) you paid the provider of medical services, as indicated on the claim.
17. **Amount Your Provider May Bill You:** The amount you are responsible for paying after TRICARE benefits were applied.

    Amount Paid To Your Provider: Benefits we paid to the provider of services.

    Amount Paid To You: Benefits paid to the beneficiary.
18. **Claim Number:** A unique number assigned to each claim for tracking purposes.
19. **Date(s) of Service:** The date(s) you received care.
20. **Service Provided:** This section describes the services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and laboratories use to identify the services you received.
21. **APC #:** Ambulatory Payment Classification (APC) program. A number assigned by Medicare or TRICARE that consists of one or more grouped medical procedure codes.
22. **Remarks:** If you see a code or a number here, refer to the "Remarks" section at the bottom of the SEOB for more information about your claim.
23. **Claim Summary:** Explains the action taken on your claim. You will find the following totals: amount your provider charged, amount allowed by TRICARE, and the non-covered amount.
24. **Beneficiary Liability Summary:** You may be responsible for a portion of the fee your doctor charged. If so, that amount will be itemized here. It will include any charges we applied to your annual deductible and any copayment or cost-share you must pay to the provider of services.

(1) PGBA, LLC
TRICARE SOUTH REGION
P.O. BOX 7032
CAMDEN, SC 29020-7032

TRICARE SUMMARY EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claims.
Keep this notice for your records.

(2) Humana. Military TRICARE

This is not a bill. Any amount you may owe your provider should not be sent directly to us.

(3) PATIENT, PARENT/GUARDIAN
ADDRESS
CITY STATE ZIP CODE

(4) June 10, 2011

SUMMARY EXPLANATION OF BENEFITS

(5)

This summary information is for claims processed for PATIENT, covered under sponsor ID *****6789. You will receive this summary if you had claim activity this reporting period. A reporting period represents approximately 28 days of claim activity. If you have questions about these claims, please visit our user-friendly Web site at www.myTRICARE.com any time to check on the status of your claims. You can also call our customer service center at 1-800-403-3950 Monday thru Friday from 8 am to 6 pm.

This EOB outlines the amount you need to pay your provider. If there is a difference, use this summary to discuss the charges with your provider.

(6) **Patient Name: PATIENT**

(7) **Claims Processed from 05/12/11 to 06/10/11**

(8) **Provider of Service:**	**Amount We Paid Your Provider:**	**Amount Your Provider May Bill You:**
PROVIDER OF MEDICAL CARE 1	$ 4. 10	$ 1. 37
PROVIDER OF MEDICAL CARE 2	$ 79. 30	$ 19. 82
(9) Total Paid This Reporting Period:	$ 83. 40	
(10) Total Patient Responsibility:		$ 21. 19

(11) This reporting period we applied $0.00 to your individual and family deductibles. We applied $21.19 to your catastrophic cap for the fiscal year beginning October 2010.

As of June 7, 2011, a total of $150.00 of your $150.00 individual deductible and $300.00 of your $300.00 family deductible has been applied. A total of $1,000.00 of your $1,000.00 catastrophic cap has been applied. Any claims processed after this date could affect these totals.

The TRICARE program is honored to serve you. Thank you for your commitment to the United States Uniformed Services.

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TRICARE SUMMARY EXPLANATION OF BENEFITS CLAIM(S) DETAIL

The following important information shows how much we covered and how much you may owe your provider for services PATIENT received.

(12) **Sponsor Name:** SPONSOR (13) **Patient Name:** PATIENT (14) **Sponsor SSN:** ***-**-6789

(15) Provider: **PROVIDER OF MEDICAL CARE 1**
(18) Claim #: **0118LLG00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: (16) **0. 00**

Amount Your Provider May Bill You: **1. 37**
Amount Paid To Your Provider: (17) **4. 10**
Amount Paid To You: **0. 00**

(19) Date(s) of Service Begin	End	(20) Service Provided	(21) APC #	(22) Remarks	Your Provider Charged (23)	Allowed Amount	Amount Not Covered	Deductible	(24) Copayment	Cost Share
05/22/11	05/22/11	Hospital services (0260)		1, 2, 3	500.00	5.47	494.53	0.00	0.00	1.37
TOTAL:					500.00	5.47	494.53	0.00	0.00	1.37

Provider: **PROVIDER OF MEDICAL CARE 2**
Claim #: **0118XXH00-00-00**

Amount Other Insurance Paid: **0. 00**
Amount You Paid: **0. 00**

Amount Your Provider May Bill You: **19. 82**
Amount Paid To Your Provider: **79. 30**
Amount Paid To You: **0. 00**

Date(s) of Service Begin	End	Service Provided	APC #	Remarks	Your Provider Charged	Allowed Amount	Amount Not Covered	Deductible	Copayment	Cost Share
05/23/11	05/23/11	Medical care (99214)		2, 3, 4	150.00	99.12	50.88	0.00	0.00	19.82
TOTAL:					150.00	99.12	50.88	0.00	0.00	19.82

REMARKS:

1. THE AMOUNT ALLOWED WAS THE LESSER OF BILLED CHARGES, CONTRACTED RATE, STATE PREVAILING, OR THE TRICARE MAXIMUM ALLOWABLE CHARGE.
2. HAVE YOU CONSIDERED USING THE TRICARE MAIL ORDER PHARMACY SERVICE? IT CAN SAVE YOU UP TO 66% ON THE COST OF YOUR MEDICATIONS. CALL 1-877-363-1433 OR CHECK ONLINE AT WWW.EXPRESS-SCRIPTS.COM/TRICARE FOR MORE INFORMATION.
3. CHOOSING NETWORK PROVIDERS CAN SAVE YOU MONEY AND TIME. USE THE PROVIDER LOCATOR AT WWW.HUMANA-MILITARY.COM TO FIND THE NETWORK PROVIDERS YOU NEED CLOSE TO YOU.
4. CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

CN: 100524S0000002

How to Read Your TRICARE EOB for the West Region

1. **Mail-to Name and Address:** We mail the TRICARE EOB directly to the patient (*or patient's parent or guardian for minors*) at the address given on the claim. **Note:** Be sure your doctor has updated your records with your current address.
2. **Date of Notice:** This is the date we prepared your TRICARE EOB.
3. **Sponsor SSN/Sponsor Name:** We process your claim using the Social Security number (SSN) or Department of Defense Benefits Number (DBN) of the service member (*active duty, retired, or deceased*) who is your TRICARE sponsor.
4. **Patient Name:** This is the name of the patient who received medical care and who this claim was filed for.
5. **Claim Number:** We assign each claim a unique number. This helps us keep track of the claim as it is processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
6. **Check Number:** A check number appears here only if a check accompanies your EOB.
7. **Toll-Free Number/Web Address:** This is how you can reach us (*TriWest Healthcare Alliance*) if you have questions.
8. **Services Provided By:** This shows who provided your medical care, the number(s) and type(s) of service(s), and the procedure code(s).
9. **Date of Service:** This is the date you received the care.
10. **Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.
11. **TRICARE Allowed:** This is the amount TRICARE approves for the services you received.
12. **Remarks:** If you see a code or a number here, look at the "Remark Codes" section (*16*) for more information about your claim.
13. **Claim Summary:** This is a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount allowed by TRICARE, non-covered amount, amount (*if any*) you already paid to the provider, amount your primary health insurance paid (*if TRICARE is your secondary insurance*), benefits we paid to the provider, and benefits we paid to the beneficiary.
14. **Beneficiary Share:** You may be responsible for a portion of the fee your doctor charged. If so, that amount will be itemized here. It will include any charges that we applied to your annual deductible and any cost-share or copayment you must pay.
15. **Out-of-Pocket Expense:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year (*October 1–September 30*). See the "Fiscal Year Beginning" date in this section for the first date of the fiscal year.
16. **Remark Codes:** Explanations of the codes or numbers listed in the "Remarks" section (*12*) appear here.
17. **Paid To:** This is the name of the provider or facility to whom the claim was paid.

West Region Explanation of Benefits Statement Sample *Figure 9.3*

TRICARE West

TRICARE EXPLANATION OF BENEFITS

Administered by: TriWest Healthcare Alliance
This is a statement of the action taken on your TRICARE claim. Keep this notice for your records.

(1) John B. Nice
123 Apple Lane
Huntsville, WA 12345-6789

(2)	Date of Notice	08/14/2011
(3)	Sponsor SSN	234567890
(4)	Sponsor Name	John B. Nice
(5)	Patient Name	John B. Nice
(6)	Claim Number	2002212 053 0017930
	Check Number	C0001545337
	Provider Number	752906887 76550 0001
	Provider Name	ABC Valley Clinic

(7) If you have any questions about this notice, please call toll-free at **1-888-TRIWEST** (874-9378). You can also visit us online at **www.triwest.com**.

THIS IS NOT A BILL

SERVICES PROVIDED BY (8)	DATE OF SERVICE (9)	AMOUNT BILLED (10)	TRICARE ALLOWED (11)	REMARKS (12)
Michael Smith, MD	03/23/11–03/27/11	$000,000.00	$000,000.00	003
Total		$000,000.00	$000,000.00	

CLAIM SUMMARY (13)		BENEFICIARY SHARE (14)	
TRICARE Amount Billed	$000,000.00	Cost-Share/Copay	$000,000.00
TRICARE Allowed	$000,000.00	Deductible	$000,000.00
TRICARE Paid	$000,000.00	Beneficiary Responsibility	$000,000.00
Other Insurance Allowed	$000,000.00		
Other Insurance Paid	$000,000.00		
Other Insurance Patient Responsibility	$000,000.00		
Amount Applied to Offset	$000,000.00		

(15) **OUT OF POCKET EXPENSE:**

	Beginning October 1, 2011		Beginning October 1, 2010		Beginning October 1, 2009	
	Limit	Met to Date	Limit	Met to Date	Limit	Met to Date
Individual Deductible	$ 000.00	$ 000.00	$ 000.00	$ 000.00	$ 000.00	$ 000.00
Family Deductible	$ 000.00	$ 000.00	$ 000.00	$ 000.00	$ 000.00	$ 000.00
Catastrophic cap	$0,000.00	$0,000.00	$0,000.00	$0,000.00	$0,000.00	$0,000.00

(16) **Remark Codes:**
003: See item 5 on reverse. If you are not satisfied with our determination, you have the right to request a review within 90 days of the notice.

(17) PAID TO	AMOUNT PAID	BENEFICIARY RESPONSIBILITY
Skagit Valley Clinic	$000,000.00	$000,000.00

TriWest HEALTHCARE ALLIANCE®

Acronyms

AAP	American Academy of Pediatrics
ABA	Applied behavior analysis
ADDP	Active Duty Dental Program
ADFM	Active duty family member
ADSM	Active duty service member
BCAC	Beneficiary Counseling and Assistance Coordinator
CAC	Common Access Card
CDC	Centers for Disease Control and Prevention
CHCBP	Continued Health Care Benefit Program
DBN	Department of Defense Benefits Number
DCAO	Debt Collection Assistance Officer
DEERS	Defense Enrollment Eligibility Reporting System
DFAS	Defense Finance and Accounting Service
DMDC	Defense Manpower Data Center
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DO	Doctor of osteopathic medicine
DoD	Department of Defense
DRG	Diagnosis-related group
DS Logon	Department of Defense Self-Service Logon
DTF	Dental treatment facility
ECHO	Extended Care Health Option
EFT	Electronic funds transfer
EFMP	Exceptional Family Member Program
EHHC	ECHO Home Health Care
EOB	Explanation of benefits
FDA	U.S. Food and Drug Administration
FEHB	Federal Employees Health Benefits
FY	Fiscal year
HMO	Health maintenance organization
HNPCC	Hereditary non-polyposis colorectal cancer
HPV	Human papillomavirus
ID	Identification
MD	Doctor of medicine
MRI	Magnetic resonance imaging
MTF	Military treatment facility
OHI	Other health insurance
PHP	Partial hospitalization program
RTC	Residential treatment center
SEOB	Summary explanation of benefits
SSN	Social Security number
SUDRF	Substance use disorder rehabilitation facility
TAMP	Transitional Assistance Management Program
TDP	TRICARE Dental Program
TFL	TRICARE For Life
TOP	TRICARE Overseas Program
TPR	TRICARE Prime Remote
TRDP	TRICARE Retiree Dental Program
TRR	TRICARE Retired Reserve
TRS	TRICARE Reserve Select
TSC	TRICARE Service Center
TYA	TRICARE Young Adult
VA	U.S. Department of Veterans Affairs

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Notes

Important Contact Information

Use this page as a guide for the most important resources available to you.

TRICARE® Web site: **www.tricare.mil**

TRICARE Regional Contractors		
TRICARE North Region	**TRICARE South Region**	**TRICARE West Region**
Health Net Federal Services, LLC 1-877-TRICARE (1-877-874-2273) www.hnfs.com	**Humana Military Healthcare Services, Inc.** 1-800-444-5445 Humana-Military.com	**TriWest Healthcare Alliance** 1-888-TRIWEST (1-888-874-9378) www.triwest.com
TRICARE Overseas Program		
International SOS Assistance, Inc. TRICARE Overseas Program Web site: www.tricare-overseas.com		
TRICARE Eurasia-Africa:[1] 1-877-678-1207	**TRICARE Latin America and Canada:**[1] 1-877-451-8659	**TRICARE Pacific:**[1] 1-877-678-1208 (*Singapore*) 1-877-678-1209 (*Sydney*)

*1. For additional overseas contact information, visit **www.tricare-overseas.com***

Defense Enrollment Eligibility Reporting System (DEERS)

DEERS is a database of uniformed service members (*sponsors*), family members, and others worldwide who are entitled under law to military benefits, including TRICARE. Sponsors are required to keep DEERS updated, including their residential and mailing address for themselves and eligible dependents. For more information, visit **www.tricare.mil/deers**.

You have several options for updating and verifying DEERS information:

In Person	Phone
Visit a local uniformed services identification card-issuing facility. Find a facility near you at **www.dmdc.osd.mil/rsl**. Call to verify location and business hours.	1-800-538-9552 1-866-363-2883 (*TDD/TTY*)
Online	**Fax**
Visit the milConnect Web site at **http://milconnect.dmdc.mil**. Visit **www.tricare.mil/bwe** to access the Beneficiary Web Enrollment (BWE) Web site.	1-831-655-8317
	Mail
	Defense Manpower Data Center Support Office 400 Gigling Road Seaside, CA 93955-6771

Health Care Claims

You can download forms and instructions from the TRICARE Web site at **www.tricare.mil/claims** or from your regional contractor's Web site. Submit claims to the addresses provided. You can also check the status of your claims at the Web sites provided.

TRICARE North Region	TRICARE South Region	TRICARE West Region
Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740 www.myTRICARE.com www.hnfs.com	TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 www.myTRICARE.com Humana-Military.com	West Region Claims P.O. Box 77028 Madison, WI 53707-1028 www.triwest.com

Premium-Based TRICARE Standard Health Plans

TRICARE Reserve Select	www.tricare.mil/trs
TRICARE Retired Reserve	www.tricare.mil/trr
TRICARE Young Adult Standard	www.tricare.mil/tya

TRICARE Pharmacy Program

Find a TRICARE retail network pharmacy, register for TRICARE Pharmacy Home Delivery, or find information on how to save money and make the most of your pharmacy benefit. Visit **www.tricare.mil/pharmacy** for more information. TRICARE has partnered with Express Scripts, Inc. to provide your pharmacy benefit.

Express Scripts, Inc.		
www.express-scripts.com/TRICARE 1-877-363-1303 1-877-540-6261 (*TDD/TTY*) Member Choice Center (*convert retail prescriptions to home delivery*): 1-877-363-1433	**TRICARE Pharmacy Home Delivery** To register for TRICARE Pharmacy Home Delivery, download the *Express Scripts New Patient Home Delivery Form* from **www.express-scripts.com/TRICARE**, complete it, and mail it to: Express Scripts, Inc. P.O. Box 52150 Phoenix, AZ 85072-9954	**TRICARE Retail Network Pharmacy** Send pharmacy claims to: Express Scripts, Inc. TRICARE Claims P.O. Box 66518 St. Louis, MO 63166-6518
Prescription Drug Formulary Search		
www.pec.ha.osd.mil/formulary_search.php		

TRICARE Dental Options

Visit **www.tricare.mil/dental** for information on all of TRICARE's dental program options.

TRICARE Dental Program	TRICARE Retiree Dental Program
https://mybenefits.metlife.com/tricare	www.trdp.org

Other Resources

TRICARE Forms	www.tricare.mil/forms
TRICARE Costs	www.tricare.mil/costs
Fraud and Abuse Reporting	www.tricare.mil/fraud
TRICARE Behavioral Health	www.tricare.mil/mentalhealth
Extended Care Health Option	www.tricare.mil/echo

TRICARE Expectations for Beneficiaries

According to the Department of Defense (DoD), as a TRICARE beneficiary, you should expect to have the following abilities and support:

- **Get information:** You should expect to receive accurate, easy-to-understand information from written materials, presentations, and TRICARE representatives to help you make informed decisions about TRICARE programs, medical professionals, and facilities.
- **Choose providers and plans:** You should expect a choice of health care providers that is sufficient to ensure access to appropriate high-quality health care.
- **Emergency care:** You should expect to access medically necessary and appropriate emergency health care services as is reasonably available when and where the need arises.
- **Participate in treatment:** You should expect to receive and review information about the diagnosis, treatment, and progress of your conditions, and to fully participate in all decisions related to your health care, or to be represented by family members or other duly appointed representatives.
- **Respect and nondiscrimination:** You should expect to receive considerate, respectful care from all members of the health care system without discrimination based on race, color, national origin, or any other basis recognized in applicable law or regulations.
- **Confidentiality of health information:** You should expect to communicate with health care providers in confidence and to have the confidentiality of your health care information protected to the extent permitted by law. You also should expect to have the ability to review, copy, and request amendments to your medical records.
- **Complaints and appeals:** You should expect a fair and efficient process for resolving differences with health plans, health care providers, and institutions that serve you.

Additionally, the DoD has the following expectations of you as a TRICARE beneficiary:

- **Maximize your health:** You should maximize healthy habits, such as exercising, not smoking, and maintaining a healthy diet.
- **Make smart health care decisions:** You should be involved in health care decisions, which means working with providers to provide relevant information, clearly communicate wants and needs, and develop and carry out agreed-upon treatment plans.
- **Be knowledgeable about TRICARE:** You should be knowledgeable about TRICARE coverage and program options.
- **You also should:**
  - Show respect for other patients and health care workers
  - Make a good-faith effort to meet financial obligations
  - Use the disputed claims process when there is a disagreement

TRICARE North Region
Health Net Federal Services, LLC
www.hnfs.com
1-877-TRICARE (1-877-874-2273)

TRICARE South Region
Humana Military Healthcare Services, Inc.
Humana-Military.com
1-800-444-5445

TRICARE West Region
TriWest Healthcare Alliance
www.triwest.com
1-888-TRIWEST (1-888-874-9378)

www.tricare.mil

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